



CITY OF CARROLLTON

EMPLOYEE HEALTH

PLAN BOOKLET

EFFECTIVE JANUARY 1, 2015

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NOTICE TO PLAN PARTICIPANTS
REGARDING CITY OF CARROLLTON'S MEDICAL PLAN
ELECTION UNDER 42 U.S.C. § 300gg-21

Under Federal laws known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Health Care and Education Reconciliation Act of 2010, group health plans, such as the City of Carrollton's plan, generally must comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements if that plan is self-funded by the employer, rather than provided through a health insurance policy. Federal law allows a self-funded, non-federal, governmental plan such as the City of Carrollton to exempt its plan in whole or in part from the requirements of HIPAA Title I. The City of Carrollton has elected to opt out of the following provisions

1. Standards relating to benefits for mothers and newborns. A health plan may not restrict benefits for a hospital stay for the birth of a child to less than forty-eight (48) hours for a vaginal delivery, and ninety-six (96) hours for a cesarean section.
2. Required coverage for reconstructive surgery following mastectomy. A health plan that provides medical and surgical benefits for mastectomy must provide certain benefits for breast reconstruction as well as for certain other related services.
3. Parity in the application of certain limits to mental health benefits. A health plan that covers treatment for medical and surgical disorders as well as for mental health and substance use disorders may not place a more restrictive limit on the dollar value or number of treatments that are available for mental health or substance use disorders than are available for medical and surgical disorders.
4. Coverage of dependent students on medically necessary leave of absence. A health plan must allow a covered dependent child, whose eligibility for coverage is based on student status, to continue coverage for up to one (1) year while on a medically necessary leave of absence from a postsecondary educational institution.

Because of this election:

- The duration of a hospital confinement for a mother and newborn following the birth of a child will be determined based on eligibility.
- Benefits for serious mental illness, mental illness and chemical dependency as defined by Texas law are treated as any other covered medical or surgical condition.
- Following a covered mastectomy/lumpectomy, the plan will pay for the initial reconstruction treatment episode of both the affected and the unaffected breast to restore symmetry. Reconstructive surgery includes tissue expanders, breast implants, nipple reconstruction and nipple tattooing and removal of initial prosthetics due to complications.
- The plan does not determine a dependent's child's eligibility based on student status. Therefore, the City of Carrollton's plan does not extend coverage for students on a medically necessary leave of absence.

For coverage ending prior to December 31, 2014, HIPAA requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered by the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a pre-existing condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy. Employees and dependents may request a certificate of creditable coverage at any time for coverage ending before December 31, 2014 by calling IEBP's Customer Care staff at (800) 282-5385. (The creditable coverage letter will not be required after December 31, 2014 due to the prohibition of the pre-existing limitation for plan year January 1, 2014 thereafter and extended plan years.)

In addition to Title I, the Federal Government imposed Title II on April 14, 2003 which pertains to Administrative Simplification on Health Plans (such as the City of Carrollton Plan). The administrative simplification process includes: Standards for Electronic Transactions and Code Sets, National Identifiers (Individuals, Employers, Health Plans, and Health Care Providers), Security and Electronic Signature Standards (Final Rule was published February 20, 2003), and Standards for Privacy of Individually Identifiable Health Information (Privacy Rule).

A self-funded, non-federal, governmental health plan cannot exempt itself from the requirements for Title II of the Health Insurance Portability and Accountability Act.

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.

This Plan Booklet summarizes the Health Plan, which was adopted by the City of Carrollton effective January 1, 1982, and contains amendments through January 1, 2015. 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 Health 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 Health Plan. The City of Carrollton offers the Health Plan described in this Booklet to assist you and your family with access to appropriate healthcare in the event of an illness or injury.

* 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.”

HEALTH PLAN DOCUMENT

The City of Carrollton (the “City”) has approved the City of Carrollton Employee Health 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 three medical 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.

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

To help you do your part, The City of Carrollton and IEBP have developed this Employee Benefits Plan Booklet to assist you in understanding how your Employee Benefits Plan works. A serious illness or injury can be an emotionally difficult time, and the many unknowns involved only make matters worse. But a problem is less frightening when understood. This Booklet has been designed to minimize the unknowns associated with an illness or injury, and to help you understand the degree of financial protection provided by the Plan in the event of a serious illness or injury.

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:

1. marriage (marriage certificate or a signed affidavit of common law marriage required)
2. divorce (court-issued divorce decree showing effective date required);
3. 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;
11. loss of coverage because a dependent no longer meets the Patient Protection and Affordability Act's definition of a full time equivalent employee: thirty (30) hours a week, one hundred thirty (130) hours a month and/or one hundred twenty (120) seasonal days a year for employers with fifty (50) or more employees; or
12. 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 or 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 COBRA Continuation of Coverage (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 COBRA Continuation of Coverage purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

In administering this coverage, 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 IEBP that an Employee has been called to active duty and submit a copy of the Member's Active Reservist Policy.

Under 38 USCA § 4316, an employee who is called for military leave may have rights to COBRA Continuation of Coverage for up to twenty-four (24) months and a right to reemployment once he/she is discharged from active military service.

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 IEBP of the qualifying event and submit a copy of the employee's written order for the call to duty.

If IEBP administers Continuation of Coverage, the Employer must notify IEBP by sending a Qualifying Event Notice and mark the qualifying event "Called to Active Duty" and attach a copy of the employee's written order for the call to duty. If the Employer administers their own Continuation of Coverage, the Employer must notify IEBP of the termination if call to active duty is more than thirty-one (31) days. The Employer is responsible for all required notices.

Section 143.072, Texas Local Government Code may require an employer to "continue to maintain" coverage on a police officer or fire fighter while he/she is on military leave if the employer has adopted civil service requirements and the leave has been approved by the Fire Fighters' and Police Officers' Civil Service Commission. This section only applies if the employer meets the requirements of Chapter 143 of that Code, including having a population of 10,000 or more and voted to adopt the applicable provisions of the law.

For the Employee to return to the Employer's plan and continue their benefits with no waiting period or pre-existing 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 MultiState 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 medical 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 Active 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. Section 615.075(c) requires that the survivor must give the employer notice of election to purchase coverage within 180 days of the decedent's death.

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.

MEDICAL INTELLIGENCE CARE MANAGEMENT FEATURES

MEDICAL INTELLIGENCE CARE MANAGEMENT

The Medical Intelligence Care Management program is included to assist you in making informed health care decisions. Occasionally proposed health care is not an eligible benefit, or the scheduled length of stay or setting is inappropriate. Please read this provision so that you understand the admission, continued stay and notification process and are not faced with a penalty for failure to provide notification or a denial of benefits for not providing notification. Although medical services are certified, reimbursement is subject to the terms and conditions of the Plan. All procedures requiring Notification must meet criteria established by the Plan's Medical Intelligence Care Management Services Staff. Medical Intelligence Care Management personnel do not verify eligibility for benefits.

If Medical Intelligence Care Management does not receive Notification prior to a scheduled service requiring Notification, claims for benefits for that service will not be considered unless an appeal is filed and benefits eligibility is reviewed. If the benefits are eligible under the Plan, they will be paid, but the Late Notification Penalty will apply.

The Group Benefits Administrator shall retain final authority for interpretation of plan language and administration, when such exceptions are recommended by Large Medical Intelligence Care Management and industry consultants as reasonable and prudent for the patient and plan's financial viability.

HOW THE NOTIFICATION PROCESS WORKS

The 23-Hour Rule

Inpatient means treatment or confinement in a hospital or other medical facility for more than 23 hours. Outpatient means treatment or confinement in a hospital or other medical facility for 23 hours or less.

What is an admission?

When the hospital or facility sends a bill to the Group Benefits Administrator, they include the length of time the patient was in their facility and a designation that can be inpatient, outpatient or observation. For the Plan, the important item is the number of hours, not the classification. If it looks like the patient will stay more than 23 hours, you must call Medical Intelligence Care Management.

An expectant mother in labor is usually classified as an inpatient admission even if she goes home after a few hours. You must call Medical Intelligence Care Management whenever an expectant mother goes to the hospital.

If a newborn requires more than routine nursery care, you must notify Medical Intelligence Care Management so that a separate notification can be made for the baby. For continued, uninterrupted coverage, the newborn child must be enrolled in the plan during this initial sixty (60) day period.

