

CITY OF CARROLLTON

EMPLOYEE DENTAL

PLAN BOOKLET

EFFECTIVE JANUARY 1, 2013

Claims Address:

TML IEBP PO Box 149190 Austin, Texas 78714-9190 **Customer Service:**

English: (800) 282-5385 / Spanish: (800) 385-9952 Professional Health Coach (888) 818-2822 Care Management: (800) 847-1213 This Plan Booklet summarizes the Dental Plan, which was adopted by the City of Carrollton effective January 1, 1982, and contains amendments through January 1, 2013. This Booklet is provided to you as a guide to assist you in obtaining the benefits contained in that Plan.

The benefits provided for the City of Carrollton Dental Plan* are calculated on a "calendar year" period. The benefit period begins on January 1st of each year and extends through December 31st of that year. On January 1st of each year, a new benefit period starts for each eligible person.

Throughout this Booklet, "Plan" will mean the City of Carrollton's Dental Plan. The City of Carrollton offers the Dental Plans described in this Booklet to assist you and your family with access to appropriate dental care.

* A Risk Pool created under and governed by the Texas Political Subdivisions Uniform Group Benefits Program (Section 172 Local Government Code). Section 172.014 provides that "A risk pool created under this Section is not insurance or an insurer under the Insurance Code or other laws of this state, and the State Board of Insurance does not have jurisdiction over a pool created under this Section." Section 172.015 provides that "The payor of employee benefits, whether a political subdivision, group of political subdivisions, pool or carrier providing reinsurance to one of these entities, shall be subrogated to the Employees' right of recovery for personal injuries caused by the tortious conduct of a third party."

Disclaimer: This book should be used as a guideline for the explanation of your healthcare benefits.

Updates and changes to this benefit book may occur during the plan year.

PLAN DOCUMENT

The City of Carrollton (the "City") has approved the City of Carrollton Employee Dental Benefit Plan (the "Plan") as a benefit to its Employees. All Employees should read this Plan Booklet carefully.

The benefits hereinafter described are available to Employees of the City during the continuance of the Plan, but such benefits are subject to modification or termination at any time with respect to expenses or treatments (including those already in process) not yet incurred.

The City also reserves the right to charge Employees for Employee or dependent coverage and to change such charges at any time. The City will inform you of such charges, or changes herein, prior to their effective date.

Eligible Employees may choose from two dental plans. Each plan has a different level of benefits, but all are subject to the terms, provisions, and conditions recited on the following pages. The Plan is not intended to cover all procedures, treatments, or programs.

The Plan Sponsor has adopted guidelines that further describe and may limit the benefits applied hereunder. Each eligible Employee may review those guidelines upon request to the Plan Sponsor. Any disputes or questions with respect to the Plan shall be decided by the Plan Sponsor whose decision shall be final.

TABLE OF CONTENTS

PLAN DOCUMENT	1
GENERAL PROVISIONS	4
PLAN ADMINISTRATION	5
HOW TO ENROLL IN THE PLAN	5
COVERAGE OF NEWBORNS	6
MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN	6
ACTIVE DUTY RESERVISTS	7
COVERAGE FOR ACTIVE EMPLOYEES AGE 65 OR OLDER	7
RETIREE COVERAGE	7
TERMINATION DATE OF COVERAGE	9
EMPLOYEE COVERAGE	9
DEPENDENT COVERAGE	9
RETIREE COVERAGE	9
RETIREE DEPENDENT COVERAGE	9
OTHER HELPFUL CLAIMS INFORMATION	10
Assignment of Benefits	10
APPEAL OF DENIED CLAIMS	10
PROTECTED HEALTH INFORMATION	10
HOW TO FILE A DENTAL CLAIM	11
FILING DEADLINE	11
WHAT YOU NEED TO SUBMIT WITH YOUR CLAIM	11
HOW TO AVOID DELAYS IN RECEIVING YOUR PAYMENT	11
Foreign Providers	12
LEGAL ACTIONS	12
SCHEDULE OF DENTAL EXPENSE BENEFITS	13
Stars Plan	13
STRIPES PLAN	13
DENTAL EXPENSE BENEFITS	13
BENEFITS AVAILABLE	13
Pre-Treatment Estimate	14
COVERED DENTAL EXPENSES	14
EXCLUSIONS AND LIMITATIONS APPLICABLE TO DENTAL BENEFITS	16

CONTINUATION OF COVERAGE (COC) RIGHTS UNDER COBRA	18
RIGHT OF RECOVERY	21
COORDINATION OF BENEFITS	
DEFINITIONS	
IMPORTANT ADDRESSES	29
SIGNATURE PAGE	30
INDEX	31

GENERAL PROVISIONS

The City of Carrollton offers this Plan out of a genuine concern for the well being of its Employees. The opportunity to participate in the Plan is one of the many benefits of working for The City of Carrollton.

The Plan must be used properly if it is to continue. For the Plan to work effectively, healthcare costs must be kept reasonable. These costs are comprised of the benefit claims submitted by you and your fellow workers.

The City of Carrollton has employed TML Intergovernmental Employee Benefits Pool (TML IEBP) to provide cost containment and claims processing services for the Plan. The City of Carrollton and TML IEBP feel that it is important that you and your fellow workers join in the effort to moderate healthcare and dental costs.

The City of Carrollton reserves the right to:

- Amend this Plan at any time, including, but not limited to, revising the provisions of this Plan and/or increasing the cost of your coverage without giving prior notice to and without obtaining approval from Employees, retirees, continuation of coverage participant, and/or any other person eligible for coverage under this Plan; and/or
- Terminate this Plan at any time without giving prior notice to or obtaining approval from Employees, retirees, continuation of coverage participant and/or any other person eligible for coverage under this Plan

The City of Carrollton feels that well-informed people make better Employees. This Booklet has been created in that spirit. If you require information about the Plan and are unable to find the information in this Booklet, please contact the Workforce Services Department.

The Plan and your enrollment identification (ID) cards, if any, constitute the entire contract of coverage between the Plan and you. The Plan may be changed by the Employer upon the execution of an Amendment at any time without your prior notice or consent.

All Amendments to the Plan will become effective as of a date established by your Employer, EXCEPT that: no increase or reduction in benefits shall be effective with respect to Covered Expenses incurred prior to the date a change was adopted by the Plan Sponsor, regardless of the effective date of the change.

Your Employer may terminate the Plan at any time; however, the Employer has established the Plan with the intent to maintain it for an indefinite period of time.

Clerical errors made on the records of your Employer and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of the Plan. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made. However, in the event you have overpaid your contributions by failing to notify the City when your Dependents are no longer eligible under the Plan (i.e. you become divorced or your Dependent child ceases to be eligible), the refund which you may receive will not exceed an amount equal to two months of the applicable Employee contribution which you overpaid.

PLAN ADMINISTRATION

The City will administer the Plan for the exclusive purpose of providing benefits to Covered Persons, and defraying reasonable expenses of administering the Plan, in the interest and for the benefits of Covered Persons as provided herein, without discrimination in favor of one or some Covered Person or as against one or some other Covered Person.

All interpretations of this Plan, questions concerning its administration and application and eligibility for benefits hereunder, shall be determined by the City and such determination shall be binding upon all persons.

HOW TO ENROLL IN THE PLAN

To enroll in the Plan, you must enroll yourself and any eligible Dependent(s) for coverage within thirty (30) days after you become eligible for coverage.

If you do not enroll yourself and your eligible Dependent(s) for coverage within thirty (30) days following the date that you are eligible for coverage, then you may not enroll for coverage until the next annual open enrollment period, unless you have a family status change. However, newborns must be enrolled within sixty (60) days from the date of birth.

If a Dependent who is hospitalized would become eligible for coverage, then coverage will not become effective for the Dependent until the Dependent leaves the hospital and resumes the duties and lifestyles of a person of like age and sex.

