
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
WILLIAMSON COUNTY
EMPLOYEE BENEFIT PLAN**

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INTRODUCTION

This document is a description of the Williamson County Employee Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Open Enrollment. Explains open enrollment.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Prescription Drug Benefits. Explains when the benefit applies, the types of charges covered and charges not covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

SCHEDULE OF BENEFITS

Verification of Eligibility 800-798-2422

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: Some services must be pre-certified or reimbursement from the Plan may be reduced or denied. Please refer to the back of your ID card for services and contact information.

Nationwide Better Health
866-224-8418

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for vaginal delivery or 96 hours or less for a cesarean delivery.

Please see the Cost Management section in this booklet for details.

This Plan is a plan which contains a Preferred Provider Organization.

PPO: PHCS
Telephone: (888) 523-7427

TPA: Consociate Dansig
151 East Decatur Street
Decatur, Illinois 62525-1068
Telephone: (800) 798-2422
www.consociatedansig.com

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed.

DEDUCTIBLE PLAN
Summary of Benefits

	IN NETWORK	OUT OF NETWORK
CALENDAR YEAR MAXIMUM	\$1,000,000	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	\$420	\$630
Per Family Unit	\$1,050	\$1,575
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	\$1,575	Unlimited
Per Family Unit	\$3,150	Unlimited
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: Deductibles Cost containment penalties Spinal manipulation/chiropractic charges Co-payments Amounts over Usual and Reasonable Charges Out of Network Out of Pocket Expenses Pharmacy Co-Payments		
COVERED CHARGES (NOTE: Please see the Cost Management Services Section for IMPORTANT pre-certification requirements)		
Note: The maximums listed below are the total for In Network and Non-Network expenses. For example, if a maximum of 100 days is listed twice under a service, the Calendar Year maximum is 100 days total which may be split between Network and Non-Network providers.		
Hospital Services		
Room and Board	90% after deductible the semiprivate room rate	50% after deductible the semiprivate room rate
Intensive Care Unit	90% after deductible Hospital's ICU charge	50% after deductible Hospital's ICU charge
Emergency Room	\$105.00 co-pay, then 90% after deductible	\$105.00 co-pay, then 50% after deductible
The Emergency Room Co-Payment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator, Nationwide Better Health, must be notified at (866) 224-8418 within 72 hours of the admission, even if the patient is discharged within 72 hours of the admission.		
Urgent Care Facility	90% after deductible	50% after deductible
Skilled Nursing Facility	90% after deductible facility's semiprivate room and board rate within 14 days of a Hospital Confinement day stay 100 days Calendar Year Maximum	50% after deductible facility's semiprivate room and board rate within 14 days of a Hospital Confinement day stay 100 days Calendar Year Maximum

	IN NETWORK	OUT OF NETWORK
Physician Services		
Inpatient Visits	90% after deductible	50% after deductible
Office visits	90% after deductible	50% after deductible
Surgery	90% after deductible	50% after deductible
Allergy testing	90% after deductible	50% after deductible
Allergy serum and injections	90% after deductible	50% after deductible
Diabetic Training/Counseling	90% after deductible \$250 Lifetime Maximum	50% after deductible \$250 Lifetime Maximum
Rehabilitation Therapy	90% after deductible 45 outpatient visits Calendar year Maximum	50% after deductible 45 outpatient visits Calendar year Maximum
Home Health Care	90% after deductible 30 visits Calendar year Maximum	50% after deductible 30 visits Calendar year Maximum
Outpatient Private Duty Nursing	90% after deductible 30 visits Calendar year Maximum	50% after deductible 30 visits Calendar year Maximum
Hospice Care	90% after deductible	50% after deductible
Ambulance Service	90% after deductible	50% after deductible
Jaw Joint/TMJ	90% after deductible \$1,000 Lifetime maximum	50% after deductible \$1,000 Lifetime maximum
Wig After Chemotherapy One per lifetime Maximum	90% after deductible	50% after deductible
Occupational Therapy	90% after deductible	50% after deductible
Speech Therapy	90% after deductible	50% after deductible
Physical Therapy	90% after deductible	50% after deductible
Durable Medical Equipment	90% after deductible	50% after deductible
Prosthetics	90% after deductible	50% after deductible
Orthotics	90% after deductible \$1,000 Calendar Year Maximum	50% after deductible \$1,000 Calendar Year Maximum
Foot Orthotics (Non Rigid)	90% after deductible \$1,000 Lifetime Maximum	50% after deductible \$1,000 Lifetime Maximum
Spinal Manipulation Chiropractic \$500 Calendar Year Maximum	90% after deductible	50% after deductible
Mental Disorders		
Inpatient	90% after deductible	50% after deductible
Partial Hospitalization	90% after deductible	50% after deductible
Outpatient	90% after deductible	50% after deductible
Substance Abuse		
Inpatient	90% after deductible	50% after deductible
Partial Hospitalization	90% after deductible	50% after deductible
Outpatient	90% after deductible	50% after deductible

	IN NETWORK	OUT OF NETWORK
Preventive Care		
Routine Well Adult Care	100% up to \$350, then 90% after deductible	50% after deductible
Includes: office visits, flu shots, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests and immunizations through age 19, shingles vaccine, pneumococcal vaccine		
Frequency for single baseline mammograms shall follow the American Cancer Society Guidelines: Ages 20 through 40. every three years Ages 40 and over annually		
Routine Well Newborn Care (applies to ages from birth to 12 months of age)	100% up to \$350, then 90% after deductible	50% after deductible
Routine Well Child Care (applies to ages 1 to age 19)	100% up to \$350, then 90% after deductible	50% after deductible
Includes: office visits, flu shots, routine physical examination, laboratory blood tests, x-rays and immunizations through maximum age listed in eligibility section.		
Organ Transplants	90% after deductible	50% after deductible
Dialysis and Outpatient Dialysis Services	Charges are subject to deductible and payment will not exceed 100% of the Medicare allowed amount.	
Infertility Services (Diagnostic Evaluation Only)	90% after deductible	50% after deductible
Pregnancy Dependent daughters not covered	90% after deductible	50% after deductible
All Other Covered Services	90% after deductible	50% after deductible

