

HAMILTON COUNTY DEPARTMENT OF EDUCATION
POSTRETIREMENT HEALTH PLAN

WHEREAS, the Hamilton County Board of Education (the "Employer") desires to establish a welfare benefit plan for the benefit of certain retired employees, hereby establishes the benefits, rights and privileges which shall pertain to participating employees and their eligible dependents, as defined herein; and which benefits are provided by the employer and hereinafter referred to as the "Plan".

WHEREAS, the Plan is a self-funded employee benefit plan.

WHEREAS, the Plan is intended to comply with and fall under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

NOW, THEREFORE, effective as of November 1, 2001 (the "Effective Date"), the Employer hereby adopts the Postretirement Health Plan, as follows:

Purpose

The purpose of this document is to set for the provisions of the employer provided postretirement health plan which provides reimbursement for covered charges incurred as a result of illness or injury of eligible retirees and their covered dependents.

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Article I – DEFINITIONS

- 1.1 "Act" Means Parts 1 and 4 of Subtitle B, Title I, of ERISA as it may be amended from time to time.
- 1.2 "Active Employees Plan" means Hamilton County Board of Education Medical Benefits Plan (as it may be amended from time to time) covering active employees of the Employer.
- 1.3 "Administrator" means the person or persons designated from time to time by the Employer, pursuant to Section 2.2, to administer the Plan on behalf of the Employer. Such person may also include the benefits manager of the Employer ("Benefits Manager").
- 1.4 "Code" means the Internal Revenue Code of 1986, as amended.
- 1.5 "Contract" shall mean such insurance contracts or policies (including group policies) that are issued by an insurer or other provider. The terms, conditions, limitations and exclusions of such Contract are hereby incorporated by reference and made a par hereof, except insofar as such Contracts is in conflict with the term of the Plan. "Contract" shall also include any agreement with a Health Maintenance Organization ("HMO"), similar health care provider or Medicare.
- 1.6 "Cobra" means Consolidated Omnibus Budget Reconciliation Act of 1985 as amended.
- 1.7 "Dependent" means, with respect to any Retiree, an individual who was covered as dependent of such Retiree under the Active Employees Plan [at the time of his or her retirement] and is:
- (a) the Retiree's legally married spouse, even if such Spouse remarries after the death of the Retiree.
 - (b) unmarried dependent child (legally adopted, foster or step)
 - (c) a child of the Retiree who is a full-time student and under the age of 25, living in a normal parent/child relationship and depending upon the parent(s) for at least 50% of their support;
 - (d) a child covered by a "qualified medical child support order" ("QMCSO"), as defined in Section 609 of ERISA, and which has been determined to be a QMCSO by the Administrator pursuant to Section 2.4;
- 1.8 "Employee" means a person who is actively employed as a "full-time" employee by the Employer scheduled to work at least 30 hours per week; except bus drivers who are considered full time at 27.5 hours per week.
- 1.9 "Employer" shall mean Hamilton County Board Of Education.
- 1.10 "Participant" shall mean any Retiree or Dependent who participates in the Plan and who has not for any reason become ineligible to participate further in the Plan.
- 1.11 "Plan Year" means the twelve-month period commencing on the first day of January and ending the thirty-first day of December.
- 1.12 "Retiree" shall mean:

- (a) anyone vested with the Tennessee Consolidated Retirement System and at least age 55 who has indicated intent to retire on or before today's date or subsequently becomes eligible to retire under the terms and conditions of the Post Retirement Health Plan.

EXCEPTION: Former City Employees who did not join TCRS are defined as retired when they qualify for Social Security Retirement and meet the system requirements for retirement with benefits.

- 1.13 "Retirement" shall mean an Employee's termination of employment upon satisfying, or being deemed to have satisfied, the conditions for being a Retiree.
- 1.14 "Spouse" shall mean the legally married spouse of the Retiree or an individual who was the legal spouse of a Retiree at the time of such Retiree's death.
- 1.15 "Year of Service" means each twelve-month period of service rendered by the Employee to the Employer, [which periods of service need not be continuous and with any fractional years being aggregated for purposes of determining the number of whole Years of Service to be credited to an Employee.