Section 125 of the Internal Revenue Code significantly restricts the circumstances under which you may add, change, or even drop coverage once coverage for you and your Dependent(s) has become effective. Once your coverage has become effective, you may **not** add, change, or even drop your coverage unless you experience one of the following family status changes:

- marriage (marriage certificate or a signed affidavit of common law marriage required)
- 2. divorce (court-issued divorce decree showing effective date required);
- death of your Covered Dependent(s);
- 4. birth (proof of birth required);
- 5. adoption, or legal guardianship of a child or dependent grandchild (court-issued document showing date of placement in the home or date legal guardianship attained is required);
- 6. commencement or termination of Spouse's employment (letter from Spouse's previous/new carrier must be provided showing employment gain/loss date);
- 7. gain/loss of Spouse's employer-provided coverage (letter from Spouse's employer showing coverage gain/loss date required);
- 8. loss of Dependent eligibility due to marriage;
- 9. an unpaid leave of absence taken by you or your Spouse;
- 10. you or your Spouse change from part-time to full-time employment or vice versa; or
- significant change in the health care coverage plan of you or your Spouse attributable to your Spouse's employment.

You must notify the Workforce Services Department within thirty (30) days of the effective date of the family status change in order to add, change or drop coverage for you or your Dependent(s). Notification includes completing and returning the required change form(s) and submitting acceptable proof of the family status change.

Employees are also responsible for any difference in contributions that are due retroactive to the effective date of the family status change.

If you do not notify the Workforce Services Department and return the appropriate completed change form(s) and proof within thirty (30) days of the date that you experience a family status change, with the exception of loss of Dependent(s) eligibility, then you may not add, change, or drop coverage on yourself or your Dependent(s) until the next annual open enrollment period.

If a Dependent becomes ineligible for coverage due to an approved IRS family status change as noted in the list above, the Dependent will be dropped and any differences in premiums will be refunded retroactive to the eligibility loss date as long as required proof of the eligibility loss is provided and Workforce Services is notified within thirty (30) days of the family status change. Should proof and/or notification of loss of Dependent eligibility be provided outside of the thirty (30) day period allowed, the Dependent will be dropped retroactive to the eligibility loss date; however, any difference in premiums as a result of the change will only be refunded to a maximum of thirty (30) days from the date notification was received. No Dependent(s) will be dropped unless acceptable proof is provided in addition to the completion of the required change form(s). If claims have been paid on any Dependent who was ineligible at the time service was rendered, the Employee will be responsible for immediate repayment of the claim and should contact Workforce Services to make repayment arrangements.

COVERAGE OF NEWBORNS

In order to obtain coverage for your newborn (this includes adopted children and children who are placed for adoption), you must enroll your newborn under the Plan within sixty (60) days following the newborn's date of birth. Within this sixty (60) day period, you must complete an enrollment form adding coverage for your newborn, and you must pay the required Employee contributions for Dependent coverage from the newborn's date of birth. Once enrolled, coverage for the newborn will be effective as of the child's date of birth. For your convenience, you may come by the Workforce Services Department prior to your delivery date to complete an enrollment form adding the newborn, but leaving the date of birth and the child's name blank. Once the newborn has arrived, you must contact the Workforce Services Department in order to furnish the newborn's name and date of birth.

If you do not add your newborn as a Dependent within the sixty (60) day period following the date of birth, then you may not add coverage for your newborn until the next annual open enrollment period <u>or</u> unless you experience a family status change.

If you enroll your newborn under the Plan within sixty (60) days following the date of birth, you may not drop coverage for the newborn unless you experience a family status change **or** until the next annual open enrollment period.

MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

If a child of a covered individual reaches twenty-six (26) years of age (at which time coverage would normally terminate) but the child is mentally or physically incapable of supporting themselves and primarily dependent upon you for support, coverage may be continued. You must submit satisfactory proof of the child's incapacity to the Group Benefits Administrator within thirty-one (31) days of the date the child reaches age twenty-six (26) Coverage may continue for such child as long as the incapacity continues, subject to payment of the required contribution and all other terms of the Plan.

The Group Benefits Administrator may require satisfactory proof of the continued incapacity documented as a disability by the Social Security Administration (SSA). The Group Benefits Administrator may have a physician examine the child or may request proof to confirm the incapacity, but not more often than once a year. If you fail to submit proof when reasonably required or refuse to allow the Group Benefits Administrator to have the child examined, then coverage for the child will terminate.

ACTIVE DUTY RESERVISTS

Active duty reservists or guard members and their covered Dependents can maintain eligibility on the Plan for up to twenty-four (24) months as prescribed by and subject to the terms and conditions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). The date on which the person's absence begins is the qualifying event for Continuation of Coverage (COC) to be offered to the reservist or guard member.

If a fire fighter or police officer is called to active duty for any period, the employing municipality must continue to maintain any health, dental or life coverage received on the date the fire fighter or police officer was called to active military duty until the municipality receives written instructions from the fire fighter or police officer to change or discontinue the coverage. Such instruction shall be provided no later than 60 days following the Qualifying Event. If no such instruction is given, then coverage will terminate on the 61st day, which shall then become the Qualifying Event for COC purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

In administering this coverage, TML IEBP will follow the time guidelines of Continuation of Coverage under 42 U.S.C.A. 300bb-1 *et seq*. To qualify for this coverage, the Employee must give written notice to the Employer within sixty (60) days of the qualifying event. The Employer must notify TML IEBP that an Employee has been called to active duty and submit a copy of the Member's Active Reservist Policy.

If the Employee will be on active duty for thirty-one (31) days or less, the Employer will keep the Employee on the plan with no change in coverage. If the Employee will be on active duty for more than thirty-one (31) days, the Employer will notify TML IEBP of the qualifying event.

If TML IEBP administers Continuation of Coverage, the Employer must notify TML IEBP by sending a Qualifying Event Notice and mark the qualifying event "Called to Active Duty."

If the Employer administers their own Continuation of Coverage, the Employer must notify TML IEBP of the termination if call to active duty is more than thirty-one (31) days. The Employer is responsible for all required notices.

For the Employee to return to the Employer's plan and continue their benefits with no waiting period or preexisting condition the Employee must return to work within the time period required by state and federal law for such return.

The additional 2% of contribution is not charged for an Employee called to active duty.

COVERAGE FOR ACTIVE EMPLOYEES AGE 65 OR OLDER

If you are age 65 or over and are actively employed with the City of Carrollton, you may elect to enroll for benefits under this Plan for yourself and your Dependents (provided you and your Dependents meet the eligibility requirements of this Plan), even if you have Medicare coverage.

If you elect coverage under this Plan and you also have Medicare coverage, this Plan will be considered primary when coordinating benefits with Medicare.

RETIREE COVERAGE

If you are retiring from the City through TMRS or a deferred compensation plan sponsored by the City, you and any of your Dependent(s) who have healthcare coverage under this Plan at the time of retirement may elect to continue the existing coverage providing that the retiring employee is under age 65. If you discontinue coverage under this Plan, due to enrollment in Medicare, a Medicare plan or death, your dependents who are on the Plan at the point of your discontinuance may continue coverage on this Plan provided your dependents meet the eligibility requirements of this Plan. A Medicare plan includes but is not limited to a Private Fee For Service Advantage plan or Medicare Supplement plan.

You are responsible for notifying the Workforce Services Department of your desire to continue coverage upon retirement. In order to continue coverage, you must complete an election form and coordinate monthly payment through TML IEBP. Furthermore, only those Dependents whose coverage is in effect prior to your retirement may continue coverage. After the effective date of your retirement, you will **not** have the option to add coverage for any Dependents during any annual open enrollment period offered by the City of Carrollton, unless a Retiree's Spouse is employed when the employee retires. In that case, when a retiree's spouse ceases to be employed and loses coverage, the spouse may enroll as a dependent of the retiree providing that they meet the eligibility requirements of this Plan.