CO-PAY PLAN
Summary of Benefits

NETWORK PROVIDERS	
Calendar Year Maximum Benefit	\$1,000,000
Hospital Services	\$368 Co-Pay
OutPatient Services Provided at an OutPatient Facility. (Includes but not limited to MRI, CT, PET scans and Sleep Studies)	\$262 Co-Pay
Physician Visits (PCP)	\$25 Co-Pay
Specialist Visit	\$40 Co-Pay
Urgent Care Facility	\$55 Co-Pay
Emergency Room	\$105 Co-Pay
The Emergency Room Co-Pay is waived if the patient is admitted to the Hospital on an emergency basis. The Utilization Review Administrator, Nationwide, must be notified at 866-224-8418 within 72 hours of the admission even if the patient is discharged within 72 hours of the admission.	
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	
Amounts that track towards the Out of Pocket Maximums are services that do not have a co-pay applied.	
Per Covered Person	\$2,100
Per Family Unit	\$4,200
The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year unless stated otherwise.	
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: Cost containment penalties Amounts over Usual and Reasonable Charges Medical and Pharmacy Co-Payments	
Covered Charges	
Room and Board	\$368 Co-Pay
Intensive Care Unit	\$368 Co-Pay
Skilled Nursing Facility	\$367 Co-Pay Immediately following Hospital stay
Home Health Care	\$40 Co-Pay 100 visits per calendar year
Hospice Care	\$368 Co-Pay
Outpatient Private Duty Nursing	\$40 Co-Pay 100 visits per calendar year
Ambulance Service	100%
Jaw Joint/TMJ	100% after \$25 co-pay with Primary Care Physician and \$40 co-pay with Specialist
Wig After Chemotherapy	80% One per lifetime maximum
Occupational Therapy	100% after \$25 co-pay with Primary Care Physician and \$40 co-pay with Specialist
Speech Therapy	100% after \$25 co-pay with Primary Care Physician and \$40 co-pay with Specialist
Physical Therapy	100% after \$25 co-pay with Primary Care Physician and \$40 co-pay with Specialist
Durable Medical Equipment (external devices)	80%
Prosthetics (external devices)	80%

	NETWORK PROVIDERS
Orthotics (external devices)	80% \$1,500 Calendar Year Maximum
Spinal Manipulation/Chiropractic	\$40 co-pay with \$35 per visit maximum 10 visits per calendar year maximum
Mental Disorders	
Inpatient	\$368 Co-Pay
Partial Hospitalization	\$368 Co-Pay
Outpatient	\$40 Co-Pay
Substance Abuse	
Inpatient	\$368 Co-Pay
Partial Hospitalization	\$368 Co-Pay
Outpatient	\$40 Co-Pay
Preventative Care	
Routine Well Adult Care	100% after co-pay
Includes: office visits, flu shots, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests and immunizations/flu shots, shingles vaccine, pneumococcal vaccine	
Frequency for single baseline mammograms shall follow the American Cancer Society Guidelines:	
Ages 20 through 40. every three years	
Ages 40 and over annually	
Routine Well Newborn Care (applies to ages from birth to 12 months of age)	100% after co-pay
Routine Well Child Care (applies to ages 1 to age 19)	100% after co-pay
Includes: office visits, routine physical examination, laboratory blood tests, x-rays and immunizations through maximum age listed in eligibility section.	
Organ Transplants	100% after co-pay
Infertility Services (Diagnostic Evaluation only)	100% after co-pay
Pregnancy Dependent daughters covered for complications only.	100% after co-pay
Dialysis and Outpatient Dialysis Centers	\$25 co-pay shall apply and payment will not exceed 100% of the Medicare allowed amount
Medical Supplies	80%
Allergy Testing and Serum	\$25 co-pay at primary care physician \$40 co-pay at specialist
Vision Care	100% after \$25 or \$40 Specialist co-pay eye exam in 12 month period (Exams only)

Benefits are not payable for Out-Of-Network Providers. Services will be covered at Out-of-Network Providers for emergency care only.

Co-Pay members must choose a Primary Care Physician (PCP). Referrals are not required to see an In-Network Specialist. A higher co-pay applies for all Specialist visits.

PRESCRIPTION DRUG BENEFIT
Summary of Benefits

Prescription coverage is included with enrollment in either the Co-Pay or Deductible medical program programs.

Maintenance Choice and Mandatory Mail Order Prescription Drug Benefit:
(90 day supply)

You can choose to receive Maintenance Prescriptions through the CVS Caremark mail service program or pick them up at a CVS/pharmacy near you. Whether you choose mail service delivery or pick-up at a CVS/pharmacy, you will pay the same co-pay. Maintenance Prescriptions are prescription drugs used on an ongoing basis. You are allowed 2 30-day fills at a network retail pharmacy for each prescription. After these 2 fills, you will need to have 90-day supply prescriptions filled at a CVS/pharmacy or through the CVS Caremark mail order program.

Generic drugs
Copayment..... \$15

Formulary Brand Name drugs (Brand Name drugs on the Performance Drug List)
Copayment..... \$45

Non-Formulary Brand Name drugs (Brand Name drugs not on the Performance Drug List)
Copayment..... \$80

PHARMACY OPTION
(30 day supply)

For immediate and short term prescriptions. 2 30-day fills will be allowed for maintenance prescriptions at a network retail pharmacy, after 2 fills mail order is mandatory.