Article II – ADMINISTRATION

2.1 Powers and Duties of the Employer

- (a) The Employer shall appoint and remove the Administrator from time to time, as it deems necessary for the proper administration of the Plan and to insure that the Plan is being operated for the exclusive benefit of the Participants and their Beneficiaries in accordance with the terms of this Plan, the Code and the Act.

2.2 Assignment and Designation of Administrative Authority

Any person, including, but not limited to, Administration, Employees of the Employer, or appointed third party shall be eligible to serve as the Administrator. Any person so appointed shall signify his acceptance by filing a written acceptance or by undertaking the duties assigned. An Administrator may resign by delivering written resignation to the Employer. The Employer may also remove any Administrator by delivery of a written notice of removal, which shall take effect upon delivery or on a date specified. Upon resignation or removal of an Administrator, the Employer shall promptly designate in writing such other person or persons as a successor Administrator. As of the Effective Date, the Employer hereby appoints the Benefits Manager as the Administrator of this Plan.

2.3 Allocation, Delegation and Majority Actions.

If more than one person is appointed as Administrator, the responsibilities of each Administrator may be specified by the Employer. In the event the Employer makes no such delegation, the Administrators may allocate the responsibilities among themselves, and shall notify the Employer in writing of such action and the responsibilities allocated to each Administrator. Except where such delegation has been made, actions taken by more than one Administrator shall be effective if approved by the majority of Administrators, but such Administrators may authorize one or more of them to effect such action.

2.4 Powers, Duties and Responsibilities.

The primary responsibility of the Administrator is to administer the Plan for the exclusive benefit of the Participants and in accordance with the terms of the Plan. The Administrator shall have the discretion

and power to determine all questions arising in connection with the administration, interpretation and application of the Plan. Any such determination by the Administrator shall be final, conclusive and binding upon all persons. The Administrator may correct any defect or reconcile any inconsistency in such manner, and to such extent, as shall be deemed necessary or advisable to carry out the purposes of this Plan; provided, however, that such interpretation or construction shall be done in a non-discriminatory and non-arbitrary manner and shall be consistent with the purposes of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish his duties under the Plan.

The Administrator, in its sole discretion:

- (a) determine all questions relating to eligibility of certain Employees to participate or continue participation as Retirees;
- (b) determine all questions relating to the eligibility of individuals to participate or continue participation as Dependents;
- (c) compute, certify and direct the amount and kind of benefits to which any Participant shall be entitled hereunder;
- (d) maintain all necessary records for the administration of the Plan;
- (e) interpret the provisions of the Plan and to make and publish such rules for regulation of the Plan as are consistent with the terms hereof,
- (f) assist any Participant regarding his rights, benefits or elections available under the Plan;
- (g) communicate the material terms of the Plan to Participants and Dependents by delivery of a summary plan description of the Plan.
- (h) determines to provide benefits under the Plan under one or more Contracts with insurers or providers, as may be entered into by the Administrator from time to time, which Contracts shall be named in Appendix A to the Plan.

2.5 Administrator's Responsibilities Regarding Qualified Medical Child Support Orders.

Coverage under this Plan shall be provided pursuant to a Qualified Medical Child Support Order ("QMCSO"), as defined in section 609(a) of ERISA, with respect to a child of certain Participants. Accordingly, the Administrator shall have the following responsibilities with respect to such order:

- (a) Determination The Administrator shall determine whether a court or administrative order purporting to qualify under section 609(a) of ERISA actually meets such requirements as soon as practicable following receipt of such order. The Administrator shall establish written procedures for making such determination.
- (b) Notification The Administrator shall notify the Participant and each alternate recipient of receipt of such order as soon as practicable following such receipt. The Administrator shall notify the Participant and each alternate recipient of the Administrator's determination as to whether such order is qualified as soon as practicable following such determination. If the Administrator is able to determine whether an order is qualified promptly upon receipt of such order, the Administrator may send one notice which informs the Participant and the alternate recipient both of the receipt of the order and of the Administrator's determination.