If you elect to continue coverage, your coverage will be identical to the coverage provided to active Employees or beneficiaries at the time of your retirement. You will be responsible for paying the full cost of your coverage. In the future, coverage and related cost for retirees may be modified the same as for active Employees and beneficiaries of the Plan.

Your Retiree coverage will terminate upon the occurrence of certain events. For details, please refer to the Termination Date of Coverage section of this Booklet.

TERMINATION DATE OF COVERAGE

This is an incurrence of expense Plan that excludes payment for any service of any type incurred after coverage ends. For information concerning your right to continuation of dental coverage and when your continuation period will terminate, please refer to the Continuation of Coverage section of this Booklet.

EMPLOYEE COVERAGE

Coverage for an Employee will terminate upon the earliest occurrence of any of the following:

- 1. to the end of the month in which your employment terminates;
- 2. the effective date of your voluntary cancellation of your coverage during any open enrollment period or the effective date of your voluntary cancellation of your coverage due to an Internal Revenue Code Section 125 family status change;
- 3. the date you are no longer eligible for coverage;
- 4. the date the group benefit Plan terminates;
- 5. as provided under any other City of Carrollton Administrative Directive.

DEPENDENT COVERAGE

Coverage for a Dependent will terminate upon the earliest occurrence of any of the following:

- 1. to the end of the month in which the covered Employee's employment terminates;
- 2. the effective date of the covered Employee's voluntary cancellation of your coverage during any open enrollment period or the effective date of the covered Employee's voluntary cancellation of your coverage due to an Internal Revenue Code Section 125 family status change;
- 3. if you fail to pay the required contribution for Dependent coverage by the last day of each month. In this case, coverage will end on the last date through which you made a timely contribution;
- 4. the date you no longer meet the definition of Dependent under this Plan;
- 5. the date this group benefit Plan terminates;
- 6. when the covered Employee's coverage terminates as provided under any other City of Carrollton Administrative Directive;
- 7. the date your dependent becomes covered under a Children's Health Insurance Program of any state.

Coverage for a dependent cannot extend beyond the date coverage for the Employee ends unless required by Section 615.071 of Chapter 615 of the Government Code for survivors of certain employees described in Section 615.003 of the Chapter who are killed in the line of duty.

RETIREE COVERAGE

Coverage for a Retiree will terminate upon the earliest occurrence of any of the following:

- 1. the effective date of your voluntary cancellation of coverage;
- 2. if you fail to pay the required contribution for your coverage by the last day of each month. In this case, your coverage will end on the last date through which you made a timely contribution;
- 3. the date you are no longer eligible for coverage;
- 4. the date the group benefit Plan terminates.

RETIREE DEPENDENT COVERAGE

Coverage for a Dependent of a Retiree will terminate upon the earliest occurrence of any of the following:

- 1. the effective date you or the covered Retiree voluntarily cancel your coverage;
- 2. if you fail to pay the required contribution for your coverage by the last day of each month. In this case, your coverage will end on the last date through which you made a timely contribution;
- 3. the date you are no longer eligible for coverage;
- 4. the date you no longer meet the definition of Dependent under this Plan;
- 5. the date the group benefit Plan terminates.

OTHER HELPFUL CLAIMS INFORMATION

ASSIGNMENT OF BENEFITS

Assignment of benefits may be made to a healthcare provider if they are assigned by the covered person. Assignment of benefits will not be accepted for any other providers, including pharmacists. If you want your healthcare provider to receive any benefit check that is due on your claim, it is necessary to assign your benefits to that provider. Many providers will ask you to sign your assignment over to them at the time of service. This is usually easier for you, since in most cases it will reduce the amount of money you will have to pay at the time of your visit. The provider will only collect from you the amount that will be unpaid by the Plan because of your remaining Deductible (if any) and your coinsurance. If you have already paid the provider in full, do not sign the Assignment of Benefits form, because if you do, the Plan will send your check to the provider rather than to you.

APPEAL OF DENIED CLAIMS

If a claim for benefits is wholly or partially denied, an Explanation of Benefits (EOB) will be furnished to the covered individual and the provider of services. This EOB will give the reason(s) the claim was denied. If the covered individual or provider of services does not agree with the claim decision or alleges that a contractual prompt payment requirement was not followed in the administration of a claim, he or she may submit an appeal. The appeal must be in writing and received by the Group Benefits Administrator (TML IEBP) within 60 days of the date of the EOB. Relevant information supplied by the covered individual or healthcare provider should be included with the appeal. For claims denied or partially denied for not being notified, the appeal must include the admission history and physical, the discharge summary and the operative and pathology reports (if applicable) before it can be considered. An appeal requested without proper documentation may not be considered. All written appeals should be sent to the Group Benefits Administrator's address printed on the Medical/Prescription ID cards. These appeal provisions shall be applicable where a provider makes a complaint that a prompt payment contract was not followed.

All appeals must be sent in writing to:

TML Intergovernmental Employee Benefits Pool Claims Appeal PO Box 149190 Austin, Texas 78714-9190

An appeal requested without proper documentation may not be considered. A decision will be rendered within thirty (30) days of all information required to reach a determination. The appealing party will be notified in writing of the results of an appeal. If the individual does not agree with the decision a second written appeal must be submitted to TML IEBP within 60 days. The request should state in clear and concise terms the reason(s) for the dispute. The appeal will be reviewed again and the final determination furnished, in writing, within 120 days. If the member is not satisfied with the decision of the second appeal, a third and final appeal may be sent to the TML IEBP for a review.

PROTECTED HEALTH INFORMATION

TML Intergovernmental Employee Benefit Pool's staff requesting protected health information will be responsible for obtaining a signed consent/authorization form from the covered person. The consent/authorization form will include the purpose of the protected health information request and will include information on the covered person's ability to revoke the consent/authorization at any time. If the covered person revokes the request, but the information has already been used, the covered person will be informed on how the information had been used.

TML Intergovernmental Employee Benefits Pool will document the accounting procedures of protected health information disclosures, procedures for resolution to protected health information concerns, and documentation will be maintained on any revocations.

TML Intergovernmental Employee Benefits Pool will not disclose protected health information without the covered person's consent/authorization, unless the regulations specify that the covered person's consent/authorization is not required.

HOW TO FILE A DENTAL CLAIM

FILING DEADLINE

A claim for a dental expense you have incurred should always be filed promptly. All claims and requests for additional information must be filed and received by the Group Benefits Administrator no later than twelve (12) months from the date the expense was incurred, unless it was not reasonably possible to furnish the information within the filing deadline as determined by the Group Benefits Administrator, or within ninety (90) days after a decision is made by the employer's workers' compensation carrier or by the Workers' Compensation Division of the Texas Department of Insurance, that the medical expense sought to be claimed is due to an injury that is non-compensable, whichever is later. Determination of "reasonably possible" is at the sole discretion of the Group Benefits Administrator.

WHAT YOU NEED TO SUBMIT WITH YOUR CLAIM

You need an original, itemized bill for each expense you submit for payment. This original, itemized bill must be filled out by the provider of the service and must show:

- 1. the patient's full name,
- 2. the Plan member's full name, employer, and social security number,
- 3. the provider's full name, address and tax identification number,
- 4. the date of each service,
- 5. the charge for each service,
- 6. the specific name of each service,
- 7. the diagnosis for each service, and
- 8. other insurance information, if applicable.

The Plan can only accept original, itemized bills. Bills written out by yourself, cash register, credit card receipts or canceled checks cannot be accepted by the Plan.

When coordinating benefits with this Plan and any other coverage you may have, you must submit a copy of the original, itemized bill **and** a copy of the explanation of benefits statement from the Group Benefits Administrator of your other coverage.

In some instances you may need to obtain a letter of necessity from your Physician for a service. TML IEBP will contact you if this letter is necessary for the claim you have submitted.