Generic drugs
Copayment..... \$15

Formulary Brand Name drugs (Brand name drugs on the Performance Drug List)
Copayment..... \$25 or 25% whichever is higher

Non-Formulary Brand Name drugs (Brand Name drugs not on the Performance Drug List)
Copayment..... \$40 or 40% whichever is higher

Maximum \$100 co-pay per prescription when purchased at retail pharmacy

Mandatory Generic Fill.

When a Generic is available and the brand name is chosen over the generic drug, the member will pay the prescription co-payment plus the difference in the drug cost.

Caremark Specialty Pharmacy.

Specialty medications are required to be purchased through Caremark's Specialty Pharmacy. Specialty medications include biopharmaceuticals, blood-derived products, complex molecules, select oral, infused and injectable medications. For further information regarding the Specialty Program, please contact 1-866-295-2779.

VISION CARE BENEFITS

Co-Pay Plan Only

Vision Care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

Benefit Payment

Benefit payment for a Covered Person will be made as described in the Summary of Benefits.

Vision Care Charges

Vision care charges are the Usual and Reasonable Charges for the vision care services and supplies shown in the Summary of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Summary of Benefits for each vision care service or supply.

Limits

No benefits will be payable for the following:

- (1) **Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under the Plan.
- (2) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.
- (3) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.
- (4) **No Prescription.** Charges for lenses ordered without a prescription.
- (5) **Orthoptics.** Charges for orthoptics (eye muscle exercises).
- (6) **Sunglasses.** Charges for safety goggles or sunglasses, including prescription type.
- (7) **Training.** Charges for vision training or subnormal vision aids.
- (8) **Hardware.** Exams only covered.

**WRAP AROUND PLAN HRA
Summary of Benefits**

MAXIMUM Annual Benefit	\$1,500 Individual \$3,000 Family
Co-Insurance (\$1,500 Annually)	100% of the first \$500 of eligible expenses (\$500 Maximum) 50% of the next \$1,000 of eligible expenses (\$500 Maximum)
Eligible Expenses	Eligible expenses must be covered expenses under the primary insurance carrier, including: Deductible Co-Insurance Physician co-pays Prescription co-pays
Wellness (\$500 Annually)	100% up to \$500 of eligible expenses not paid by the primary insurance carrier per family member
Eligible Wellness Expenses	PSA Pap Smears Mammograms Child Immunizations Well Exam Lab Work Well Baby check-Ups Adult Routine Physicals Reimbursement for wellness expenses may be allowed when a primary carrier excluded wellness benefits from their plan
Eligibility	The above schedule of benefits is only applicable for expenses incurred by the employee and eligible dependents who are covered by a primary insurance plan.
Ineligible Services	Services not covered by the other insurance plan. Charges above Usual and Customary fees.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active, Elected Officials and Retired Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

- (1) is a Retired Employee of the Employer if the following criteria are met:
 - (a) Employee must have a hire date prior to July 1, 2009;
 - (b) Employee and/or dependents coverage must have been in effect a minimum of one year prior to retirement;
 - (c) Employee must have ten continuous years of full-time service with Williamson County Government or the Board of Education and be 55 on his/her date of retirement (or) the Employee must have 30 continuous years of full-time service with Williamson County Government or the Board of Education and will be allowed continuation of coverage at retirement regardless of age. Leave of absences that occur during this period will be handled in accordance with state and federal laws.
- (2) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 32 hours per week and is on the regular payroll of the Employer for that work.
- (3) is in a class eligible for coverage, or an Elected Official of the Board of Education or Williamson County Government.

An elected official will be identified in the "elected officials" class of coverage unless he/she is covered as an Employee or dependent for either Williamson County Government or the Board of Education.

If the elected official has other coverage available through the course of his/her regular job or otherwise, the County's Plan will be considered a secondary coverage plan and coordination of benefit will apply.

Tennessee Code Annotated Sections 8-27-301, 8-27-501 and 8-27-601 authorize such coverage for elected officials of the County and Board of Education.

- (4) completes the employment Waiting Period of 30 consecutive days as an Active Employee. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse and children from birth to the limiting age of 26 years, except that a child age 18 and through 25 shall not be eligible for coverage under the Plan if eligible to enroll in a group health plan of the child's employer.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children, adopted children, Foster Children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

- (2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

A child age 18 through 25 shall not be eligible for coverage under the Plan if eligible to enroll in a group health plan of the child's employer. At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Working Spouse Rule. If an Employee's spouse declines health coverage through his or her employer and elects coverage under the Williamson County Employee Benefit Plan, the Employee will be charged the designated contribution set by Williamson County for the number of dependents enrolled plus an additional \$100 monthly surcharge for the enrollment of the spouse.

If the Employee's spouse does not have health coverage through his or her employer and the Employee elects to cover the spouse under the Williamson County Medical benefits Program, only the designated contribution will apply.

A spouse enrolled in the Williamson County Employee Benefit Plan with coverage effective on or before January 1, 2007, will not be subject to the surcharge for the duration of his or her continued enrollment period thereafter. If said spouse terminates coverage from the Williamson County Employee Benefit Plan on or after January 2, 2007, and re-enrolls at a later time with Employer coverage available, the Employee will pay the surcharge in addition to the designated contribution. Enrollment of a spouse that has Employer coverage available on or after January 2, 2007, will be subject to the surcharge in addition to the designated contribution under the circumstances described above.

Enrollment of a Spouse on or after January 2, 2007. If the Employee's spouse is enrolled under both his or her employer's plan and the Williamson County Employee Benefit Plan, the Employee will not be charged the additional surcharge so long as the spouse's coverage with his or her employer is considered the spouse's primary coverage and the Williamson County Employee Benefit Plan is considered excess only.