Responsibilities of the Covered Person

Between the hours of 8:30 AM – 5:00 PM Central time, **call the notification number on the ID card** to notify Medical Intelligence Care Management prior to any health care service that requires notification. After hours, Voice Mail records your notification 24 hours a day and Medical Intelligence Care Management Intake Staff will return your call the next business day.

Responsibilities of Medical Intelligence Care Management

Medical Intelligence Care Management does not confirm eligibility or benefits for any treatment or service. Upon Notification, Medical Intelligence Care Management will provide the Covered Individual or Provider with contact information to enable the person to confirm eligibility and benefits with a Customer Care Representative.

What Happens on Inpatient Treatment?

The covered person must notify Medical Intelligence Care Management of a scheduled admission five (5) working days prior to the date of service; within one (1) business day after an emergency admission. If the notification is made after the above referenced time frames, a late notification penalty will apply. Continued stay review requirements apply to all inpatient confinements.

What Happens if Outpatient Services go over the 23-Hour Limit?

Outpatient Surgery not on the Outpatient Surgery List

If Notification is provided to Medical Intelligence Care Management within forty-eight (48) hours of an outpatient surgery that exceeds the twenty-three (23) hour limit, it will be considered an admission, and a late review will be performed. If the services and the length of stay are eligible benefits, there is no penalty. If the services are determined to be non-eligible benefits, charges are not covered. If you do not provide Notification to Medical Intelligence Care Management within forty-eight (48) hours of the admission, the outpatient Late Notification Penalty will apply. Failure to provide Notification to Medical Intelligence Care Management will result in no paid benefits for related charges.

Outpatient Surgery on the Outpatient Surgery List

If notification was provided on surgery requiring notification and unforeseen circumstances require more than a twenty-three (23) hour stay, the continued stay review process is required. If the length of continued stay is determined to be inappropriate, charges related to the time for which Notification was not provided will not be a paid benefit. A Late Notification Penalty will not be applied if prior Notification was provided.

Immediate Care (Emergency) Medical Admission

If Notification is provided to Medical Intelligence Care Management within one (1) business day of the admission requiring immediate care, no late notification penalty will apply.

CONTINUED STAY REVIEW

Medical Intelligence Care Management does not solicit Continued Stay clinical information. At the time of notification, the Nurse will inform the facility/provider representative of the assigned Length of Stay, based on the diagnosis provided. If a longer length of stay is required, the facility/provider representative must call Medical Intelligence Care Management Intake Staff at (800) 847-1213 to provide Notification.

MEDICAL INTENSIVE CARE MANAGEMENT

Medical Intensive Care Management is designed to help manage the care of patients who have catastrophic or long-term illnesses or injuries requiring extensive care. The purpose of Medical Intensive Care Management is to identify and coordinate cost effective medical care alternatives which meet accepted standards of medical practice. Medical Intensive Care Management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients, and others. These objectives will be met through Plan benefits (and non-Plan benefits as arranged by Medical Intensive Care Management) to patients who are eligible.

Medical Intensive Care Management is an option. However, should Medical Intensive Care Management be refused by the covered individual or physician, benefits will pay at the non-network benefit percentage and will not, at any time, pay at 100% for any medical services under the plan maximum out of pocket provision. If Medical Intensive Care Management is refused, all future payments for any medical services will be paid at the reduced benefit.

POPULATION HEALTH ENGAGEMENT

Population Health Engagement is an optional program that supports members in all stages of health. This program provides information to the covered individual regarding healthy lifestyle choices and management of chronic disease states. The program offers personalized professional coaching to support the healthy lifestyle of change and plan of action. Online tools and educational material(s) are available to the covered individual. The population health engagement team consists of an interdisciplinary team of licensed professional nurses, licensed professional counselors and registered dietitians. **To contact a Professional Health Coach, call (888) 818-2822.**

The Personal Health Engagement Program includes:

Opt In: Enrollment method by which covered individuals call the professional health coaching line and request a professional healthcare coach or agree to professional health coaching upon receipt of an outreach call or letter. Covered individuals may enroll by calling (888) 818-2822.

Self Assessment Tools and Healthy Living Resources

There are self assessment tools located on the IEBP website including the Health Power Assessment and Wheel of Life. Healthy Living Resources include: Healthy Living Guides, Healthy Living Fact Sheets, and helpful website links.

Professional Health Information Line

Professional Health Coaches will answer basic health and medication questions and assist covered individuals with the Healthy Initiatives Incentive Program.

HEALTHY LIVING GUIDES

IEBP offers Healthy Living Guides to Covered Individuals to assist them with managing their disease states, maintaining good health and supporting healthy lifestyle choices. Below is a list of the guides currently available.

To request a Healthy Living Guide, contact a Professional Health Coach at (888) 818-2822.

- Asthma Guide to Good Health
- Chronic Fatigue Syndrome Guide to Good Health
- COPD Guide to Good Health
- Coronary Artery Disease Guide to Good Health
- Depression Guide to Good Health
- Hyperlipidemia Guide to Good Health
- Hypertension Guide to Good Health
- Osteoarthritis Guide to Good Health
- Osteoporosis Guide to Good Health
- Guide to a Healthy Pregnancy
- Smoking Cessation Guide to Good Health
- Type 2 Diabetes Guide to Good Health
- Weight Management Guide to Good Health

The Intake Staff in IEBP's Medical Intelligence Care Management department are available to take your call from 8:30 a.m. to 5:00 p.m. Monday through Friday. A confidential voice mail is available 24 hours a day, 7 days a week so you can leave a message after regular operating hours. When you call them you must provide the following information:

1. Your Employer's name;
2. Your name and address;
3. Your social security number or identification number, whichever is applicable;
4. Your group number;
5. The name of the hospital;
6. The patient's admitting diagnosis; and
7. The proposed admission date.

IEBP's phone number to provide Notification is: **Toll free: (800) 847-1213**

Always bring your identification card with you whenever you or any of your Dependents go to a hospital. If you do not have an identification card, please contact IEBP at **(800) 282-5385**.

NOTIFICATION REQUIREMENTS

Notification enables clinical support and educations, such as:

- Perform pre-op education for the patient and ensure adherence to nationally recognized guidelines in order to maximize quality and cost efficiency;
- Facilitate post-op discharge planning to optimize clinical outcomes; and
- Refer patients to Centers of Excellence.

SERVICE	NOTIFICATION REQUIRED	LATE NOTIFICATION PENALTY
INPATIENT		
Emergency Admissions	One (1) business day following an emergency admission or as soon as reasonably possible. In an emergency, Voice Mail records and dates your notification twenty-four (24) hours-a-day. A Medical Intelligence Care Management Intake Staff will return your call the next business day	\$500
Scheduled/Elective Admissions Acute Care Admissions Rehabilitation Facility Admissions Convalescent Nursing Homes for Non-custodial Rehabilitation Services Long Term Care Facility Admissions Skilled Nursing Facility Admissions Mental Health/Substance Use Disorder Admissions Mental Health/Substance Use Disorder Day & Residential Treatment	Five (5) days prior to a non-emergency admission	\$500
Pregnancy/Maternity Other Services • Sonogram/Ultrasound in excess of three (3) • Amniocentesis • Home Health (uterine monitoring) • Following multiple birth notification	Prior to commencement for outpatient and Home Health procedures. Within forty-eight (48) hours of multiple birth notification.	\$500
Newborns	Within forty-eight (48) hours of admission if the newborn requires more than routine care	\$500
Pregnancy/Maternity (Delivery Admission) Normal Vaginal Birth	Within forty-eight (48) hours admission.	\$500
Pregnancy/Maternity (Delivery Admission) Cesarean Section delivery	Within ninety-six (96) hours following admission.	\$500
Transplant Services	Ten (10) working days prior to initial evaluation	\$500

MISCELLANEOUS

Durable Medical Equipment	For charges in excess of \$1,000	\$500
Dialysis for End Stage Renal Disease (ESRD)	Prior to commencement	\$500
Treatment of a Dental Injury	Prior to commencement	\$500
Reconstructive Surgical Procedures	Prior to commencement	\$500
Physician Home Visits	Prior to commencement	\$500
Home Healthcare	Prior to commencement	\$500
Positron Emission Tomography (PET) Scans	Prior to commencement	\$500
Magnetic Resonance Imaging (MRI) scans	Prior to commencement	\$500
Magnetic Resonance Angiography (MRA)	Prior to commencement	\$500