- (c) Payment of Dependent Premiums Upon determining that an order is qualified, the Administrator shall determine what premium, if any, shall be due with respect to the alternate recipient and take all necessary steps to assure payment of such premium.
- (d) Suspension of Claims Claims for a proposed alternate recipient shall be suspended until the Administrator has determined whether the order is qualified and whether or not any required premiums have been paid.

2.6 Records and Reports

The Administrator shall keep a record of all actions taken and shall keep such other books of account, records and other information that may be necessary for proper administration of the Plan. The Administrator shall file and distribute all reports that may be required by the Internal Revenue Service, Department of Labor or others, as required by law.

2.7 Appointment of Advisors

The Administrator may appoint accountants, actuaries, counsel, advisors and other persons that it deems necessary or desirable in connection with administration of the Plan.

2.8 Employee Information

The Employer shall supply full and timely information to the Administrator concerning an individual's death, employment status, termination, prior eligibility under the Active Employees Plan and such other pertinent facts as the Administrator may require from time to time. The Administrator may rely upon the correctness of such information supplied by the Employer.

Article III – ELIGIBILITY AND BENEFITS

3.1 Eligibility

Only Employees who are Retirees, as defined in section 1.12, and Dependents who are covered as of the date of retirement, and described in Section 1.7 shall be eligible to become Participants in this Plan on the first day after the Retiree's Retirement. A Retiree and/or Dependent who is eligible for participation and declines participate in the plan shall not be eligible to re-enroll in the plan. All eligible participants shall be considered enrolled in the Plan on the first day after the Retiree's Retirement unless the Participant provides written notification to the Administrator that they decline to participate.

3.2 Coverage Available

- (a) Coverage Prior to Eligibility for Medicare Retirees and Dependents shall be eligible for the same medical benefits for which Employees and their dependents are eligible under the Active Employees Plan.

EXCEPTION: Dependents must be enrolled prior to retirement.
Retirees and/or Dependents who cancel or lose coverage may not re-enter the Plan.

Such coverage shall be effective until the date such Participant becomes eligible for Medicare or until a Participant who is a Dependent ceases to be a Dependent. Participants who retire after the effective date of this document may be required to contribute to the cost of such coverage in accordance with the premium schedule attached as Exhibit A, as it may be amended from time to time.

- (b) COBRA Participants may elect COBRA coverage in lieu of the Postretirement Health Plan subject to the terms and conditions of the Act.
- (c) Coverage Upon Eligibility for Medicare Upon becoming eligible for Medicare, (either upon attaining age 65 or prior to attaining age 65 due to a disability), Participants shall not be eligible for benefits under this Plan. An eligible spouse and/or eligible dependent children under age 65 will remain covered under the post Retiree's medical plan for the remainder of their eligibility period when a retired participant over age 65 becomes eligible for Medicare.
- (d) Premium Payments If, or to the extent, a Participant is required to pay premiums for coverage under subsections (a) or (b) of this section 3.2, all such premiums must be paid prior to the month for which the coverage is applicable, either by authorized deduction from any payments due the Participant or by direct payment to the Administrator.
- (e) Coverage Upon Death of Retiree If the Participant should die after retirement, and at the time of death, his/her spouse is covered under the Postretirement Medical Plan the participant's spouse may continue to be covered under the plan until attaining the age of 65 provided they meet all of the appropriate provisions of the Plan.