Falsification of information regarding the spouse's available coverage will result in, at a minimum, the additional premium surcharge being assessed retro-actively back to the date of the spouse's enrollment in the Plan and/or termination from the Plan. In addition, willful provision of false information may result in disciplinary action against the Employee up to and including termination. Employees enrolling a spouse on or after January 2, 2007 will be required to furnish verification from the spouse's employer regarding insurance status before coverage will become effective under the Williamson County Employee Benefit Plan.

FUNDING

Cost of the Plan. Williamson County pays the entire cost of Employee coverage under this Plan.

Williamson County shares the cost of Dependent coverage under this Plan with the covered Employees.

Williamson County also shares the cost of retiree coverage under the Plan with retirees. Retirees will contribute 20% of the expected cost as reported by the renewal notification furnished July 1st of each year.

Employee contribution may be changed January 1st of each year or at any time by the discretion of the Williamson County Commission.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

PRE-EXISTING CONDITIONS

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan even if that coverage is still in effect. The Plan will reduce the length of the Pre-Existing Condition Limitation period by each day of Creditable Coverage under this or a prior plan; however, if there was a significant break in the Creditable Coverage of 63 days or more, then only the coverage in effect after the break will be counted.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

A Covered Person will be provided a certificate of Creditable Coverage from this Plan if he or she requests one either before losing coverage or within 24 months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred 12 consecutive months after the person's Enrollment Date. This time, known as the Pre-Existing Conditions Limitation period, may be offset if the person has Creditable Coverage from his or her previous plan.

A Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within 6 months prior to the person's Enrollment Date under this Plan. Genetic information is not, by itself, a condition. Treatment includes receiving services and supplies, consultations,

diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

This Pre-Existing Condition exclusion does not apply to Pregnancy or to Covered Persons who are under age 19.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

For coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, the newborn child must be enrolled as a Dependent under this Plan within 31 days of the child's birth in order for non-routine coverage to take effect from the birth.

TIMELY ENROLLMENT

Timely Enrollment - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (father and mother) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Williamson County, 1320 West Main, Franklin, Tennessee, 37064, (615) 595-1270.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the

first day of coverage is not treated as a Waiting Period. This means that any Pre-Existing Condition will be determined on the basis of the look back period prior to the Enrollment Date, and the period of the Pre-Existing Conditions Limitation will start on the Enrollment Date.

- (1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:
- (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.
 - (d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
 - (e) For purposes of these rules, a loss of eligibility occurs if:
 - (i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).
 - (ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
 - (iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
 - (iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) **Dependent beneficiaries.** If:

- (a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

- (3) **Medicaid and CHIP.** An eligible Employee and/or his eligible Dependents whose coverage under a Medicaid Plan under title XIX of the Social Security Act or under a state Child Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, may be eligible for coverage under this Plan. A request for enrollment must be made within 60 days of the date coverage ends.

Should an eligible Employee and/or his or her eligible Dependent become eligible for state premium assistance through Medicaid or a state Child Health Insurance Program (CHIP), he or she may have a right to enroll in this Plan. A request for enrollment must be made within 60 days of the date the Employee or Dependent is determined eligible for such assistance. Contact the Plan Administrator if you have questions regarding application of this provision.

Coverage will begin the first of the month following the date the completed enrollment form is received.

- (4) **Overage Children.** Children whose coverage ended, or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage ended before age 26 are eligible to enroll in the Plan during the month of November, 2010 with coverage to be effective as of January 1, 2011.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) or Elected Official for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan is terminated.
- (2) The date the covered Employee's Eligible Class is terminated.
- (3) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or layoff, unless the Plan specifically provides for continuation during these periods.
- (4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Continuation During Periods of Employer-Certified Disability, Leave of Absence, or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence, or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work and continues his COBRA coverage until he again becomes eligible for coverage as an Employee, any Pre-Existing Conditions Limitations provision will apply only to the extent it was in effect on the last day of COBRA coverage.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage is not required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If you wish to elect this coverage or obtain more detailed information, contact the Plan Administrator Williamson County, 1320 West Main, Franklin, Tennessee 37064, 615-595-1270. In general, you must meet the same requirements for electing USERRA coverage as are required by COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) On first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

OPEN ENROLLMENT

OPEN ENROLLMENT

During the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods and Pre-Existing Conditions Limits will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

The amount will not accrue toward the 100% maximum out-of-pocket payment.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Calendar Year Maximum Benefit Amount or any listed limit of the Plan. Amounts paid under the Plan shall apply to both the Deductible Plan and Co-Pay Plan options.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

BENEFITS

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

- (2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may 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 vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your plan administrator.

There is no coverage of Pregnancy for a Dependent child except as noted under the Co-Pay Plan Summary of Benefits.

(3) Skilled Nursing Facility Care. The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- (a)** the patient is confined as a bed patient in the facility; and
- (b)** the confinement starts within 14 days of a Hospital confinement; and
- (c)** the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- (d)** the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Coverage Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(4) Physician Care. The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

- (a)** If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
- (b)** If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and
- (c)** If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

(5) Private Duty Nursing Care. The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
 - (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not custodial in nature. The only charges covered for outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour shift basis is not covered.
- (6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide, and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

- (7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

- (8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

- (a) **Agricultural** Injuries and Illnesses. Any Injury and Illnesses arising from activities involved in the raising of live stock or crops for wage or profit, must be on the property owned and/or operated by the Employee or covered Spouse. Only those Participants under the Plan at the time of Injury or Illness will be covered for such Injuries or Illnesses.
- (b) Local Medically Necessary professional land **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- (c) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (d) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan. This Plan covers Phase I and II cardiac rehabilitation services only.
- (e) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (f) Initial **contact lenses** or glasses required following cataract surgery.
- (g) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

- (h) Medically Necessary services for care and treatment of **jaw joint conditions**, including **Temporomandibular Joint Syndrome (TMJ)**.

Charges for TMJ are subject to the limits as described in the Summary of Benefits.