All paperwork sent in with a claim, including all itemized bills, are kept by TML IEBP. Please make copies of any paperwork you are submitting BEFORE sending it in.

HOW TO AVOID DELAYS IN RECEIVING YOUR PAYMENT

Your claim can only be processed if all paperwork and necessary information is received by TML IEBP. For this reason, be sure to submit only original, itemized bills. If you are filing a preventive/routine benefit claim, be sure to have your Physician utilize the appropriate diagnosis and procedure codes for a preventive/routine exam.

If there is other coverage, which is primary, TML IEBP cannot process your claim until you first submit a statement from the other coverage indicating how much they paid on the same charge. This statement is usually referred to as an "Explanation of Benefits," and will be sent to you from the other coverage once they have made their payment. This form must be sent in to TML IEBP with your claim even if the other coverage made no payment whatsoever.

If for any reason there will be a delay in processing your claim, TML IEBP will contact you to let you know what information is needed to complete your claim. If TML IEBP contacts the provider of the service to obtain this information, they will send a copy of the letter to you as well, so that you are aware that there is a delay, and the reason for the delay. If you know the answer to the question TML IEBP is asking the provider you may contact TML IEBP yourself to provide that information.

FOREIGN PROVIDERS

When services are rendered by a provider who is located outside the United States or its territories for the treatment of an emergency or illness that requires immediate care, TML IEBP may require that such provider submit, at their own expense, a copy of any and all medical records that will support and/or substantiate the charges. Furthermore, all such records must be in English and all such charges must be in U.S. dollars. No benefits will be payable on any charges for which medical records have been requested until such records are received and reviewed by TML IEBP's Medical Management staff. The plan's facility guidelines by definition of will not apply if the facility is not located within the United States or its territories.

LEGAL ACTIONS

No legal action may be brought against the Group Benefits Administrator prior to the expiration of sixty (60) days after a written request for reimbursement has been furnished to the Group Benefits Administrator in accordance with the requirements of the Plan, **and** all appeal rights available to the Plan have been exhausted. No such action shall be brought after the expiration of two (2) years from the date service was incurred. This paragraph shall be applicable where a medical provider makes a complaint that a prompt payment contract was not followed.

The Group Benefits Administrator reserves the right to take any legal action available against a covered individual to recover expenses incurred by the Group Benefits Administrator to defend frivolous lawsuits or actions brought before all appeal rights have been exhausted.

CITY OF CARROLLTON COVERAGE SUMMARY

SCHEDULE OF DENTAL EXPENSE BENEFITS

Description of Benefits	Benefit Percentage
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STARS PLAN

Preventive Dental	80%
Basic Dental	80%
Major Dental	80%
Orthodontic (no age limit)	50%

Benefit Deductibles and Maximums

Individual Deductible Amount \$50 per calendar year
Preventive, Basic and Major Dental Expense Benefit \$1,500 per calendar year
Orthodontic Benefit \$1,000 per lifetime

All Covered Dental Expenses Unlimited lifetime benefit while covered under the Plan

STRIPES PLAN

Preventive Dental 50%
Basic Dental 50%
Major Dental 50%

Orthodontic No Orthodontic Coverage

Benefit Deductibles and Maximums

Individual Deductible Amount

Preventive, Basic and Major Dental Expense Benefit

All Covered Dental Expenses

There is not a deductible on the Dental Low Plan

\$1,000 per calendar year

Unlimited lifetime benefit while covered under the Plan

DENTAL EXPENSE BENEFITS

The dental expenses described in this section are designed to be used in conjunction with the medical expense benefits of this Plan. If you elect dental coverage under this Plan, and do not elect medical coverage under this Plan, you will experience some gaps in coverage. For example, medications prescribed for dental services or treatment will only be payable if you are covered for medical benefits under this Plan. Also, only those oral surgeries specifically listed in the Dental Schedule of Benefits will be payable under your dental coverage. No other surgical procedures will be payable unless the procedure is a covered medical expense under this Plan, and you have elected medical coverage under this Plan. All dental charges and orthodontic charges are subject to reasonable and customary guidelines. You may use the dental provider of your choice regardless of plan.

BENEFITS AVAILABLE

The Plan will cover charges for Preventive, Basic, and Major Services in excess of the deductible amount and subject to certain maximums. The Benefit Percentage, the Deductible, and the Maximum Benefits are shown in the Dental Schedule of Benefits.

PRE-TREATMENT ESTIMATE

While a Pre-Treatment Estimate is not required for any dental treatment, it is **recommended** that you obtain a Pre-Treatment Estimate for any dental treatment other than a routine cleaning or filling so that you will know in advance of receiving the treatment whether or not the dental procedure is a Covered Expense, **and** if there is an alternate and professionally adequate treatment (one that is usually less expensive) that could be substituted for the dental procedure you are considering. By obtaining a Pre-Treatment Estimate, you will avoid being surprised with any benefit reductions once the claim is processed.

COVERED DENTAL EXPENSES

Covered Expenses will include the Reasonable and Customary charges incurred for Preventive, Basic, Major, and Orthodontic Services in excess of the Deductible. The Percentage Payable, Deductibles, and any Maximum Amounts are given in the Dental Schedule of Benefits.

If a Covered Person has Medical and Dental Coverage, or Medical Coverage only, benefits for cutting procedures in the oral cavity for cysts and tumors will be payable as a Medical benefit **only**.

- 1. Preventive Benefit includes:
 - a. two routine dental examinations per Calendar year;
 - b. two prophylaxis (teeth cleaning) treatments per Calendar year;
 - c. two (2) routine bitewing x-rays (four films) twice each Calendar year; and
 - d. fluoride treatments if less than 18 years old.
- 2. Basic Benefits includes:
 - a. extractions;
 - b. treatment of tooth pulp, including root canal therapy;
 - c. oral surgery apicoectomies and extractions of impacted or erupted teeth (including alveolectomy, alveoplasty, and tori removal in connection with extractions);
 - d. local anesthesia or I.V. sedation for covered oral surgery;
 - e. general anesthesia when medically indicated and administered by a Physician other than the operating dentist;
 - f. restorative services (fillings) using amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations, but excluding gold and baked porcelain fillings;
 - g. periodontal scaling, treatment, diagnosis, and surgery;
 - h. full mouth series of x-rays limited to one series in any 36 month period, and other diagnostic x-rays, provided no x-rays are in connection with a program of orthodontics;
 - i. antibiotic injections;
 - repair or recementation of crowns, inlays, onlays, bridgework or dentures; and relining or rebasing of dentures 6 months after the denture is installed, limited to one relining or rebasing within any 36 month period;
 - k. initial installation of partial or full removable dentures, including precision attachments and any adjustments during the first 6 month period following installation;
 - I. replacement of an existing full or partial removable denture or fixed bridgework by a new denture or new bridgework due to the extraction of teeth after the denture or bridgework was installed;
 - m. replacement or modification of existing bridgework or denture which cannot be made serviceable, and which are installed more than 5 years prior to replacement or modification;
 - n. space maintainers for missing primary teeth for a Covered Person younger than 14 years of age;
 - o. emergency palliative treatment; and
 - p. sealants

3. Major Benefit includes:

- a. initial fixed bridgework, including inlays and crowns as abutments;
- b. initial inlays, onlays, gold fillings or crown restoration; and
- c. removable mouthguard to alleviate bruxism.

4. Orthodontic Benefit includes:

- a. essential services required for the straightening of misaligned teeth, by use of braces. Related Covered Expenses are:
 - initial diagnostic procedures;
 - orthodontic diagnostic procedures and treatment, including oral examination, surgery and extractions for Covered Persons;
 - removal of teeth;
 - the first essential appliances;
 - correction of misaligned teeth; and
 - correction of malocclusion by wire appliances, braces and other mechanical aids.