SERVICE	NOTIFICATION REQUIRED	LATE NOTIFICATION PENALTY
Computerized Axial Tomography (CAT) scans	Prior to commencement	\$500
Computerized Tomographic Angiography (CTA) scans	Prior to commencement	\$500
Hospice	Prior to commencement	\$500
Surgical Treatment of Morbid Obesity after the approved six (6) consecutive months (within the most recent twelve (12) months) physician supervised weight management treatment plan	Prior to commencement	\$500
Cardiac Rehabilitation	Prior to commencement	\$500
Oncological Chemotherapy	Prior to commencement	\$500
Radiation therapy	Prior to commencement	\$500
Medically Necessary Evidence Based Genetic Testing to direct treatment (after diagnosis has been established)	Prior to commencement	\$500

MAJOR MEDICAL EXPENSE BENEFITS

The following charges are considered Covered Expenses provided they are for services or supplies, which are eligible expenses. Covered Expenses are payable by this Plan at the appropriate Benefit Percentage shown in the Summary of Benefits and Coverage once you or your Dependent have satisfied the applicable Deductible.

Inpatient hospital (See Notification requirements):

1. semi-private room and board up to the semi-private rate; if the hospital has only private rooms, 90% of the private room rate will be considered as the semi-private rate;
2. intensive care and cardiac care room and board up to the usual, reasonable and customary rate; and
3. ancillary services & supplies.

Charges made by a Physician for professional services, regardless where rendered, and including surgical procedure charges for performing an operation, and charges of an assistant Surgeon when they are eligible for the procedure performed;

Telemedicine Services

1. Medical information that is communicated in real-time with the use of interactive audio and video communications equipment, and is between the treating physician and/or a distant physician or health care specialist with the patient present during the communication.
2. IEBP's contracted telemedicine services via the convenience of phone or online, video consultation, diagnostic and/or medication management services for many conditions including allergies, cold and flu symptoms, ear infection, and other minor medical conditions.

Genetic Testing – medically necessary evidence based testing to direct treatment (after diagnosis has been established) and/or maternity related amniocentesis to direct treatment.

Breast Oncology – evidence-based initial mastectomy/lumpectomy, reconstructive oncology surgery of affected and non-affected breast, to include removal of initial prosthetics due to complications. Reconstructive surgery includes tissue expanders, breast implants, nipple reconstruction, and nipple tattooing.

Oophorectomy – evidence-based genetic testing for ovaries with positive results will be required before a prophylactic oophorectomy will be considered as an eligible benefit.

Cosmetic Procedures/Reconstructive Surgery – cosmetic surgery for eligible benefits in connection with medically necessary treatment of an accidental injury.

Cosmetic procedures/reconstructive surgery only if:

1. for the repair of an accidental injury;
2. for reconstruction incidental to or following surgery resulting from an injury or illness; or
3. for correction of congenital anomalies (if under age 19) that result in a functional defect.

Certified Nurse Midwife (CNM)/Certified Professional Midwife (CPM) – in connection with normal pregnancy and delivery care.

Chiropractor (DC) charges for treatment of an illness or injury by manipulation of the spine and appropriate treatments, subject to the maximum as shown on the Summary of Benefits and Coverage;

Anesthesia and its administration by a Licensed Anesthesiologist or Certified Registered Nurse Anesthetist;

Charges for Physical Therapy – Services prescribed by a Physician to restore or improve a previous level of body function. Inpatient therapy services must be performed or rendered at a hospital or licensed healthcare facility by a licensed physical or occupational therapist or Physician. This benefit includes treatment of a developmental delay. Outpatient charges are subject to the Calendar Year Maximum.

Charges for Occupational Therapy Services – prescribed by a Physician to restore or improve a previous level of body function. Inpatient therapy services must be performed or rendered at a hospital or licensed healthcare facility by a licensed physical or occupational therapist or Physician. This benefit includes treatment of a developmental delay. Outpatient charges are subject to the Calendar Year Maximum.

Aquatic Therapy charges for evidence based aquatic services, when prescribed by a Physician. Must be direct, one-on-one treatment; by a licensed Physical Therapist. This benefit includes treatment of a developmental delay. Outpatient charges are subject to the Calendar Year Maximum.

Charges of a Licensed Speech Therapist for restoratory or rehabilitary speech therapy, provided the therapy is for speech loss or impairment due to an illness or accidental bodily injury, surgery on account of illness or accidental bodily injury, or impairment due to a congenital anomaly, provided such loss or impairment is not due to a functional nervous disorder. This benefit includes treatment of a developmental delay. Outpatient charges are subject to the Calendar Year Maximum.

Charges for services of a Nurse as follows:

1. in a hospital, services of a Registered Professional Nurse (RN), services of a Licensed Practical Nurse (LPN), Registered Nurse First Assistant (RNFA) if medically necessary, Advanced Nurse Practitioner (ANP) or services of a Licensed Vocational Nurse (LVN), and
2. other than in a hospital, services of a Registered Professional Nurse (RN); Licensed Practical Nurse (LPN); or the services of a Licensed Vocational Nurse (LVN).

Charges for Mental Health Disorders and Serious Mental Health Illness are covered as follows, subject to the limitations stated in the Summary of Benefits and Coverage:

1. the same as any other illness when hospital confined,
2. charges for psychological testing ordered by a Physician to diagnose the nature of a Mental or Nervous Disorder,
3. consultation, diagnostic and individual treatment visits,
4. prescription drugs, and
5. group therapy.

Services must be provided by a hospital or Physician as those terms are defined in the “Definitions” section of this Plan;

Licensed Professional Ambulance – services to the nearest hospital or emergency care facility equipped to treat a condition requiring immediate care. This does not include transportation for non-emergency medical services; subject to the benefit maximum per the Summary of Benefits and Coverage.

Lactation Support – comprehensive prenatal and postnatal lactation support, counseling and standard equipment/non-disposable supply rental and/or purchase; standard equipment is provided for duration of breastfeeding.

Charges for drugs and medications:

1. in a hospital, drugs, medicines, dressing and supplies furnished by the hospital, and
2. other than in a hospital, insulin and drugs;

Artificial Limbs, Prosthetic Appliances and Prosthetic Devices – Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and noses; and
- speech aid prosthetics and tracheo-esophageal voice prosthetics.

If more than one prosthetic device can meet your functional needs, benefits will only be available for the usual, reasonable and customary charges of standard models as determined by Medical Intelligence Care Management. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

The plan will cover one (1) appliance/device (per condition) per lifetime, unless there is physiological change or the appliance/device is no longer serviceable. The benefit does not include the replacement of lost or stolen prosthetic devices.

Charges for the rental and/or purchase of Durable Medical Equipment (or purchase if the Group Benefits Administrator determines that the course of purchase is less than anticipated total rental charges). All rental and/or purchases are limited to the lesser of contractual charge, usual, reasonable and customary fee schedule or cost reasonable rental/cost of standard model items. Charges for the rental of Durable Medical Equipment in excess of the purchase price are not covered. Charges where purchase or rental exceeds \$1,000 per piece of equipment require Notification with Medical Intelligence Care Management. If Medical Intelligence Care Management does not receive Notification prior to a rental or purchase of Durable Medical Equipment that exceeds \$1,000 per piece of equipment, claims for benefits for that equipment will not be considered unless an appeal is filed and benefits eligibility is reviewed. If the benefits are eligible under the Plan, they will be paid, but the Late Notification Penalty will apply.

Cornea Transplants are eligible as a medical expense.

Charges for **prosthetic appliances** (excluding dental appliances) that are an eligible expense for the alleviation or correction of conditions arising out of accidental bodily injury or illness sustained or surgery occurring while covered hereunder.

The first pair of eyeglasses or contact lenses prescribed as part of postoperative treatment for intra-ocular surgery or due to accidental bodily injury shall be included as a Covered Expense. Replacement of such appliances shall not be a Covered Expense;

Charges for the following medical supplies: colostomy bags, catheters, oxygen, and syringes and needles for the treatment of allergies or diabetes.