- (i) **Laboratory studies.**

- (j) **Medical Supplies** such as crutches, dressings, splints, casts, colostomy bags and other similar items which serve only a medical purpose. Items usually stocked in the home such as band-aids, thermometers, and petroleum jelly are not a covered expense.

- (k) Treatment of **Mental Disorders and Substance Abuse**. Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

- (l) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures. Removal of impacted teeth is not covered under the Medical Benefits Plan.

- (m) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

- (n) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

- (o) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness, subject to the limits as described in the Summary of Benefits.
- (p) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.
- (q) **Prescription Drugs** (as defined).
- (r) Routine **Preventive Care**. Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

- (s) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.
- (t) **Reconstructive Surgery**. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

- (u) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.
- (v) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.
- (w) **Sterilization** procedures.
- (x) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (y) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2)

enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the benefits of the newborn child.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may 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 vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your plan administrator.

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for the first pediatric visit to the newborn child after birth while Hospital confined.

Charges for covered routine Physician care will be applied toward the benefit of the newborn child.

- (z) Charges associated with the initial purchase of a **wig after chemotherapy**.
- (aa) Diagnostic **x-rays**.

SURVIVORSHIP BENEFITS

Upon the death of an active Employee who is not eligible for retirement, the surviving Dependents will be allowed to continue medical and dental coverage at no cost for a period of one year. After one year, coverage may be extended as allowed under COBRA continuation,

If both a husband and wife are County Employees, this policy will apply only for the death of the spouse responsible for the Dependent coverage premium. However, at the end of the year, the surviving spouse may elect to pay the Dependent premium if he/she is still a full-time County Employee and desires Dependent coverage.

In the event of the death of a retired Employee, the surviving spouse and/or Dependents will be permitted to continue medical coverage. The surviving spouse may continue for life if payments are continued. Dependents must meet eligibility requirements and also must continue payments. The rate charged for continuation of coverage for the surviving spouse and/or Dependents will be determined by the County,

The surviving Dependents of a deceased active employee who was eligible for retirement should not lose the protection that would have been afforded them had the Employee not continued his/her service to the County. The survivors of these Employees will be given the opportunity to select either of the aforementioned plans. The selection must be made within sixty (60) days of the date of notification from the Benefits Department and may not be changed at a later date.

It should be noted that this includes medical, dental and prescription coverage. Life insurance is not included. Any changes made in the medical plans for active County Employees may affect the coverage of survivors.

RETIREE COVERAGE

Purpose: To provide health benefits to those Employees who have provided years of service to the citizens of Williamson County. Also, to ensure coverage for the eligible Dependents of said Employees.

Eligibility: Employees who meet the retirement criteria established by Williamson County and have applied for retirement on or after July 1, 1995, are eligible for retirement benefits. Employees who qualified and chose to retire prior to July 1, 1995, may qualify for continued medical coverage if they return to full time employment and complete one full year of service. To be eligible for benefits as a retiree, the following criteria must be met:

- (1) Employee must have a hire date prior to July 1, 2009
- (2) Employee and/or dependents coverage must have been in effect a minimum of one year prior to retirement.
- (3) Employee must have ten continuous years of full-time service with Williamson County Government or the Board of Education and be age fifty-five (55) on his/her date of retirement (or) the Employee must have thirty (30) continuous years of full-time service with Williamson County Government or the Board of Education and will be allowed continuation of coverage at retirement regardless of age. Leave of absences that occur during this period will be handled in accordance with state and federal laws.

Dependents must be enrolled in the County's medical plan for a minimum of twelve months before an Employee retires in order to be eligible for continued coverage. Dependents who have been enrolled in the plan for less than twelve months are not eligible for continued benefits and no Dependents may be added after retirement.

Exceptions: Employees who retire from the County and become eligible for group medical insurance due to accepting employment with another employer will be provided secondary medical coverage under the County's Plan. The new employer's medical plan will pay "first dollar" on all medical claims. Retired Employees who are eligible for medical coverage through a spouse's employment are not subject to this restriction.

When a retired Employee becomes eligible for Medicare, the County Plan will become the secondary plan with Medicare paying "first dollar" on all medical claims.

Employees who are discharged for "gross misconduct" are not eligible for Retiree Health Insurance.

A retired Employee may change from Dependent coverage to individual coverage after retirement. However, he/she may not change to Dependent coverage once individual coverage has been selected.

The payment schedule will be determined by the Benefits office and the retired Employee. However, payments should remain current to the month of coverage. Failure to make timely payments of administration fees and premiums could result in a loss of coverage.

It is the intent of Williamson County to provide continuing medical and life insurance for retired Employees and their Dependents. However, this intent does not imply a contract with retired Employees. The County, through the County Commission, reserves the right to change, alter, or eliminate this coverage at any time.

Continuation of Retiree Health Insurance. Employees hired on or after July 1, 2009 and elected officials elected or appointed on or after July 1, 2009, shall not be eligible to receive group hospitalization, medical, and life insurance benefits at retirement. Those employees hired on or after July 1, 2009 or officials elected or appointed after July 1, 2009 shall have the option to continue benefits through COBRA as permitted by law at the time of Retirement or termination of employment, but shall not be eligible for the benefits extended by Resolutions 7-95-18 and 1-01-27.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

National Better Health
(866) 224-8418

The patient or family member should call this number to receive certification of certain Cost Management Services. This call must be made at least 24 hours in advance of services being rendered or within 48 hours after an emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Pre-certification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Inpatient Hospitalizations
Substance abuse/Mental Illness Treatments

- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis as well as pre-procedure review for the following outpatient surgeries or treatment;