3.3 Coordination of Benefits

Benefits under this Plan shall be coordinated with and payable only to the extent benefits to which a Participant is eligible are not payable under another plan. In determining which plan is primarily responsible for paying benefits ("Primary Plan"), the following rules apply:

- (a) the plan that contains no coordination of benefits feature is considered to be the Primary Plan;
- (b) the plan under which the patient is a member, rather than a Dependent, is considered to be the Primary Plan;
- (c) the plan covering the parent whose birthday (month and day) falls earlier in the calendar year is considered to be the Primary Plan when the patient is a Dependent child;
- (d) when the above subsections do not apply, the plan which has covered the patient for the longer period of time is considered to be the Primary Plan;
- (e) coverage under Medicare and benefits through worker's compensation insurance and/or accident insurance shall be considered as provided under a Primary Plan, to the extent permitted by applicable laws.
- (f) any other plan covering (as a member or as a dependent) the Retiree's Spouse or a Dependent, who first became a Dependent pursuant to Section 1.6(h), is considered the Primary Plan.

- (g) Should the retiree become eligible to participate in another employer sponsored health plan due to subsequent employment, the health plan where the retiree is actively employed shall be primary.

3.4 Future Benefits Not Guaranteed

The provision of any benefits under the Plan shall not be construed as any accrual of benefits or a guarantee of or a right to any benefits in the future.

Article IV – FUNDING AND CONTRIBUTIONS

4.1 Funding

The Employer may, at its discretion, contribute to the Plan all or a portion of such amounts as may ordinary and necessary to meet the cost of the medical benefits provided under the Plan, and to provide for the administrative expenses of the Plan. Employees who have retired prior to the effective date of this Plan, and have elected to continue coverage will not be required to contribute to the cost of benefits provided under the Plan. Employees who retire after the effective date of this plan will contribute an amount equal to a full time employee of the Hamilton County Department of Education. Dependents covered at the time of retirement may continue coverage under the Plan according to the terms of the Plan. Contributions for dependent coverage will be equal to the amount paid by full time employees for dependent coverage. Contributions are subject to change annually.

Article V – CESSATION OF BENEFITS

5.1 Cessation of Benefits

A Participant shall cease to be eligible for benefits under the Plan upon the occurrence of one or more of the following events:

- (a) The Participant, or the Retiree through which a Dependent is entitled to coverage, fails to make any required minimum payments to the Plan;
- (b) The death of the Participant.
- (c) The Participant ceases to be a Dependent.
- (d) The Participant or Dependent becomes eligible for Medicare.

5.2 Continuation of Coverage

In the event that a Participant's cessation of coverage under this Plan entitles the Participant to continue such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), or any applicable state law, such Participant's coverage shall continue in accordance with such applicable law. Contracts in effect pursuant to this Plan may also contain a provision, which shall permit, upon payment of applicable premiums, the conversion of the policy to provide individual coverage upon termination of eligibility for coverage under this Plan. This Section 5.2 shall not be construed to provide any Participant with any additional continuation of benefits except as described in the preceding sentences.

Article VI – PAYMENT OF BENEFITS

6.1 Payments to Participants

Payment of benefits under the Plan will be paid by the Administrator as soon as practicable after a claim for such benefits is submitted to the Administrator. Claims must be received within 90 days of the date the expenses underlying the claim were incurred. Notwithstanding the foregoing, if the benefits are provided under a Contract that contains other terms related to the payment of claims and Participants have been informed of such terms, in writing, the terms of the Contract shall govern the manner in which benefits under the Plan are paid. Any payments to minors will be subject to the terms of Section 6.2.

6.2 Payments to a Minor Participant.

In the event a distribution is to be made to a minor, then the Administrator may, in the Administrator's sole discretion, direct that such distribution be paid to the legal guardian, or if none, to a parent of such minor or a responsible adult with whom the minor resides, or to the custodian for such minor under the uniform gift to minors act or the uniform transfer to minors act enacted by the state in which such minor resides, or if no such legislation exists, under any other applicable state law. Any payment in accordance with this Section 6.2 shall fully discharge the Administrator, the Employer and the Plan from further liability on account thereof.