Radiation services, including diagnostic x-rays and interpretation, x-ray therapy, radiation therapy and treatment;

Clinical and pathological laboratory examinations and professional interpretation of their results;

Electrocardiograms and electroencephalograms

Surgical dressings, ordinary splints, plaster or fiberglass casts, and sterile supplies;

For Physician services related to contraceptive management, including the insertion and removal of contraceptive devices. Oral contraceptives and injectable contraceptives are covered under the prescription plan with regard to the cost of medication. This benefit includes charges for contraceptive management, including the insertion and/or removal of contraceptive devices including, but not limited to IUD and Norplant;

Surgical Sterilizations

Diabetic Education and Diabetes Self-Management Training for Covered Persons who have been diagnosed with:

1. Insulin dependent or non-insulin dependent diabetes.
2. Elevated blood glucose levels induced by pregnancy.
3. Another medical condition associated with elevated glucose levels.

Cutting procedures in the oral cavity for tumors or cysts. However, if the patient has City Dental coverage only, benefits for oral surgery in connection with cysts and tumors will be payable as Dental, rather than Medical, benefit;

Dental charges (including inpatient hospital facility expense when necessary) **for treatment of a fractured or dislocated jaw**, or injury to sound natural teeth ("sound" means undiseased, undamaged natural teeth or natural teeth restored to function), including replacement of such teeth as a result of a bodily injury within three (3) months after the date of such accident;

Treatment of infertility. The plan covers the initial diagnosis only;

Abortions for Covered Persons where the mother's life is in danger or when in connection with incest or rape;

Newborn procedures including screening test to determine hearing loss from birth through the date the child is 30 days old. Diagnosis and treatment is covered for Covered Persons from birth through the date the child is 2 years old. Newborn care, circumcision and any illness or injuries affecting the newborn;

One Wig or artificial hairpiece, only after chemotherapy or radiation, subject to the usual, reasonable & customary limit as shown on Summary of Benefits and Coverage;

Charges for the purchase and/or repair of **Hearing Aids and/or Hearing Appliances**, up to the usual, reasonable & customary limit. This benefit does not include charges for batteries;

Charges for Podiatric Appliances for the prevention of complications associated with Diabetes. Limited to two (2) pairs of therapeutic footwear/shoes per year; and

Charges for **Custom Molded Foot Orthotics**, limited to:

1. One (1) pair per lifetime for adults, over age twenty-one (21), unless there is a medically documented physiological change.
2. Two (2) pair per lifetime for covered individual, up to age twenty-one (21), unless there is a medically documented physiological change.

Second Surgical Opinions, Surgery is always a serious undertaking. If your Physician recommends to you that you have non-emergency surgery, it is a good idea to get a second opinion on just how necessary the surgery really is before being admitted to the hospital.

By getting a second opinion, you're assured of having another Physician, one who is free to make his or her own recommendations, thoroughly review your case. Often this review will suggest a non-surgical method of treating your illness, which will spare you the expense and discomfort of an operation.

In order to help you avoid unnecessary surgery, the Plan will pay the eligible charges you incur obtaining a second opinion, as stated in the Summary of Benefits and Coverage. If the first and second opinions do not agree, the Plan will then pay for a third opinion for you, once again as stated in the Summary of Benefits and Coverage. Naturally, these benefits will only be paid if you obtain the second (or third) opinion from an in-network Physician who is **not** related to or in a business partnership with the Physician who first recommended the surgery.

Non-routine Mammograms are covered as shown on the Summary of Benefits and Coverage, are not covered under the Preventive Care/Wellness benefit. Non-routine Mammograms in excess of one per calendar year, will be considered at the regular plan benefit for the plan that the covered persons enrolled in, with no limits.

PREVENTIVE CARE/WELLNESS BENEFIT

Routine checkups for the purpose of monitoring health, tests and procedures are listed below. The Routine procedures will be reimbursed at the benefit percentage as stated on the Summary of Benefits and Coverage, subject to usual, reasonable and customary charges, when billed with a routine diagnosis. This routine list is a guideline but is not an all-inclusive list. However the Preventive Care/Wellness Benefit does not cover charges for genetic testing (unless otherwise listed as eligible), or virtual colonoscopies.

TESTS/PROCEDURES

Routine Physical
Well Baby/Child Exams
Well Woman Exam
Prostate Specific Antigen (PSA) exam PAP Test
Routine Venipuncture
Routine Hearing Exam
Routine Vision Screening (refractions and exams are not covered)
Routine Mammograms
General Health Panel
Coronary Risk Profile (lipid panel)
Urinalysis
(TB) Tuberculosis test
Handling of specimen to/from physician's office to a laboratory
Occult Stool Test
Skin Cancer Counseling
Autism Screening – eighteen (18) and twenty-four (24) months of age

Recommended, at and after age 40:

Chest X-Ray (front & lateral)
EKG (electrocardiogram)
Digital Rectal Exam
Bone Density

Colon-Rectal examination – Coverage for the medically recognized screening examination for the detection of colorectal cancer for covered individuals at any age who have a personal or family history of polyps (or colon cancer), or who are at normal risk for developing colon cancer. This benefit includes expenses incurred while conducting a medically-recognized screening examination for the detection of colorectal cancer. In addition, the Colon-Rectal Examination benefit will also apply for the first non-routine colon-rectal exam claim received during the 5/10 year time period as noted below.

This includes annual fecal occult blood tests and a flexible sigmoidoscopy performed every 5 years with a family or personal history of polyps (or colon cancer) or a colonoscopy performed every 10 years. This benefit excludes coverage for virtual colonoscopies.

This plan will also cover more frequent colonoscopies, sigmoidoscopies and fecal occult blood tests for all covered individuals at any age, with no limits at regular plan benefits, including when they are billed with a routine or non-routine diagnosis. This includes when they are billed with a diagnosis of personal or family history of polyps (or colon cancer).

IMMUNIZATIONS/INOCULATIONS – ALL AGES

Charges for immunizations and administrative fees are covered under the plan, subject to usual, reasonable and customary limits. Allergy injections and expenses related to routine newborn care are not considered as part of this benefit.

This benefit included state-mandated and non-state-mandated immunizations and is available to all covered persons under the plan, with no age limitations. To be considered under this benefit, the provider's bill must designate a routine diagnosis code. This list is a guideline, not an inclusive list.

- DT (Diphtheria and Tetanus Toxoids)
- DtaP Diphtheria, Tetanus Toxoids and Pertussis
- Td (Tetanus) booster
- MMR (Measles, Mumps, Rubella)
- MMR booster
- Poliomyelitis Vaccine
- Oral Polio
- Varicella Vaccine (Chicken Pox)
- Influenza
- Hepatitis A
- Hepatitis B
- Pneumococcal (Pneumonia)
- Pediarix (Diphtheria and Tetanus Toxoids and Acellular Pertussis Absorbed, Hepatitis B (Recombinant) and Inactivated Poliovirus Vaccine Combined)
- HIB (Hemophilus Influenza B)
- HPV (Genital Human Papillomavirus)
- Rotovirus
- Zosatax (Shingles Vaccine)
- Any other immunization required by federal or state law or regulation

PRE-ADMISSION TESTING

The Plan will pay benefits, for outpatient x-ray and laboratory tests made within ten (10) days of a scheduled inpatient hospital confinement. For this benefit to apply, the laboratory tests and x-rays must meet all of the following requirements:

1. performed in connection with an illness or injury which results in hospital confinement;
2. ordered by the attending Physician; and
3. performed by a provider accepted by the hospital, (which would otherwise be done while the Covered Individual is hospital-confined) and not duplicated when the Covered Individual is in the hospital.

HOME HEALTH CARE

To be an Eligible Benefit, a home health care plan must be in writing, ordered by the attending Physician. Medical Intelligence Care Management must receive Notification prior to home health care commencement. Home health care services will be reviewed as an Eligible Benefit if the attending Physician states that proper treatment of the disability would otherwise require confinement as an inpatient in a hospital, Skilled Nursing Facility or rehabilitative hospital in the absence of the services and supplies provided as part of the home health care plan. Home health care charges are paid per the Schedule of Medical Benefits up to a maximum of two (2) hours per visit, custodial care is excluded. Benefits are subject to the Plan's Calendar Year.