Blepharoplasty
Mammoplasty
Mandibular reconstruction, osteotomy/jaw surgery
Maxillary osteotomy, orthognathic jaw surgery
Rhinoplasty
Septoplasty
Uvulopalatopharyngoplasty/Uvulectomy (UPPP)
Uvulopalatoplasty, laser assisted/LAUP
Varicose Vein Surgery
Excision of benign skin lesion(s)
Excision of warts
Strabismus surgery
Potential organ transplant
Acute rehabilitation
Hospice Care
PET scans
Home Health Care, Infusion IV/Intravenous therapy
Cardiac rehab, pulmonary rehab
Durable medical equipment and supplies including oxygen equipment, CPAP, concentrators
Physical therapy

Upon notification, the Utilization review Administrator will review for the following:

- (1) the Medical Necessity for the treatment;
 - (2) the appropriateness of the place of treatment for the Sickness or Injury;
 - (3) the duration of the treatment; and
 - (4) the extension, if necessary, of a previously reviewed Hospital treatment.
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Pre-certification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card at least 24 hours before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an emergency admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator within 48 hours of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by \$500. This only applies for failure to pre-certify inpatient admissions.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

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

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

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

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

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee, Elected Official, Retiree, or Dependent who is covered by this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dialysis Treatment is the process of removing solutes that accumulate as a result of diminished renal function. This process removes waste products from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. Dialysis is typically indicated in the management of patients with end stage renal disease (ESRD). Dialysis may also be required because of temporary kidney failure due to sudden trauma. Types of Dialysis services include Hemodialysis, Intermittent Peritoneal Dialysis, Continuous Ambulatory Peritoneal Dialysis, and Continuous Cycler-assisted Peritoneal Dialysis.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. It also includes, where appropriate, an Elected Official or Retiree.

Employer is Williamson County, Tennessee.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

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

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

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

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

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

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

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

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

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is

primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy except for the Pregnancy of a dependent child.

Injury means an accidental physical Injury to the body caused by unexpected external means.

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

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

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

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Williamson County Employee Benefit Plan, which is a benefits plan for certain Employees of Williamson County and is described in this document.

Plan Participant is any Employee, Elected Official, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on July 1 and ending on the next June 30.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

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

Retired Employee is a former Active Employee of the Employer who was retired while employed by the employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Sickness is a person's Illness, disease or Pregnancy (including complications). For a covered Dependent other than Spouse, a Sickness does not include Pregnancy or its complications, except as specifically provided herein.

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

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

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

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

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered.
- (2) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (3) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.
- (4) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (5) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (6) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (7) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (8) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (9) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.
- (10) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
- (11) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- (12) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (13) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.
- (14) **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are skydiving, auto racing, hang gliding, jet ski operating or bungee jumping.

- (15) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.
- (16) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (17) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (18) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (19) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.
- (20) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.
- (21) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.
- (22) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (23) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.
- (24) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (25) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (26) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (27) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (28) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Medically Necessary non-surgical charges for Morbid Obesity will be covered.

- (29) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.
- (30) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (31) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (32) **Pregnancy of daughter.** Care and treatment of pregnancy and complications of pregnancy for a dependent daughter only, except as provided in the Co-Pay Plan Summary of Benefits.
- (33) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (34) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (35) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
- (36) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (37) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (38) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (39) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
- (40) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung illness such as emphysema or asthma.
- (41) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (42) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.
- (43) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Caremark is the administrator of the pharmacy drug plan. Their Customer Service number is 800-966-5772.

Copayments

The copayment is applied to each covered pharmacy drug charge and is shown in the schedule of benefits. The copayment amount is not a covered charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Mandatory Mail Order Drug Benefit:

(90 days supply)

You can choose to receive Maintenance Prescriptions through the CVS Caremark mail service program or pick them up at a CVS/pharmacy near you. Whether you choose mail service delivery or pick-up at a CVS/pharmacy, you will pay the same copay. Maintenance Prescriptions are prescription drugs used on an ongoing basis. You are allowed 2 30-day fills at a network retail pharmacy for each prescription. After these 2 fills, you will need to have 90-day supply prescriptions filled at a CVS/pharmacy or through the CVS Caremark mail order program.

Covered Prescription Drugs

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician. Other injectables are not covered.
- (4) Disposable insulin needles/syringes.
- (5) Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Clinitest tablets, Diastix Strips and Tes-Tape).
- (6) Disposable insulin needles/syringes and/or disposable diabetic testing syringes when prescribed and dispensed at the same time as insulin will be included under the same copayment. Disposable insulin/syringes and/or disposable diabetic testing supplies must be dispensed in days supply corresponding to the amount of insulin to be dispensed and must be submitted at the same time to be included under the same copayment as the insulin.
- (7) Alcohol Swabs.
- (8) Blood Glucose monitors.
- (9) Glucose elevating agents.
- (10) Lancets and lancet devices.
- (11) Tretinoin topical (e.g. Retin-A) for individuals through the age of 25 years.

- (12) ADD/ADHD agents. Amphetamines, Methylphenidate (e.g. Ritalin) Strattera and Cyclert for individuals through the age of 18 years. Prior Authorization required for ages 19 and older.
- (13) Any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.
- (14) Legend contraceptives except for contraceptive devices.
- (15) Vaccine for Shingles.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for antiobesity agents, Meridia and Xenical.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as antiwrinkle agents, pigmentation and depigmentation agents, or medications for hair growth or removal.
- (6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, unless prior approval and determination of medical necessity is obtained through Caremark.
- (9) **Immunization.** Immunization agents or biological sera.
- (10) **Impotence.** A charge for impotence medication.
- (11) **Infertility.** A charge for infertility medication.
- (12) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (13) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (14) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