EXCLUSIONS AND LIMITATIONS APPLICABLE TO DENTAL BENEFITS

There are certain expenses that the Plan will not pay. The Plan will not pay any expenses incurred by you or your Dependents for any illness, accidental bodily injury or disability or any charge for care or services which is:

- 1. dental treatment received from a dental or medical department maintained by the Employer, a mutual benefit association, labor union, trustee, or similar type of group;
- 2. education counseling with regard to dietary planning, plaque control, or oral hygiene instruction;
- 3. congenital or developmental malformation existing when the person became covered under this Plan;
- 4. the replacement of lost, missing, or stolen prosthetic devices;
- 5. dental treatment involving the use of gold if such treatment could have been rendered at a lower cost by means of a reasonable substitute;
- 6. installation of an initial prosthodontic appliance when such charges are incurred for replacement of congenitally missing teeth or replacement of teeth all of which were lost while the individual was not covered by this Plan;
- 7. replacement of an existing prosthodontia appliance unless:
 - a. necessitated by the extraction of additional natural teeth while covered under this Plan, or
 - b. the existing appliance is at least 5 years old and cannot be made serviceable and 12 months have elapsed since the effective date of coverage, or
 - c. the replacement appliance is made necessary as a result of an initial placement of an opposing denture while covered;
- 8. any expenses incurred for treatment rendered after the date of termination of an individual's coverage, except that Covered Expenses incurred after coverage has terminated for laboratory work for:
 - a. dentures
 - b. fixed bridgework (including pontics and retaining crowns), and
 - c. restorative crowns, inlays, or onlays that were ordered prior to termination of coverage <u>and</u> delivered within 30 days following such termination.

Ordered means for dentures, that impressions have been taken from which the denture will be prepared; or for the other types of services, that the teeth which will serve as retainers or support or which are being restored have been fully prepared to receive, and impressions have been taken from which the fixed bridgework, restorative crowns, inlays or onlays will be prepared;

- 9. dental treatment other than by a duly licensed dentist or Physician, except for work done by a dental hygienist, technician, or laboratory that is within the scope of their license and which is performed under the direction of a Dentist or Physician;
- 10. temporary restorations;
- 11. any duplicate prosthetic device or any other duplicate appliance;
- 12. implantology;
- 13. charges for care or treatment of occlusion by adjustment, appliance, or restorations, except for orthodontics, if provided;
- 14. any expense incurred prior to becoming covered or any dental work in progress at the time a patient becomes covered under this Plan;
- 15. any charges in excess of the charges customarily made when alternate services or supplies are customarily available for such treatment, beyond the charge for the least expensive service or supply resulting in professionally adequate treatment, unless alternate services or supplies have previously been utilized and have subsequently proven to be unsuccessful;

- 16. services and supplies that are cosmetic in nature, including charges for personalization or characterization of dentures, unless such charges are:
 - a. because of an accidental bodily injury which took place while the patient was covered under this Plan,
 - b. for facings for crowns on molar teeth if needed as a result of an accidental bodily injury, or
 - c. for a birth defect or illness of a Covered Dependent born to you or your spouse while covered for Dependent's Coverage;
- 17. for periodontal splinting.
- 18. for any condition, illness, injury or complication thereof arising out of or in the course of employment;
- 19. for any condition, illness, injury or complication thereof which could or might have been furnished if pursued, or sought, according to the provision of any workers' compensation or occupational disease law, or any other law or regulation of the United States or of a state, territory or subdivision thereof, or under any policy of workers' compensation or occupational disease coverage, or according to any recognized legal remedy available to a Covered Person;
- 20. the result of an act of war, declared or undeclared, or any type of military conflict, nor loss caused by any means for disease contracted or injuries sustained in any country while such country is at war or while en route to or from any such country at war;
- 21. rendered on an unproven, research basis when not generally accepted medical or dental practice;
- 22. not actually rendered;
- 23. for any services or supplies furnished to an individual prior to the date coverage became effective for such individual or subsequent to termination of the individual's coverage under this Plan, except as provided in any subsection of this Plan;
- 24. rendered by a member of your family or close relative, including a person related by blood or marriage;
- 25. not specifically listed as a Covered Dental Expense;
- 26. the result of travel outside the United States or its territories specifically to receive medical or dental treatment; however, the Plan does provide benefits for you and your Covered Dependents for covered medical treatment which you receive while traveling outside the United States on a trip whose purpose is other than specifically to receive medical care;
- 27. filed later than twelve (12) months from the date the expense was incurred;
- 28. the result of:
 - mandibular or maxillofacial surgery to correct growth defects, jaw disproportion's or malocclusions, except for correction of a congenital anomaly in a child who was covered under this Plan from birth, or
 - b. appliances or restorations used solely to increase vertical dimension, reconstruct occlusion or correct or treat dysfunction pain syndromes to include temporomandibular joint (TMJ) dysfunction, or
 - c. hospital confinements for the treatment or correction of any conditions excluded in a. or b. above.

CONTINUATION OF COVERAGE (COC) RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA Continuation of Coverage (COC), which is a temporary extension of coverage under the Plan. This notice generally explains Continuation of Coverage when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to Continuation of Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Continuation of Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan book or contact TML IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754, (800) 282-5385.

WHAT IS CONTINUATION OF COVERAGE?

Continuation of Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, Continuation of Coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect Continuation of Coverage may be required to pay depending on the policy of your employer.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- 1. Your hours of employment are reduced; or
- 2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of the employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 1. Your spouse dies;
- 2. Your spouse's hours of employment are reduced;
- 3. Your spouse's employment ends for any reason other than his or her gross misconduct;
- 4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B and/or Part C); or
- 5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- 1. The parent-employee dies;
- 2. The parent-employee's hours of employment are reduced;
- 3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
- 4. The parent-employee becomes entitled to Medicare benefits (Part A, Part B and/or Part C);
- 5. The parents become divorced or legally separated; or
- 6. The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title II of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer and the bankruptcy results in the loss of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS CONTINUATION OF COVERAGE AVAILABLE?

The Plan will offer Continuation of Coverage to qualified beneficiaries only after the Group Benefits Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or the employee's becoming entitled to Medicare benefits (under Part A, Part B and/or Part C), the employer must notify the Plan Sponsor of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

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 must notify the Group Benefits Administrator within sixty (60) days after the qualifying event occurs. The City of Carrollton is the Group Benefits Administrator.

WHEN ARE CONTINUATION OF COVERAGE PAYMENTS DUE?

If the qualified beneficiary elects Continuation of Coverage, then the qualified benefit has forty-five (45) days from election to make the first payment. If insignificant partial payments are made, TML IEBP will contact the qualified beneficiary for full payment. The qualified beneficiary has thirty (30) days from deficiency notification to make payment. Insignificant payment deficiency is \$50 or 10% of amount due.

HOW IS CONTINUATION OF COVERAGE PROVIDED?

Once the Group Benefits Administrator receives notice that a qualifying event has occurred, Continuation of Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect Continuation of Coverage. Covered employees may elect Continuation of Coverage on behalf of their spouses, and parents may elect Continuation of Coverage on behalf of their children.

Continuation of Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (Part A, Part B and/or Part C), your divorce or legal separation or a dependent child's losing eligibility as a dependent child, Continuation of Coverage lasts for up to a total of thirty-six (36) months. When the qualifying event is the end of the employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, Continuation of Coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, Continuation of Coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six (36) months minus eight (8) months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, Continuation of Coverage generally last for only up to a total of eighteen (18) months. There are two ways in which this eighteen (18) month period of Continuation of Coverage can be extended.

DISABILITY EXTENSION OF EIGHTEEN (18) MONTH PERIOD OF CONTINUATION OF COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Sponsor in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of Continuation of Coverage for a total maximum of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of Continuation of Coverage and must last at least until the end of the eighteen (18) month period of Continuation of Coverage.