6.3 Procedures Regarding Claims for Benefits.

- (a) **Determination Procedure.** All determinations with respect to claims for benefits shall be made and decided in accordance with the terms of this Plan, and to the extent not inconsistent with the Plan, in accordance with the provisions of the applicable Contract which constitutes a part of this Plan.

Determinations with respect to all claims shall be made by the Administrator, insurer, or service provider acting as a delegate of the Administrator. The Administrator and any such delegate shall follow the procedures described in Subsections (b) through (d), below.

- (b) **Notification of Decision.** Within 90 days after the receipt of a claim filed in accordance with the provisions of subsection (a) above, the Administrator, after consultation with any delegate making the determination with respect to a claim, shall provide the claimant with written notice of its decision on the claim. If, because of special circumstances, a decision cannot be rendered on a claim within the 90-day period, the period in which to render the decision may be extended up to 180 days after receipt of the written claim by providing to the claimant, before the end of the initial 90-day period, a written notice of the special circumstances requiring the extension and the expected decision date. If the claim is wholly or partially denied, the written notice of the decision shall inform the claimant in a manner calculated to be understood by the claimant of.
- (1) The specific reason or reasons for the denial;
 - (2) Specific reference to pertinent Plan or Contract provisions on which the denial is based;
 - (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

- (4) An explanation of the procedures for requesting a review of the claim denial.

If written notice of the decision is not given to the claimant within 90 days after receipt of a claim, plus extensions, the claim shall be deemed to be denied for purposes of the claimant's right to request a review of the denial in accordance with the provisions of subsection (c) below.

- (c) Request for Review of Denial of a Claim Within 60 days after the earlier of the date of receipt of written notice of a denial of all or a portion of a claim, or the expiration of the period within which a decision must be rendered, the claimant or his authorized representative may request a review of such denial. Such request must be in writing and delivered to the Administrator, the appropriate delegate of the Administrator, or the Employer. Written issues and comments may accompany the review request. During the 60-day period following notice of the denial of a claim, the claimant or his authorized representative may examine the Plan or Contract or any other document upon which the denial is based.
- (d) Notification of Decision on Review of Denial of a Claim Upon receipt of a request for review of a denial of a claim, which was filed in accordance with the provisions of subsection (c), the Administrator or his or her delegate shall undertake a full and fair review of such denial. The claimant shall be provided with written notice of a decision within 60 days after receipt of the request for such review. If, because of special circumstances, a decision cannot be rendered within the period described, the period in which to render the decision may be extended up to 120 days after receipt of the such request by providing to the claimant, before the end of the initial period, a written notice of the extension and the expected decision date. The written notice of the subsequent decision shall inform the claimant of the specific reasons for the decisions and the specific provisions of the Plan or Contract or other document upon which the decision is based. If written notice of the decision is not given to the claimant within the initial period, plus extensions, the claims shall be deemed denied on review. Except as may otherwise be required by law, the decision which follows a review of the denial of a claim shall be binding on all parties.

Article VII - AMENDMENT AND TERMINATION

7.1 Amendment.

The Employer shall have the absolute right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, including provisions determining the types and levels of benefits provided under the Plan. Any amendment to the Plan that results in a reduction or elimination of any benefit shall be on a prospective basis only, and a Participant shall not be entitled to retain any type or level of benefit, except as provided under a Contract that remains in effect with respect to such Participant, as of the date of such change.

7.2 Termination.

The Employer shall have the absolute right at any time and for any reason to terminate the Plan by delivering to the Administrator written notice of such termination.

Article VIII - MISCELLANEOUS

8.1 Genders and Number.

Whenever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where such would apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in another form in all cases where they would so apply.

8.2 Action by the Employer.

Whenever the Employer, under the terms of this Plan, is permitted or required to do or perform any act or thing, it shall be done and performed by a duly authorized person or agent of the Employer.