Home health care professional services include charges made by a home health care agency for the following medically eligible services:

1. skilled nursing care under the supervision of a Physician or registered nurse (R.N.);

2. rehabilitative therapy and respiratory therapy provided by the home health care agency;
3. social worker to assess and identify community resources; and
4. Physician services if the covered individual is homebound and Physician homebound intervention is appropriate.

Supplies, Durable Medical Equipment, physical therapy, occupational therapy, aquatic therapy and speech therapy are not subject to the 100 visit maximum per calendar year. However, these charges will be subject to the limits as shown on the summary of benefits and coverage for these services, if any. If prescription medication is part of the Home Health Care Plan, please refer to the Prescription Drug Benefit for coverage information.

HOSPICE CARE

The Group Benefits Administrator will pay for the usual, reasonable and customary charges for hospice care services provided in accordance with a hospice care program to terminally ill covered individuals. Medical Intelligence Care Management must receive Notification prior to hospice care commencement. Hospice benefits are subject to the Lifetime Maximum indicated on the Summary of Benefits and Coverage. This benefit will include bereavement counseling services.

Hospice care must be established, reviewed and approved in writing by the attending physician and meet all of the following:

Hospice care charges are paid per the Schedule of Medical Benefits. These benefits are eligible under the plan if the hospice stay or services meet all of the following:

1. provided while the terminally ill person is a covered individual;
2. ordered by the supervising Physician as part of the hospice care program;
3. charged for by the hospice care program;
4. the terminally ill person's Physician has estimated life expectancy to be six (6) months or less; and
5. Medical Intelligence Care Management Notification.

EXTENDED CARE FACILITY

Covered Expenses are room and board and facility charges. Any professional services are not covered. Extended care confinements separated by less than 7 days are considered by the Plan as one confinement. A skilled nursing facility meets the definition of an extended care facility but does not include any institution which is primarily for custodial care or of the aged or senile. Benefits are limited as stated in Summary of Benefits and Coverage.

MORBID OBESITY

Bariatric Surgery: Morbid Obesity Services (after the approved six (6) consecutive months [within the most recent twelve (12) month] physician supervised weight management treatment plan

Morbid Obesity is defined as a condition for which a Covered Individual, eighteen (18) years of age or older, is 200% over ideal weight or 100 pounds overweight with a Body Mass Index (BMI) of greater than 40. A Notification Review is required to review the eligibility for the medically evidence -based surgical procedure. This review requires documentation of six (6) consecutive months (within the most recent twelve (12) months) physician-supervised weight management program that may include but is not limited to nutritional education and a physical activity program. The Covered Individual, treating physician or family member must provide information for the Medical Intelligence Care Management notification review. Failure to do so will result in no benefit coverage for morbid obesity services. Medically evidence -based morbid obesity treatment will be an eligible benefit subject to the lifetime maximum morbid obesity benefit limitation.

Morbid Obesity treatment will not be eligible for individuals with a substance use disorder who do not have Physician-documented six (6) consecutive months (within the most recent twelve (12) months) of recovery.

Morbid Obesity treatment procedures will not be paid if the procedure is an Unproven Medical Procedure as defined in this booklet.

Under this provision, Morbid Obesity includes the pre-treatment evaluation, medical and surgical treatment for post treatment care including but not limited to evidence-based medicine device adjustments, device removal, and/or body sculpting services. The Morbid Obesity surgical treatment must be performed at a Designated Centers of Excellence Morbid Obesity Treatment Center by an American Bariatric Surgery accredited Network Provider, unless services are deemed emergent or immediate. The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) designates the facilities that have been accredited. The Centers and physicians must also participate in the UnitedHealthcare Choice Plus Network for IEBP Plan to consider them as a designated provider.

Non-Designated Morbid Obesity Center

A non-accredited, non-network UnitedHealthcare Choice Plus, and non-designated Center of Excellence facility will not be eligible for benefit plan consideration.

TRANSPLANT BENEFIT

Transplant benefits provided at an OptumHealth/Centers of Excellence/Designated Transplant Center an OptumHealth/Centers of Excellence/Designated Transplant Center differ from those provided at a Non-Designated Transplant Center. At least ten (10) working days prior to any pretransplant evaluation, the covered individual or a family member must provide Notification to Medical Intelligence Care Management; failure to do so will result in a Late Notification Penalty of \$500.

If the Covered Individual's treatment plan changes, the Healthcare Provider must provide Notification to Medical Intelligence Care Management at (800) 847-1213. Medical Intelligence Care Management will obtain an update on the treatment plan and will conduct a concurrent review regarding additional length of stay and any new treatments/procedures.

Eligible Transplant expenses incurred in connection with any organ or tissue transplant will be covered subject to Medical Intelligence Care Management approval and Plan limitations. Under this provision, the term Transplant includes the pretransplant evaluation, procurement, the transplant itself and one (1) year of post transplant follow-up care, excluding outpatient prescription drugs covered elsewhere under the Plan.

Eligible Transplant expenses incurred for harvesting and storage of stem cells for the recipient and the donor will be considered under the Transplant benefit. Transplant benefits are paid at the benefit percentage on the Schedule of Medical Benefits as long as services are provided at an OptumHealth/Centers of Excellence/Designated Transplant Center and approved by Medical Intelligence Care Management.

Benefits will not be paid if the procedure is an Unproven Medical Procedure or Phase I and/or II of clinical trial as defined in this booklet or if it involves an artificial (mechanical) organ or non-human tissue. A Cornea transplant is not covered as a transplant benefit, but will be covered as any other major medical benefit.

NON-OPTUMHEALTH/CENTERS OF EXCELLENCE/DESIGNATED TRANSPLANT CENTER

If the organ transplant is performed at a Non-Designated OptumHealth/Centers of Excellence Transplant Center or Medical Intelligence Care Management is refused, the pre-transplant, transplant and post transplant care will not be covered.

Benefits will not be paid if the procedure is an Unproven Medical Procedure or a Phase I and/or II clinical trial as defined in this booklet or if it involves an artificial (mechanical) organ or non-human tissue. A Cornea transplant is not covered as a transplant benefit, but will be covered as any other Major Medical Benefit.

TRANSPLANT CENTER

The transplant must be performed at a hospital or facility designated by the Plan as a Transplant Center, or the plan will not consider food, travel and/or lodging expenses. A list of such hospitals may be obtained from Medical Intelligence Care Management.

This benefit will cover charges resulting from organ transplantation at an OptumHealth/Centers of Excellence/ Designated Transplant Center plus charges for:

1. travel (if the covered person lives more than one hundred (100) miles one way to hospital or facility);
2. organ transportation;
3. donor medical benefits not covered under the donor's plan of benefits;
4. locating and preserving the tissue for the transplant procedure;
5. fees for maintenance on an organ transplant waiting list; and
6. lodging (if the covered person lives more than one hundred (100) miles one way from hospital or facility).

REIMBURSEMENT

Reimbursement requests for travel and lodging shall be submitted on an Expense Activity Report to Medical Intelligence Care Management. Reimbursement for food will be calculated and dispersed by the Group Benefits Administrator based on travel and lodging information as submitted on the Expense Activity Report. All benefits under this provision, not directly billed to the Group Benefits Administrator, will be paid to the Employee. The maximum travel, food and lodging benefit for the covered individual is \$10,000 and \$5,000 for an eligible companion. Eligible companion is a person of the covered individual's choice.

Travel

Eligible travel expenses (ground, air transportation, lodging and food) will only be reimbursed for the covered individual or eligible companion if they live more than one hundred (100) miles from the hospital or facility designated by the Plan as a Transplant Center. Private vehicle use will be reimbursed at the maximum allowable amount determined by the Internal Revenue Service and reimbursement is limited to travel between home and the Transplant Center. Airfare will be reimbursed at cost. The purchase of commercial airline tickets may be arranged by Medical Intelligence Care Management.

The Plan provides for ground or air transportation of the covered individual to and from the pre-transplant evaluation, organ transplantation and any other Eligible Benefit or follow-up appointment.

The Plan provides for ground or air transportation of each eligible companion to and from the pretransplant evaluation, organ transplantation and any other eligible provider services or follow-up appointment.