SECOND QUALIFYING EVENT EXTENSION OF EIGHTEEN (18) MONTH PERIOD OF CONTINUATION OF COVERAGE

If your family experiences another qualifying event while receiving eighteen (18) months of Continuation of Coverage, The spouse and dependent children in your family may get up to eighteen (18) additional months of Continuation of Coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving Continuation of Coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B and/or Part C) or gets divorced or legally separated, of if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your Continuation of Coverage rights should be addressed to the contact or contacts identified below. State and local government employees seeking more information about their rights under COBRA Continuation of Coverage, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, can contact the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services at:

- www.cciio.cms.gov/programs/protections/cobra/cobra fact sheet.html; or
- www.cciio.cms.gov/programs /protections/cobra/cobra qna.html.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

RIGHT OF RECOVERY

The City of Carrollton offers you the benefits described in this Booklet to protect you against the cost of hospital and medical-surgical services required in case of illness or injury. The Plan is not intended to serve any other purpose.

If you are injured and someone else is legally responsible to pay the expenses of your treatment or damages, the Plan Sponsor reserves the right to have the expenses reimbursed from whomever was responsible. However, the Plan will pay your expenses first. The benefits payable under this right of recovery provision will never exceed the benefit percentage applicable to each Covered Expense under this Plan.

This Plan will have a right of recovery for any expenses paid under the Plan where recovery is made due to a cause of action for these expenses. This right of recovery in no way entitles the patient to reimbursement of legal expenses unless agreed to by the Plan.

Since this Plan is a self-funded plan, we request that Employees notify the Workforce Services Department of those circumstances in which a third party may be liable.

The Covered Person agrees to cooperate fully with TML Intergovernmental Employee Benefits Pool in asserting its right to subrogate for the Plan. This means that the Covered Person must supply the Group Benefits Administrator with all information and sign and return all documents reasonably necessary to carry out the Plan's right to recover from the third party any benefits paid under the Plan, which are subject to the provision.

The payor of employee benefits, whether a political subdivision, group of political subdivisions, pool or carrier providing reinsurance to one of these entities, shall be subrogated to the employees' right of recovery for personal injuries caused by the tortuous conduct of a third party.

Covered charges due to an accidental injury will be subject to the deductible and paid according to the Medical Schedule of Benefits percentage. A Right of Recovery Form will need to be completed on all accidents.

RIGHT OF RECOVERY

The Group Benefits Administrator has the right to seek reimbursement on any overpayment from one or more of the following:

- 1. the covered individual;
- 2. the person to whom such payments were made;
- 3. any other insurance company;
- 4. any other benefit plan; or
- 5. any other organization providing benefits.

In addition, the covered person specifically delegates to the Group Benefits Administrator the right to make a claim or assert a cause of action on the covered person's behalf against any source of recovery, and assign to the Plan the right to any proceeds from the claim or cause of action.

Right of Recovery: The covered person agrees to cooperate fully with the Plan in asserting its right to subrogate. This means the Covered Person must supply the Group Benefits Administrator with all information and sign and return all documents reasonably necessary to carry out the Plan's right to recover from the third party any benefit paid under the Plan which are subject to the provision.

COORDINATION OF BENEFITS

The City of Carrollton Plan will coordinate with other dental group plans, individual plans and no-fault insurance plans. When coordinating benefits, all of the provisions of the City Plan, including, but not limited to, Reasonable and Customary charges, annual and/or lifetime Maximums, exclusions/limitations, Covered Expenses and Benefit Percentages Payable will apply. The benefits payable under this Plan will not exceed 100% of eligible expenses when combined with all other plans. In other words, as secondary payor the plan will figure what the allowable amount for the service billed would be in the absence of the primary carrier and subtract any payment made by the primary payer from that amount. Any difference would be what the plan would pay as the secondary payer. When coordinating as the secondary payer, the payment under this plan would never exceed our total allowable for the service rendered, or what the plan's normal payment would be.

For example:

Charge = \$100 (deductible already satisfied) Allowable Amount = \$100 Primary Carrier Payment = \$75 The Plan's Payment = \$25

When the City Plan is secondary, the Employee will submit the claim to the primary carrier first for payment. After the primary carrier has paid the claim, the Employee submits the bill and the documentation of what has been paid by the primary carrier to TML IEBP. The City of Carrollton Plan will coordinate with all of the following plans under which a person is entitled to receive, or has received, benefits or services for or by reason of dental treatment:

- 1. Group plans, individual plans, insured or noninsured; group blanket or franchise insurance coverage; group hospital or medical service plans, and other group pre-payment coverage; any coverage under labor management trusteed plans, union welfare plans, employer organization plans or Employee benefit organization plans;
- 2. Any coverage required or provided by any statute, including any no-fault automobile insurance provided or required by statute;
- 3. Any plan sponsored by or provided through a school or other educational institution.

The rules establishing the order of benefit determination between the City of Carrollton Plan and any plan under which you may have coverage are as follows:

- 1. If the claim is on a person who is covered as both an Employee (or a Member) under one plan and as a Dependent under another plan, then the primary payor is the plan where the person is employed (or is a member).
- 2. If the claim is on a person who is a Dependent child under both parents' plans, the plan which covers the claimant as a Dependent child of the parent whose birthdate (month and day) occurs earlier in the calendar year will determine its benefits before a plan which covers the claimant as a Dependent child of the parent whose birthdate occurs later in the calendar year. If both parents have the same birthdate, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
- 3. When rules 1 and 2 do not establish an order of benefits determination, the benefits of a plan which has covered the individual for whom claims are made for the longer period of time will be the primary payor.
- 4. If the parents are divorced or legally separated, the rules of establishing the order of benefit determination are as follows:
 - a. If there is a court decree which establishes financial responsibility for medical, dental or other health care expenses for the Dependent child, the plan covering the parent who has that responsibility will be the primary payor.
 - b. If there is no such court decree, the plan covering the parent who has custody of the Dependent child will be the primary payor.

- c. If there is no such court decree, and the parent who has custody has not remarried, the order of benefit determination is:
 - The plan covering the parent who has custody.
 - The plan covering the spouse of the parent who has custody (that is, the step-parent of the child).
 - The plan covering the parent without custody.

If the claim is on a Retiree covered under a plan in which the covered Retiree (or a Dependent of a retiree) who is under another plan, primary coverage will be established as to the plan first effective.

If the claim is on an Active Employee, then the benefits of the plan that covers you as an Employee who is are determined before those of a plan which cover you as Retired Employee. The same would hold true if you are a Dependent of a person covered as a retiree and as an Employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this paragraph does not apply.

If none of the above rules determine the order of benefits, then the plan that has covered the person for the longest period of time is primary.

DEFINITIONS

These terms define words that may be used in the Plan Booklet/Document. These definitions shall not be construed to provide coverage under any benefit unless specifically provided.

ACCIDENTAL INJURY – A traumatic bodily injury defined as to time and place sustained independently of all other causes by outside event, external force or due to exposure to the elements.

ACTIVELY AT WORK – Is an Employee who works at least twenty (20) hours per week or is accessing vacation, sick (including days accessed through the City's donated leave program) or paid/unpaid Family Medical Leave Act of 1993 (FMLA) and is receiving the same benefits as all other employees. Paid leave per the Employer's policy may exceed a period of twelve (12) or more consecutive months, if the employee has accrued vacation and sick time, and/or if they access paid leave through the City's donated leave program.

ADMINISTRATIVE DIRECTIVE – Any directive, policy, rule or regulation approved by the City of Carrollton City Manager and/or any directive, policy, rule or regulation adopted by the Police Officers' and Fire Fighters' Civil Service Commission of the City of Carrollton.

AMENDMENT – A formal document adopted by the Plan changing the provisions of the Plan. Amendments apply to all covered individuals, including those persons who are covered before the amendment becomes effective, unless otherwise specified.

BENEFIT – The amount payable by the Plan for Eligible Benefits.

BENEFIT PERCENTAGE – The percentage of Eligible Benefits payable by the Plan after deductible and copay.