8.3 Headings.

The headings and subheadings of this Agreement have been inserted for convenience of reference only and shall not be used in the construction of any of the provisions hereof.

8.4 Uniformity and Nondiscrimination.

All provisions of this Plan shall be interpreted and applied in a uniform nondiscriminatory manner.

8.5 Agent for Service of Legal Process.

The agent for service of legal process shall be the Employer or the Administrator.

8.6 Governing Law.

The Plan will be construed, administered and enforced according to the laws of the State of Tennessee; to the extent such laws are not inconsistent with and preempted by ERISA.

IN WITNESS WHEREOF, this Plan has been executed this 1st day of November, 2001.

HAMILTON COUNTY DEPARTMENT OF EDUCATION

By: _____

Title: _____

Exhibit A

Post Retirement Medical PREMIUM SCHEDULE

CERTIFIED EMPLOYEES retiring directly from active service at age 55 or over, or with 30 years of creditable service with the Tennessee Consolidated Retirement System (TCRS) including accumulated sick leave, **and** with 20 years of Hamilton County Department of Education service, will qualify for continued individual health coverage at the same rate that an active Hamilton County Schools employee pays. The current rate charged to active Hamilton County Schools employees for individual health insurance coverage is \$100 per month.

CERTIFIED EMPLOYEES retiring directly from active service at age 55, or with 30 years creditable service in the Tennessee Consolidated Retirement System (TCRS) including accumulated sick leave and military time accepted by TCRS, **and** with between 10 and 19 years of Hamilton County Department of Education service, will qualify for continued individual health coverage for 40% of the actual cost to the Board at the current rate of \$215 per month. This rate is subject to change each year based upon the premiums charged by our health insurance carriers.

CERTIFIED EMPLOYEES retiring directly from active service at age 55 or over, while vested in the Tennessee Consolidated Retirement System (TCRS) with at least 5 years of HCDE creditable service will qualify for continued individual health coverage by paying the full cost of individual coverage. The current rate for individual coverage is \$336.85 per month for Blue Cross PPO and \$299.95 per month for the CIGNA HMO Plan. This rate is subject to change each year based upon the premiums charged by our health insurance carriers.

CLASSIFIED EMPLOYEES Retiring directly from active service at age 55 or over, **or** with 30 years of creditable service in the Tennessee Consolidated Retirement System (TCRS) **and** with 15 years of Hamilton County Department of Education service (including accumulated sick leave and military time accepted by TCRS) will qualify you for continued individual health coverage at the same rate that an active Hamilton County Schools employee pays. The current rate charged to active Hamilton County Schools employees for individual health insurance coverage is \$100 per month.

CLASSIFIED EMPLOYEES Retiring directly from active service at age 55 or over, while vested in the Tennessee Consolidate Retirement System with at least 5 years of HCDE creditable service will qualify you for continued individual health coverage by paying the full cost for individual coverage. The current rate for individual coverage is \$336.85 for Blue Cross PPO and \$299.95 for the CIGNA HMO Plan. This rate is subject to change each year based upon the premiums charged by our health insurance carriers.

Dependent coverage may be continued at the time of retirement by paying the full cost of this coverage. The current rates for dependent coverage are:

	<u>BLUE CROSS PPO</u>	<u>CIGNAHMO</u>
Spouse only	\$261.85	\$224.95
Family w/o Spouse	\$514.38	\$514.38
Family	\$514.38	\$514.38

These rates are subject to change each year based upon the premiums charged by our health insurance carriers. Retirees must have dependent coverage at the time of retirement to continue to cover dependents after retirement. Retirees may not add dependent coverage after retirement.

APPENDIX A
PLAN CONTRACTS

CIGNA HealthCare of Tennessee Inc.
Group Service Agreement
Group Number 3316472 Effective Date 1/1/2005

Blue Cross Blue Shield of Tennessee
Administrative Services Agreement
Group Number 81009 Effective Date 10/2001

Group Insurance Contracts subject to change annually.