Lodging

The Plan will pay for the covered individual's lodging when not hospital confined and the eligible companion's lodging when the patient is confined to an OptumHealth/Centers of Excellence/Designated Transplant Center. Receipts will be required for reimbursement.

Food

The Plan will pay for the covered individual and eligible companion's food during transplant-related outpatient treatment that is an Eligible Benefit and the eligible companion's food during transplant-related inpatient treatment that is an Eligible Benefit at an OptumHealth/Centers of Excellence/ Designated Transplant Center up to a maximum rate of \$35 each per day.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) is a counseling service purchased by the City of Carrollton for its Employees and their family members. All expenses for the EAP are paid for by the City of Carrollton. The City of Carrollton has chosen Deer Oaks EAP Services to operate the Employee Assistance Program. You may call Deer Oaks EAP Service to receive assistance for problems you are having with your family's well-being, marital conflicts, relationships, parenting, job stress, financial management and a wide range of other problems you would like help resolving. **Any information you share with Deer Oaks EAP Services and your counselor will be kept confidential.**

You may contact the Deer Oaks Employee Assistance Program 24 hours a day, 7 days a week, at (866) 327-2400.

The Employee Assistance Program (EAP) provides six (6) "free" EAP outpatient counseling sessions to each Employee and each family member per episode of care.

An "episode of care" is defined as an uninterrupted course of EAP counseling, mental health treatment or substance use disorder treatment.

A new episode of care, including six (6) free additional EAP counseling sessions, can begin at any time AFTER a previous episode of care has ended. A new episode of care can involve EAP counseling sessions or mental health or substance use disorder treatment for the same or different problems, symptoms, or diagnoses with the following exception: If the Employee or family member terminated an episode of care on their own volition or against the advice of his or her EAP counselor, he or she is no longer eligible for any free EAP counseling sessions.

These six (6) "free" sessions are provided only when the treatment is a Covered Expense under this Plan. For Employees and family members covered under the Plan, the six routine outpatient visits, (per person, per identifiable problem), will be covered at 100%, not subject to the Deductible. The six "free" routine outpatient visits shall include the initial assessment visit. If you or your family members are not covered under this Plan, you may also utilize the EAP for a free assessment, a referral visit, and receive the six "free" routine visits per person, per identified problem.

When you call Deer Oaks EAP Services, you will be asked your name, address, telephone number and a brief explanation of the reason you called. Deer Oaks EAP Services will arrange an appointment at a time convenient for you to come in and discuss your problem with a professional counselor. If additional counseling is necessary, Deer Oaks EAP Services will refer you to a provider taking into account both your therapeutic and financial needs.

The City of Carrollton is making this Employee Assistance Program available free of charge out of the genuine desire to help you and your family members cope with the stresses and problems of modern life.

SUBSTANCE USE DISORDER AND MENTAL HEALTH DISORDERS

The Plan will pay benefits for treatment of Substance Use Disorder only upon the diagnosis and recommendation of a Physician.

Expenses for the treatment of Substance Use Disorder conditions are considered the same as any other illness. Expenses for the treatment of Substance Use Disorder have a lifetime maximum three (3) treatment programs.

A series of treatments is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities and is complete when the Covered Person is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient or a series of these levels of treatments without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of 30 days.

SERIOUS MENTAL HEALTH DISORDERS

Expenses incurred by a Covered Person for treatment of "Serious Mental Health Illness" are payable as any other illness. The term "Serious Mental Health Illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic & Statistical Manual (DSM):

1. schizophrenia;
2. paranoia and other psychotic disorder;
3. bipolar disorder (hypomanic, manic depressive and mixed);
4. major depressive disorders (single episode or recurrent);
5. schizo-affective disorders (bipolar or depressive);
6. pervasive development disorder;
7. obsessive compulsive disorder; and
8. depression in childhood and adolescence.

MENTAL HEALTH DISORDERS

The Plan will pay benefits for treatment of Mental Health disorders only upon the diagnosis and recommendation of a Physician, and only when the treatment is performed by a hospital, a Licensed Psychiatrist or a Licensed Psychologist. If you are seeking inpatient treatment for Mental/ Nervous Disorders at a network hospital, you may only be admitted to a participating psychiatric network hospital.

MENTAL HEALTH AND SUBSTANCE USE DISORDER CATEGORIES OF TREATMENT

The categories of treatment for Mental Health and Substance Use Disorder are as follows:

1. Routine outpatient
2. Intensive outpatient
3. Partial hospitalization/day treatment
4. Residential/sub-acute inpatient
5. Hospital based acute inpatient

MAIL ORDER AND RETAIL PRESCRIPTION DRUG PROGRAM

Refer to your Schedule of Prescription Expense Benefits for details on the Mail Order and Retail Prescription Drug Program.

Coverage for SpecialtyRx medications under the Medical plan provided in the physician's office are covered as at the same as any other injection under the "physician service" benefit and are payable at the Network or Non-Network benefit percentage.

Prescriptions, if purchased through the medical plan, are subject to Average Wholesale Pricing or reasonable & customary charges.

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.

CLAIMS AUDIT REIMBURSEMENT PROGRAM

The City of Carrollton has implemented a claims audit reimbursement program as an incentive for you and your Dependent(s) to audit your hospital and doctor bills in order to detect incorrect charges made by the provider. Detecting such a charge on your hospital or doctor bill for a service that you did not receive could result in the provider reducing the total charge on your bill, thereby reducing the total cost of your claim for both you and the City of Carrollton. Under this bonus program, you or your Dependent(s) must detect such errors on your hospital and doctor bills **before your claim is paid by the Group Benefits Administrator (IEBP)**. If you personally detect such errors and your total bill is subsequently reduced by the provider, the City of Carrollton will reimburse you for 50% of the savings, **not to exceed the individual, annual plan maximum Out of Pocket**, which resulted from your audit of the hospital or doctor bill.

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. Venue for any dispute arising under the terms of this plan, including but not limited to claims and subrogation disputes or declaratory judgment actions, shall be in Austin, Travis County, Texas.

CLAIM APPEALS

The Group Benefits Administrator will conduct a full and fair review of your appeal. The appeal will be reviewed by appropriate individual(s) on the Group Benefits Administrator’s staff for internal review; or a health care professional with appropriate expertise during the initial benefit determination process.

The Covered Individual (or their authorized representative) may request an independent review from an independent state licensed external review organization that is credentialed under URAC (Utilization Review Accreditation Commission). The external review will be conducted by a random URAC selected reviewer who was not consulted initially during the external clinical excellence review.

Once the review is complete, if the denial is maintained, the appellant will receive a written explanation of the reasons and facts relating to the denial.

Appeal for Urgent Care Request for Benefits (Adverse Notification Determination Prior to Claim Submission)

Type of Request for Benefits or Appeal	Appeal for Urgent Care Request for Benefits (Adverse Pre-Determination/Notification Request)	
	Internal/External Process	Business Hours/Days
If the appellant appeals the adverse notification determination or declination of notification, the appellant must appeal within:	Internal	one hundred eighty (180) days after receiving the denial based on a completed review process
If the appellant’s request for emergent benefits is incomplete TML MultiState IEBP will send the <u>urgent care incomplete pre-determination/ notification information declination letter</u> within:	Internal	twenty-four (24) hours of receipt of appellant’s information
The appellant must provide a completed information request within:	Internal	forty-eight (48) hours after receiving the TML MultiState IEBP declination due to incomplete information
If the request for urgent/emergent benefits is complete and not approved, TML MultiState IEBP will send an <u>urgent care pre-determination/notification denial letter</u> within:	Internal	seventy-two (72) hours

Type of Request for Benefits or Appeal	Appeal for Urgent Care Request for Benefits (Adverse Pre-Determination/Notification Request)	
	Internal/External Process	Business Hours/Days
If the appellant's request an Independent Review Organization, (IRO), the external review appeal request must be submitted for the review within:	External	one hundred twenty (120) days of receipt of the original denial or response to your appeal
The IRO will complete the review and TML MultiState IEBP will submit the response of <u>an expedited urgent care pre-determination/notification</u> of a benefit appeal within:	External	seventy-two (72) hours