CALENDAR YEAR – A period of twelve (12) consecutive months beginning 12:01 a.m. on January 1 and ending at midnight, December 31.

CLEAN CLAIM – A claim for covered services that is received from a network provider that reflects the standard claim format, and accurately contains the following information: patient name, patient's date of birth, unique identification number, provider's name, address and tax ID number, date(s) of service, diagnosis narrative or ICD-9 code, procedure narrative or CPT-4 codes, services and supplies provided, physician name and license number, provider charges and an itemized bill if the bill is in excess of \$15,000 outpatient and \$20,000 inpatient. Such itemized bill will be required to adjudicate the claim. Claim must be submitted by provider no later than the filing deadline. If the provider fails to submit the claim within compliance of the filing deadline and the clean claim definition the provider forfeits the right to payment unless the failure to submit the claim in compliance is a result of a catastrophic event that substantially interferes with the normal business operations of the network provider.

CLINICAL TRIALS – Clinical trials are controlled scientific studies designed to assess the effectiveness of procedures, drugs and devices. Typically, clinical trials are performed after a treatment shows promise during limited testing.

- 1. Phase I Trials Medical researchers test the drug with a small group of people to discover its metabolic and pharmacologic actions in humans, as well as its safety, dosage and side effects. They also test the impact of increasing doses and early evidence of effectiveness. This trial may include healthy participants or patients.
- 2. Phase II Trials This stage is a controlled clinical study that evaluates the effectiveness of the drug for a particular indication or indications in patients with the condition under study. During this stage, researchers test the new drug with a slightly larger group of people (100 to 300) to collect more information about it common short-term side effects, efficacy and risks.
- 3. Phase III Trials The third stage expands controlled and uncontrolled trials after preliminary evidence suggests the effectiveness of the drug has been determined. Its purpose is to gather more information to evaluate the overall risk benefit of the drug and provide a satisfactory basis for physician labeling. Researchers give the drug to an even bigger group (between 1000 to 3000 people) monitor its use, compare it to other treatments and further ensure its safety.
- 4. Phase IV Trials Post marketing studies to identify additional uses for an FDA approved medication. The studies also identify the drug's risks, benefits and optimal use.

CONTRIBUTION – The amount payable by the Employer, the amount payable by the Employee, or the amount payable by the Employer/Employee jointly for participation in the benefits of the Plan.

COVERED EMPLOYEE – An Employee who is eligible for coverage and who has enrolled in the Plan.

COVERED BENEFITS – See Eligible Benefits.

COVERED INDIVIDUAL – An Employee, Dependent of an Employee, a Retiree, and dependents of Retirees, who are eligible and have enrolled in the Plan.

DEDUCTIBLE – Eligible Benefits in a given calendar year, which are the responsibility of the Employee before benefits become payable by this Plan.

DENTIST – Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) who is a member or eligible member of the state Dental Association or eligible for membership in such association.

DEPENDENT – means one or more of the following person(s):

- An Employee's lawful Spouse (marriage certificate or a signed affidavit of common law marriage required).
- An eligible child of a Covered Employee. The term child shall include a natural child, legally adopted child, foster child, or stepchild. Grandchildren are also eligible, if the Covered Employee has Legal Guardianship. A child to be acquired by adoption is eligible for coverage upon proof of physical placement in the Covered Employee's home. A child must be principally dependent upon the Employee for support and Maintenance or must be required to be covered by the Employee by a Qualified Medical Child Support Order
- 3. An eligible child may be covered from birth to the end of the calendar month in which he/she reaches age 26.
- 4. An eligible child may be covered past age 26 provided the child is totally disabled as defined herein. Proof of these criteria must be furnished the Plan within 31 days of the child's 26th birthday or when requested at any time thereafter.
- 5. An eligible grandchild may be covered to age 26 if the grandchild resides with the employee, and is a dependent upon the employee for support. Coverage for an eligible grandchild will not be terminated solely because the child ceases to be principally dependent on the Employee for support and maintenance.
- 6. A Spouse of a Retiree or a dependent child who continues coverage per dependent definition once employee has retired.
- 7. Excluded as dependents are:
 - Any person(s) legally separated or divorced from a Covered Person: or
 - any person(s) on active Military duty for any country, except to the extent required by applicable law; or
 - any person(s) who fails to meet any of the eligibility criteria.

DISABILITY – Any of the following conditions:

- 1. illness;
- 2. bodily malfunction (impairment, disturbance or abnormality of the functioning of an organ or limb);
- 3. accidental injury;
- 4. pregnancy;
- 5. mental/nervous conditions; or
- 6. chemical dependency.

All expenses incurred as a result of the same or a related cause are considered one disability.

ELIGIBLE BENEFITS – The usual, reasonable and customary fees charged for medical service and supplies covered by this Plan and that are generally furnished for cases of comparable nature and severity in the particular geographical area where incurred. Any agreement as to fees or charges made between the individual and the doctor shall not bind the Plan in determining its liability with respect to expenses incurred. Expenses are incurred on the date which the service or supply is rendered or obtained. The covered individual also must have an obligation to pay the expense.

EMERGENCY SERVICES – See Emergent/Immediate Care.

EMERGENT/IMMEDIATE CARE – Services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

- 1. Placing the patient's life in serious jeopardy;
- 2. Serious impairment to bodily functions; or
- 3. Serious dysfunction of any bodily organ or part.

EMPLOYEE – means an individual who is regularly scheduled to work for the Employer in an Employee-Employer relationship at least twenty (20) hours per week for which such individual is paid a regular wage or salary, or accessing paid vacation, sick or paid/un-paid FMLA, or is on an Employer approved extended leave or is an Employee by the Employer approved definition. An Employee shall not include individuals who perform services for the Employer other than for a salary or wage.

EMPLOYER OR EMPLOYER MEMBER – The City of Carrollton.

ENROLL – To make written application for coverage on the prescribed forms. Enrollment is not completed until such forms are <u>accepted by the employer and received</u> by the Group Benefits Administrator within required timelines.

EXCLUSIONS – Those charges for which benefits are not provided.

FILING DEADLINE – The latest date a claim may be received by the Group Benefits Administrator in order to be considered eligible for payment. All requested additional information relating to the claim must also be received within the same time frame. This Plan's filing deadline is twelve (12) months from the date the expense was incurred, unless it was not reasonably possible to furnish the information within the filing deadline as determined by the Group Benefits Administrator, or within ninety (90) days after a decision is made by the employer's workers' compensation carrier or by the Workers' Compensation Division of the Texas Department of Insurance, that the medical expense sought to be claimed is due to an injury that is non-compensable, whichever is later. Determination of "reasonably possible" is at the sole discretion of the Group Benefits Administrator.

GROUP BENEFITS ADMINISTRATOR – TML Intergovernmental Employee Benefits Pool (TML IEBP).

HANDICAPPED CHILD/TOTAL DISABLED/INCAPACITATED CHILD — A dependent child over age twenty-six (26) who is mentally or physically incapable of supporting himself/herself and is primarily dependent upon the covered individual for financial support. The Group Benefits Administrator may require satisfactory proof of the continued incapacity documented as a disability by the Social Security Administration (SSA). The Group Benefits Administrator may have a physician examine the child or may request proof to confirm the incapacity, but not more often than once a year. If you fail to submit proof when reasonably required or refuse to allow the Group Benefits Administrator to have the child examined, then coverage for the child will terminate.

HE, HIM, HIS – Whenever the masculine pronoun is used in this Plan it shall include the feminine gender as well, unless the context clearly indicates otherwise.