- (15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (16) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
- (17) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (19) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent patches, for smoking cessation.
- (20) **RU486.** Mefeprex-mefaprestone.
- (21) **Contraceptives.** Devices such as IUD's, diaphragms and cervical caps.
- (22) **Anabolic Steroids.**
- (23) **Anti-wrinkle agents.** (e.g. Renova)
- (24) **Cosmetic** hair removal products.
- (25) **Hair** growth stimulants.
- (26) **Hematinics.**
- (27) **ADD/ADHS agents.** Amphetamines, Methylphenidate (e.g. Ritalin), Strattera and Cyclert for individuals 19 years or older without prior authorization.
- (28) **Non-legend** drugs other than those listed above.
- (29) **Tretinoin** topical (e.g. Retin-A) for individuals 26 years of age or older.
- (30) **Prescription vitamins**, singly or in combination. Exceptions: Legend prenatal vitamins are covered.
- (31) **Prescription supplements** such as minerals, nutrients, fluoride and calcium.
- (32) **Therapeutic** devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use.
- (33) **No** coordination of benefits with RX under this Plan.
- (34) **No** shoe boxing of claims for RX. If prescriptions are paid for at the time of services, claims must be submitted within sixty days for reimbursement.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

- (1) Obtain a Claim form from the Personnel Office or the Plan Administrator.
- (2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- (3) Have the Physician complete the provider's portion of the form.
- (4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
 - Name of Plan
 - Employee's name
 - Name of patient
 - Name, address, telephone number of the provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of services
 - Charges
- (5) Send the above to the Claims Administrator at this address:

Consociate Dansig
151 East Decatur Street
Decatur, Illinois 62525-1068
800-798-2422

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:

Notification of	15 days
Response by claimant	45 days

Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
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Ongoing courses of treatment:

Reduction or termination before the end of the treatment	15 days
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Request to extend course of treatment	15 days
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Review of adverse benefit determination	15 days per benefit appeal
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Reduction or termination before the end of the treatment	15 days
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Request to extend course of treatment	15 days
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Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
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Extension due to matters beyond the control of the Plan	15 days
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Extension due to insufficient information on the Claim	15 days
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Response by claimant following notice of insufficient information	45 days
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Review of adverse benefit determination	60 days
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Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- (1) The specific reason or reasons for the adverse determination.
- (2) Reference to the specific Plan provisions on which the determination was 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 review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures.
- (5) 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 Claim.
- (6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

- (7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Only the following matters shall be appealable:

- (1) whether appropriate documentation was relied upon in making the benefit determination;
- (2) whether there was substantial compliance with the administrative processes and safeguards outlined in the Plan;
- (3) whether the determination was inconsistent with the terms of the Plan concerning the denied treatment option or benefit; or
- (4) whether the Plan provisions have been applied consistently with regard to the claimant and other similarly situated claimants.

Determination as to the experimental or investigational nature of a treatment, drug, or other item, determinations as to medical necessity and determinations as to whether charges are usual and reasonable are solely within the discretion of the Plan Administrator and are not appealable.

The review shall take 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. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes Medicare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of

a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
- (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with applicable law, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

**The PHIA Group, LLC
Subrogation & Reimbursement Specialists
888-986-0080**

SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries, and/or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

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

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

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim which any Covered Person(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional Payment by the Plan plus reasonable costs of collection.

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

If the Covered Person(s) fails to file a claim or pursue damages against:

- (1) the responsible party, its insurer, or any other source on behalf of that party;
- (2) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (3) any policy of insurance from any insurance company or guarantor of a third party;
- (4) worker's compensation or other liability insurance company; or,

- (5) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;
- (6) the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s) and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

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

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

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

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

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

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

- (1) the responsible party, its insurer, or any other source on behalf of that party;
- (2) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (3) any policy of insurance from any insurance company or guarantor of a third party;
- (4) worker's compensation or other liability insurance company or
- (5) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the

death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

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

Obligations

It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

- (1) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- (2) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
- (3) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- (4) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- (5) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- (6) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

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

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

Offset

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

Minor Status

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

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

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the

Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Williamson County Employee Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Williamson County, 1320 West Main, Franklin, Tennessee 37064, 615-595-1270. COBRA continuation coverage for the Plan is administered by Consociate, Inc., 151 E. Decatur Street, Decatur, Illinois 61525, 800-798-2422. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be

considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the employee,
- (3) commencement of a proceeding in bankruptcy with respect to the employer, or
- (4) enrollment of the employee in any part of Medicare.

IMPORTANT:

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

NOTICE PROCEDURES:

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

Williamson County
1320 West Main
Franklin, Tennessee 37064

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

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.
- (4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

COBRA PREMIUM REDUCTION PROVISIONS UNDER ARRA

The American Recovery and Reinvestment Act of 2008 ("ARRA") modifies COBRA rights and responsibilities otherwise set forth in the Plan in the manner described below. The ARRA gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to fifteen (15) months. If you qualify for reduced premiums, you need only pay thirty-five percent (35%) of the COBRA premium otherwise due under the Plan.

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- (1) MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through May 31, 2010 and elect the coverage;
- (2) MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through May 31, 2010;
- (3) MUST NOT be eligible for Medicare; and
- (4) MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional sixty (60) day election period.

IMPORTANT

If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the Plan Sponsor in writing. If you do not, you may be subject to a tax penalty.

Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.

The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium deduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

If you had exhausted the nine (9) month reduced premium period of prior law before December 19, 2009, you will have a grace period to pay the premium reduction amounts for time periods after that date until the later of February 17, 2010 or, if later, thirty (30) days after notice of the extension to fifteen (15) months is provided by the Plan Administrator.

For general information regarding the Plan's COBRA coverage you can contact the Plan Administrator.

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

For specific information related to the Plan's administration of the ARRA Premium Reduction or to notify the Plan of your ineligibility to continue paying reduced premiums, contact the Plan Administrator.