Appeal of Non Urgent Care Request for Benefits for Pre Determination/Notification (Prior to Claim Submission)

Type of Request for Benefits or Appeal	Appeal of Non-Urgent Care Request for Benefits (Adverse Pre-Determination/Notification Request)	
	Internal/External Appeal Process	Business Hours/Days
The appellant must appeal the denial no later than:	Internal	one hundred eighty (180) days after receiving the denial
If the request for a pre- determination/notification is <u>benefit information incomplete</u> , TML MultiState IEBP will notify the appellant within:	Internal	five (5) days
If the request for pre-determination/notification is <u>clinical information incomplete</u> , TML MultiState IEBP will notify you within:	Internal	fifteen (15) days
The appellant must then provide completed information within:	Internal	forty-five (45) days after receiving an extension notice*
TML MultiState IEBP will notify you of the first level appeal decision within:	Internal	fifteen (15) days after receiving the first level appeal
The appellant must appeal the first level appeal (file a second level appeal) within:	Internal	sixty (60) days after receiving the first level appeal decision
TML MultiState IEBP will notify you of the second level appeal decision within:	Internal	fifteen (15) days after receiving the second level appeal*
The appellant may request the appeal be submitted to an Independent Review Organization, (IRO). The External Review Request must be submitted within:	External	one hundred twenty (120) days of receipt of the original denial or response to your appeal
The IRO must complete the review of a <u>non urgent care claim or benefit appeal</u> within:	External	thirty (30) days

* A one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control

Post Service Claims Appeal

Type of Claim or Appeal	Post Service Claims Appeal	
	Internal/External Process	Business Hours/Days
The appellant must appeal the claim denial no later than:	Internal	one hundred eighty (180) days after receiving the denial
If the appellant's claim is incomplete, TML MultiState IEBP will notify the appellant within:	Internal	thirty (30) days
The appellant must then provide completed claim information within:	Internal	forty-five (45) days after receiving an extension notice
TML MultiState IEBP will notify the appellant of the first level appeal decision within:	Internal	thirty (30) days after receiving the first level appeal
The appellant must file the second level appeal within:	Internal	sixty (60) days after receiving the first level appeal decision
The appellant will be notified of the second level appeal decision generally within:	Internal	thirty (30) days after receiving the second level appeal

Type of Claim or Appeal	Post Service Claims Appeal	
	Internal/External Process	Business Hours/Days
The appellant may request an appeal be submitted to an Independent Review Organization, (IRO). This request must be submitted for the review within:	External	one hundred twenty (120) days of receipt of the original denial or response to your appeal
The IRO must complete the review of a non-emergent claim or benefit appeal within:	External	thirty (30) days
The IRO must complete a requested expedited review of an emergent claim or benefit appeal within:	External	seventy-two (72) hours

* *Covered Individuals have access to all documents and records used in making the decision—medical consultants used in making the decision must be disclosed.*

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. 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).

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 or complete the appeal form online at www.iebp.org. Your request must contain the employee’s name, social security or unique ID number and the exact reason(s) for requesting the appeal and include any supporting documentation. TML MultiState IEBP will notify you of the results of the review within thirty (30) days, unless TML MultiState IEBP informs you that special circumstances require an extended review process. These appeal provisions shall be applicable where a provider makes a complaint that a prompt payment contract was not followed.

The appealing party will be notified in writing of the results of an appeal for failure to provide Notification, and/or a denial or reduction in benefits after receipt of all necessary information to make a determination. All available medical information must be provided at no cost to the Plan. The Group Benefits Administrator shall be under no obligation to respond to an appeal of a claim based upon complaints that have previously been addressed by a prior appeal.

PROTECTED HEALTH INFORMATION

IEBP’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.

IEBP 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.

IEBP 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.

EXCLUSIONS AND LIMITATIONS APPLICABLE TO MEDICAL 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 sickness, illness, accidental bodily injury or disability or any charge for care or services which is:

1. the result of:
 - a. mandibular or maxillofacial surgery to correct growth defects, jaw disproportions 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;
2. for eye examinations for the purpose of prescribing corrective lenses or determining visual acuity or for treatment of refractive errors, eye glasses or contact lenses (including the fitting thereof), orthoptics, vision therapy, or other special vision procedures including but not limited to Radial Keratotomy (RK), Laser Assisted In-Situ Keratomileusis (LASIK) and Excimer Laser Photorefractive Keratectomy (PRK), unless required due to disease or accidental bodily injury to the eye;
3. for batteries (at any time), or for the purchase and/or repair of hearing aids, in excess of the usual, reasonable & customary limit;
4. for care or treatment to the teeth, alveolar processes, gingival tissue, or for malocclusion and/or dental implants;
5. for any Orthognathic surgery, including any appliance, medical or surgical treatment for correction of malocclusion or protrusion or recession of the mandible or maxilla or maxillary or mandibular hypoplasia or hyperplasia;
6. for orthotics, orthopedic or corrective shoes, and supportive appliances for the feet, unless otherwise stated as a covered expense.
7. for a covered individual where the primary carrier is a Health Maintenance Organization (HMO);
8. incurred in connection with remedying a condition by means of cosmetic surgery unless otherwise specifically covered under this plan;
9. prophylactic procedures due to family history, unless otherwise specifically covered under this plan;
10. for custodial or sanitary care and service, or for maintenance care or rest care;
11. for care and treatment of Mental Health Disorders in excess of the specified Covered Expenses and in excess of the limitations shown in the Summary of Benefits and Coverage;
12. for treatment by hypnosis, except as part of the Physician's treatment of a mental health condition or when hypnosis is used in lieu of an anesthetic;
13. for examinations or tests for check-up purposes which are not incident and necessary to the treatment of injury or illness, except as specified for annual physical or listed as eligible;
14. for rhinoplasty, blepharoplasty or brow-lift due to a nonfunctional condition;
15. incurred for the treatment of corns, calluses or toenails, unless the charges are for the removal of the nail or part thereof or for treatment of a metabolic or peripheral vascular disease;
16. for hospital care and services or supplies to the extent it shall be established upon review of a claim submitted hereunder that:
 - a. the condition does not require:
 - i. constant direction and supervision of a Physician,
 - ii. constant availability of licensed nursing personnel, and
 - iii. immediate availability of diagnostic therapeutic facilities and equipment found only in the hospital setting, or

- b. the primary cause of such confinement was for rest care or custodial type care consisting of daily routine personal maintenance, administration of medication on schedule, preparation of diet and assistance in ambulation;
- 17. for dentistry of any kind as a medical, rather than a dental benefit, except where specifically provided as a Covered Medical Expense;
- 18. for in vitro fertilization, embryo transfer, artificial insemination or any surgical procedure for the inducement of pregnancy (this exclusion does not apply to any pregnancy that might be a result of one or more of these excluded services);
- 19. for treatment, non-surgical and surgical procedures to reverse sterilization;
- 20. for sex therapy, marriage counseling or other social services unless specified otherwise;
- 21. for unproven drug therapy or any health procedures not approved by the Food and Drug Administration;
- 22. For prescription drugs dispensed on an outpatient basis which are covered under a fixed copayment prescription drug card program (including copayments and any required payment differentials between generic and brand name drugs). This exclusion does not apply to testosterone (requires Prior Authorization through RxResults and is only covered only for hormone replacement not for erectile dysfunction) or SpecialtyRx/Biotech medications, which are eligible under the Medical plan;
- 23. for a sex change, gender reassignment or treatment for transsexual purposes;
- 24. for over-the-counter drugs, drugs not approved for sale in the United States, or vitamins, food, nutritional or dietary supplements, even if any of these items are prescribed by a Physician. (This exclusion does not apply to over-the-counter and/or drugs listed as covered under the Prescription plan);
- 25. for Diabetic equipment and/or supplies used for testing blood and urine samples at home. (These are covered under the Prescription plan);
- 26. for chelation therapy, unless blood poisoning;
- 27. for air purification, humidifying, cooling or heating equipment;
- 28. for exercising equipment, vibratory equipment, swimming or therapy pools, health club memberships, massage therapy or hippo therapy;
- 29. incurred in connection with acupuncture or acupressure;
- 30. for a hospital admission for diagnostic or evaluation tests or procedures unless such tests or procedures could not be performed on an outpatient basis without adversely affecting the health of the patient;
- 31. for educational therapy, educational testing, training, aversion therapy, acupuncture, hippo therapy, or any behavior modification therapy (This exclusion does not apply to the treatment of autism spectrum disorder);
- 32. for hospital room and board charges when admission occurs one or more nights before a surgery, unless such admission is an eligible benefit;
- 33. expenses for appointments made but not kept or for completion of claim forms or pre-treatment forms required by your Employer;
- 34. any care or services covered in whole or in part under any other section of this Plan, unless specified otherwise;
- 35. furnished in any veteran's hospital, military hospital, institution or facility operated by the United States Government, agency of the United States Government, or by any foreign government for which you have no legal obligation to pay for services rendered or expenses incurred;
- 36. for any condition, illness, injury or complication thereof arising out of or in the course of employment;
- 37. 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. In applying this exclusion, work on the covered individual's family farm or ranch is not considered an employment arrangement;