HEALTHCARE PROVIDER – A Physician or a person acting within the scope of applicable state licensing/certification requirements, including, but not limited to, the following designations: Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Optometry (OD), State Licensed Durable and Medical Device/Equipment Organizations, Certified Nurse Midwife (CNM), Registered Respiratory Therapist (RRT), Licensed Physical Therapist (LPT), Licensed Psychologist, Doctor of Chiropractic (DC), Doctor of Podiatry Medicine (DPM), Podiatrist (DSC), Registered Nurse (RN), Licensed Vocational Nurse (LVN), Licensed Practical Nurse (LPN), Speech Therapist, Audiologist, Occupational

Therapist, Licensed or Registered Dietitian (LD or RD), Certified Registered Nurse Anesthetist (CRNA), Advanced Nurse Practitioner (ANP) or Registered Nurse First Assistant (RNFA).

HIPAA – Federal law referred to as the Health Insurance Portability and Accountability Act of 1996. HIPAA went into effect for most group health plans on the anniversary that occurred on or after July 1, 1997. HIPAA provides individuals certain rights and protections relating to healthcare coverage.

Federal law gives the plan sponsor of self-funded, non-federal, governmental plans the right to exempt the plan in whole or in part from requirements of Title I except for the creditable coverage certificate requirements. The City of Carrollton's Plan has opted out of HIPAA Title I and is exempt from the HIPAA Title I Requirements.

HIPAA Title I:

- Refers to creditable coverage, restrictions on pre-existing, special enrollments, non-discrimination based on Health Status Factors, Newborns' and Mothers' Health Protection Act, Mental Health Parity and Addiction Equity Act, Women's Health and Cancer Rights Act and coverage of dependent students on medically necessary leave of absence;
- Has an exemption option for self-funded, non-federal, governmental plans.

HIPAA Title II:

- Effective April 14, 2003, Administrative Simplification guidelines have been mandated. The administrative simplification process includes standards for electronic transactions and code sets, national identifiers (for employers, health plan and providers), Security and Electronic Signature Standards (Security Rule) and Standards for Privacy of Individually Identifiable Health Information (Privacy Rule);
- A self-funded, non-federal, governmental health plan cannot exempt itself from the Title II requirement.

INCAPACITY – See Disability.

INCURRED – The date on which a service is rendered or a supply is obtained.

INFUSION THERAPY – Medications administered intravenously (IV).

INJURY – See Accidental Injury.

INPATIENT – Treatment or confinement to a medical facility where a covered individual has been admitted to the hospital for bed occupancy with the expectation they will remain overnight for the purposes of receiving inpatient hospital services.

INTENSIVE CARE UNIT – A section, ward or wing within a hospital which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by nurses. This definition includes neonatal care, coronary care, pulmonary and other special care units.

INTENSIVE OUTPATIENT THERAPY – Outpatient Mental/Nervous/Chemical Dependency treatment of high frequency over a short period of time.

LARGE CARE MANAGEMENT – Large Care Management services help you use your benefits wisely during periods of treatment due to serious sickness or injury. This is done through early identification of the need for Large Care Management. Followed by ongoing work with you and your provider to plan health care alternatives to meet your needs. The Large Care Manager will try to conserve your benefits by making sure that your care is handled as efficiently as possible.

OPEN ENROLLMENT – The period as defined by the Employer in which Dependents who are not currently covered by the Plan can be added. The pre-existing benefit limitation will apply to eligible Dependents added during the Open Enrollment time period. However, the Pre-Existing condition limitations do not apply to covered individuals less than nineteen (19) years of age.

OUT OF POCKET AMOUNT – The portion of eligible expenses for which a covered individual is responsible to pay.

PHYSICIAN – A person acting within the scope of his license and holding the degree of Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD) who is eligible for membership in his respective society or association.

PLAN – The provisions for coverage and payment of benefits as described in this booklet. This is an incurrence of expense plan that excludes payment for any service of any type incurred before or after coverage ends.

PLAN ADMINISTRATOR – The City of Carrollton (the Employer).

PLAN SPONSOR – The Employer.

PLAN YEAR – The 12-month period beginning January 1st through December 31st.

PROTECTED HEALTH INFORMATION – A Federal regulation, called the "Privacy Rule," requires the City of Carrollton to protect the privacy of each covered individual's identifiable health information. Under the Privacy Rule, the Plan may use and disclose a covered individual's identifiable health information only for certain permitted purposes, such as the payment of claims under the health plan. If the Plan needs to use or disclose a covered individual's health information for a purpose not permitted under the Privacy Rule, the Plan must first obtain a written authorization signed by the covered individual.

In addition to restrictions on how the Plan may use and disclose a covered individual's identifiable health information, the Privacy Rule gives each covered individual certain rights. These include the right of a covered individual to access his or her health information, to amend his or her health information and to receive an accounting of certain disclosures of his or her health information.

The City of Carrollton's Notice of Privacy Practices explains fully how TML IEBP and the Plan may use and disclose a covered individual's identifiable health information and a covered individual's rights under the Privacy Rule.

RETIREE / RETIRED EMPLOYEES – Is a former full time employee of the employer with 25 years of employment who is under the age of 65 and was retired while employed by the employer, excluding termination. The Plan will extend the benefits for 6 months at the level of coverage in effective at the time of the employee's retirement at the employee's request. After 6 months the Plan will offer an additional 18 months of COBRA.

SOUND NATURAL TEETH – Teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

SPOUSE - Individual legally married to the Covered Employee under the laws of the State of Texas.

SUBSTANCE ABUSE – See Chemical Dependency.

USUAL, REASONABLE AND CUSTOMARY – A usual, reasonable and customary charge is deemed to be 110% of the amount prescribed by the Centers for Medicare and Medicaid Services (CMS), RBRVS, other specialty CMS fee schedules and the Ingenix Essential RBRVS Fee Schedule.

WAITING PERIOD – A period of continuous, active, full-time employment, required by the Employer that must be completed before an Employee or his eligible Dependents can be effective for coverage under this Plan.

IMPORTANT ADDRESSES

Employer/Plan Sponsor

City of Carrollton 1945 E. Jackson Road Carrollton, Texas 75011 (972) 466-3090 www.city of carroll ton.com

Group Benefits Administrator

TML Intergovernmental Employee Benefits Pool (TML IEBP) PO Box 149190 Austin, TX 78714-9190 (800) 282-5385 www.tmliebp.org Group#: ACARROL1

SIGNATURE PAGE

The effective date of the City of Carrollton Group Dental Benefit Plan January 1, 1982, as amended through January 1, 2013.

It is hereby agreed by the City of Carrollton that the provisions of this document are correct and will be the basis for the administration of the City of Carrollton Group Benefit Plan.

Dated this 6 day of <u>December</u>, 2012

BY Title: <u>Dovkforce Services</u> Director

Carrollton Eff 01/01/13 | Page 30

INDEX

\boldsymbol{A}	I
Active Duty Reservists · 7	Important Addresses · 29
B	L
Benefit Percentage · 22	Legal Actions · 12
\overline{C}	\overline{N}
Care Management · 27	Notice of Privacy Practices · 28
Claim Filing Deadline · 11 Continuation of Coverage · 7, 18, 19	0
Continuation of Coverage (COC) Rights under COBRA	Other Helpful Claims Information \cdot 10
· 18 Coordination of Benefits · 22	P
Covered Dental Expenses · 13, 14	Plan Administration · 5
<u> </u>	Plan Document · 1
D Definitions · 24	Pre-Treatment Estimate · 14 Protected Health Information · 10
Dental Expense Benefits · 13	- Totected Health Information - 10
Dependent Coverage · 9	$\overline{\varrho}$
	Qualifying Events · 19
E	\overline{R}
Employee Coverage · 9	Retiree Coverage · 7, 9
Exclusions and Limitations Applicable to Dental Benefits · 16	Retiree Dependent Coverage · 9
Deficitios 10	Right of Recovery · 21
F	C
Foreign Providers · 12	S Schedule of Dental Expense Benefits \cdot 13
\overline{G}	Stars Plan · 13
General Provisions · 4	Stripes Plan · 13
\overline{H}	T
How to Enroll in the Plan · 5	Termination Date of Coverage · 9

How to File a Medical or Dental Claim · 11