If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

www.dol.gov/COBRA or call 1-866-444-EBSA (3272)

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Williamson County Employee Benefit Plan is the benefit plan of Williamson County, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by Williamson County to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Williamson County shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To perform all necessary reporting as required by applicable law.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified.
- (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- (3) in accordance with the Plan documents to the extent that they agree with applicable law.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
 - (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
 - (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
 - (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
 - (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
 - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
 - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
 - (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
 - (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
 - (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
 - (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
 - (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The members of Williamson County's workforce with Plan responsibilities are designated as authorized to receive Protected Health Information from Williamson County Employee Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information and to immediately notify the Employer of any breach of confidentiality with regard to Protected Health Information. Such security

measures shall include the implementation and maintenance of reasonable and appropriate administrative, technical, and physical safeguards to protect the security, integrity, confidentiality, and availability of Protected Health Information created, maintained, received, or transmitted by any agent or subcontractor. Any agent or subcontractor whom receives Protected Health Information pursuant to this Health Plan shall comply with additional or modified requirements set forth in any annual guidance as to the security requirements published by the Secretary of Health and Human Services and with the additional requirements of the HITECH Act that relates to security of Protected Health Information. Any agent or subcontractor who receives Protected Health Information pursuant to this Health Plan shall require any agent or subcontractor that carries out any duties for the agent or subcontractor involving the use, custody, disclosure, creation of, or access to Protected Health Information to enter into a written contract with the agent or subcontractor containing provisions substantially identical to the restrictions and conditions set forth in this paragraph..

- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the HIPAA Privacy Standards and the HITECH Act.
- (4) In the case of a breach of Protected Health Information, the Employer shall notify each Covered Person whose unsecured Protected Health Information has been, or is reasonably believed by the Employer to have been accessed, acquired or disclosed as a result of such breach and the Employer reasonably believes that such breach poses a significant risk of financial, reputational, or other harm to the Covered Person. All notifications required under this paragraph shall be made without unreasonable delay and in no case later than sixty calendar days after the discovery of a breach by the Employer. Notice under this paragraph shall be provided in the following form: (1) written notification by first-class mail to the Covered Person (or the next of kin of the Covered Person if the Covered Person is deceased) at the last known address of the Covered Person or the next of kin, respectively, or, if specified as a preference by the Covered Person, by electronic mail; (2) in the case in which there is insufficient, or out-of-date contract information (including a phone number, e-mail address, or any other form of appropriate communication) that precludes direct written notification to the Covered Person, a substitute form of notice shall be provided, including, in the case that there are ten (10) or more Covered Persons for which there is insufficient or out-of-date contact information, a conspicuous posting for a period of ninety (90) days on the home page of the website of the Employer or notice in major print or broadcast media, including major media in geographic areas where the Covered Persons affected by the breach likely reside. Such a notice in media or web posting will include a toll-free number where a Covered Person can learn whether or not the Covered Person's unsecured Protected Health Information is possibly included in the breach; (3) in any case deemed by the Employer to require urgency because of possible eminent misuse of unsecured Protected Health Information, the Employer, in addition to written notification in the form provided above, may provide information to Covered Persons by telephone, or other means, as appropriate. The Employer shall also provide notice to prominent media outlets following the discovery of a breach involving unsecured Protected Health Information of more than 500 Covered Persons without unreasonable delay and in no case later than sixty (60) calendar days after discovery of such breach. Regardless of the method by which notice is provided to Covered Persons under this paragraph, notice of breach shall include, to the extent possible, the following: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known; (2) a description of the types of unsecured Protected Health Information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code); (3) the steps the Covered Persons should take to protect themselves from potential harm resulting from the breach; (4) a brief description of what the employer is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and (5) contact procedures for Covered Persons to ask questions or learn additional information which shall include a toll-free telephone number, an e-mail address, web site, or postal address. The Employer shall provide notice to the Secretary of the Department of Health and Human Services of any breach that requires notification to any Covered Person pursuant to this paragraph.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived solely from the funds of the Employer.

For Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

**MODEL NOTICE OF
MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
OFFER FREE OR LOW-COST HEALTH COVERAGE
TO CHILDREN AND FAMILIES**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of March 3, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 602-417-5422	
ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237
GEORGIA – Medicaid	MONTANA – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	NEBRASKA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 208-334-5747 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	NEVADA – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
IOWA – Medicaid	CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: www.dhh.louisiana.gov/offices/?ID=92 Phone: 1-888-342-6207	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	NEW YORK – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 800-657-3739	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	UTAH – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414

OKLAHOMA – Medicaid	VERMONT – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.oregon.gov/DHS/healthplan/index.shtml Medicaid Phone: 1-800-359-9517 CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml CHIP Phone: 1-800-359-9517	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicallasistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Williamson County Employee Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 62-6000913

PLAN EFFECTIVE DATE: July 1, 1997

EFFECTIVE DATE OF PLAN RESTATEMENT: January 1, 2011

PLAN YEAR ENDS: June 30th

EMPLOYER INFORMATION

Williamson County
1320 West Main
Franklin, Tennessee 37064
(615) 595-1270

PLAN ADMINISTRATOR

Williamson County
1320 West Main
Franklin, Tennessee 37064
(615) 595-1270

AGENT FOR SERVICE OF LEGAL PROCESS

Williamson County
1320 West Main
Franklin, Tennessee 37064

CLAIMS ADMINISTRATOR

Consociate Dansig
151 East Decatur Street
Decatur, Illinois 62525-1068
800-798-2422

NOTICE OF GRANDFATHERED STATUS

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

GENETIC INFORMATION NONDISCRIMINATION NOTICE

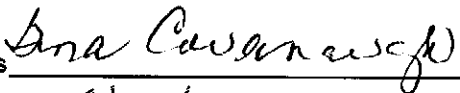
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by GINA. To comply, we are requesting that you not provide any genetic information when responding to a request for medical information. "Genetic information" includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

BY THIS AGREEMENT, Williamson County Employee Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Williamson County on or as of the day and year first below written.

By 
Williamson County

Date 3-15-11

Witness 

Date 3/15/11

510-345.d5