38. 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;
39. an expense for which the provider of a service customarily makes no direct charge or for which you or your Dependent are not legally obligated to pay or for which no charges would be made in the absence of this coverage;^[n1]
40. caused or contributed to by the commission or attempted commission of a felony or caused or contributed to by being engaged in an illegal occupation;
41. in connection with participation in a civil disturbance or insurrection;
42. not an eligible benefit, which are not incident and necessary to the treatment of an injury or illness, as determined by the Plan or its agents;
43. rendered on an unproven, research basis when not generally accepted medical or dental practice;
44. not actually rendered;
45. 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;
46. for services rendered by any of the following relatives:
 - a. spouse;
 - b. parent(s), step-parent(s) or parent(s)-in-law;
 - c. child(ren) or child(ren)-in-law;
 - d. brother(s) or brother(s)-in-law;
 - e. sister(s) or sister(s)-in-law;
 - f. grandparent(s) or grandparent(s)-in-law;
 - g. grandchild(ren) or grandchild(ren)-in-law;
 - h. aunt(s) or uncle(s) or aunt(s)- or uncle(s)-in-law;
47. for travel or accommodations(except in connection with a covered transplant), whether or not recommended by a Physician;
48. in excess of the reasonable and customary allowances for non-negotiated services;
49. the result of travel outside the United States or its territories specifically to receive medical 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;
50. filed later than or information received later than twelve (12) months from the date the expense was incurred;
51. for elective abortions for covered persons except in the case of incest, rape or situations which are life threatening to the mother;
52. for services related to intersex surgery (transsexual operations) and any resulting complications;
53. for personal comfort, convenience or safety items; including but not limited to, the purchase or rental of telephones; televisions; guest meals or cots; orthopedic mattresses; allergy-free pillows, blankets and/or mattress covers; non-hospital adjustable beds; waterbeds; structural changes to a house including tub rails and portable or fixed shower benches; purchase, rental or modification of motorized transportation equipment, manual or electronic lifts; elevators; escalators; or ramps;
54. congenital or developmental malformation existing when the person became covered under this Plan;
55. for genetic testing, except as specifically listed as a Covered Expense;
56. for penile implants and/or devices (including external);
57. for cosmetic hair loss treatment (except as covered under the Wig benefit);
58. for cryotherapy;
59. for employer-mandated immunizations, medical services, medical testing;

60. for charges for internet medical management services and/or telemedicine, unless medical information is communicated in real-time with the use of interactive audio and video communications equipment, and is between the performing physician and a distant physician or health care specialist with the patient present during the communication (the plan offers contracted telemedicine services through the convenience of phone calls or online, video consultation. Services include diagnostic and/or medication management services for many conditions including allergies, cold and flu symptoms, ear infection, and other minor medical conditions);
61. for virtual colonoscopies; and
62. items not specifically listed as a Covered Expense.

HOW BENEFITS ARE PAID

DEDUCTIBLE AND OUT OF POCKET

Meeting the Annual Deductible

The Network and Non Network deductible are separate and do not accumulate toward one another. The family deductible is accumulative. Once the Family Deductible has been satisfied, it will not apply for any other family member's charges. Other family member's charges previously applied toward the Deductible will not be recalculated.

Meeting the Annual Out Of Pocket Maximum Limit

When a Covered Person meets their individual annual plan maximum Out of Pocket limit, or when the family meets their annual plan maximum Out of Pocket limit for in network services, all remaining Covered Expenses for network services will be payable at 100% for the remainder of that same calendar year (unless stated otherwise).

The following do not apply to the plan out of pocket maximum: penalties for failure to provide Notification or non compliance with Large Care Management, the portion of a charge that exceeds the usual, reasonable and customary guidelines, non-covered services, charges that exceed the maximum benefit, and morbid obesity treatment.

BENEFIT PERCENTAGE FOR COVERED EXPENSES IN EXCESS OF THE CALENDAR YEAR DEDUCTIBLE

Covered Expenses for each category will be paid per the Summary of Benefits and Coverage. The percentage is applied to the amount of Covered Expenses remaining after the application of any Deductible. In order to receive the full benefit available, you **must** comply with the Notification procedure.

HOW TO FILE A MEDICAL CLAIM

FILING DEADLINE

A claim for a medical 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. Additional information may also be submitted within the ninety (90) day period. Determination of "reasonably possible" is at the sole discretion of the Group Benefits Administrator. To avoid a prompt pay penalty, and in the sole discretion of IEBP, but not later than the prompt pay contract deadline, the required information must be received by IEBP.

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 unique subscriber identification number (or 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. 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 EBP. 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 MultiState 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 MultiState 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 MultiState 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 MultiState IEBP will contact you to let you know what information is needed to complete your claim. If TML MultiState 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 MultiState IEBP is asking the provider you may contact TML MultiState 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 MultiState 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 MultiState 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.

COBRA CONTINUATION OF COVERAGE (COC) RIGHTS UNDER COBRA

You're getting this notice because you have recently gained coverage 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 explains COBRA 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.** When you become eligible for COBRA Continuation of Coverage, you may also become eligible for other coverage options that may cost less than COBRA Continuation of Coverage.

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

You may have other options available to you when you lose group health coverage

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out of pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation of Coverage?

COBRA Continuation of Coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA 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 COBRA Continuation of Coverage may be required to pay for coverage depending on the policy of your employer.

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

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

If you're the spouse of the employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

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 of any of the following qualifying events:

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."

Any decision of whether an Employee was terminated because of gross misconduct will be made by the Employer. The employer may not change its decision of whether or not a termination was for gross misconduct more than the forty-fifth (45th) day after the date employment terminated or the date a COBRA Continuation of Coverage election notice was mailed to the employee, whichever is earlier. Any determination of gross misconduct shall be based on events prior to the termination.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage for any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. 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.

Please note that COBRA Continuation of Coverage does not include any life benefits. If you had voluntary life coverage, you may convert it to an individual policy within thirty-one (31) days of your qualifying event. Contact your employer's human resources office for more information and conversion forms.

When is COBRA Continuation of Coverage available?

The Plan will offer COBRA Continuation of Coverage to qualified beneficiaries only after IEBP has been notified that a qualifying event has occurred. The employer must notify IEBP of the following qualifying events:

1. The end of employment or reduction of hours of employment;
2. Death of the employee;
3. Commencement of a proceeding in bankruptcy with respect to the employer; or
4. The employee's becoming entitled to Medicare benefits (under Part A, Part B and/pr Part C).

You must give notice of some Qualifying Events

For all 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 IEBP within 60 days after the qualifying event occurs. You must provide notice to: TML MultiState IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385.

How is COBRA Continuation of Coverage provided?

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

COBRA 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, COBRA 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, COBRA 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, COBRA 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, COBRA Continuation of Coverage generally lasts for only up to a total of eighteen (18) months. There are three (3) ways in which this eighteen (18) month period of COBRA Continuation of Coverage can be extended.

Active Duty Reservists

If covered by the plan as an employee at the time of call to active duty, 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 COBRA 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 employer 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 employer receives written instructions from the fire fighter or police officer to change or discontinue the coverage. Such instruction shall be provided no later than sixty (60) days following the Qualifying Event. If no such instruction is given, then coverage will terminate on the sixty-first (61st) day, which shall then become the Qualifying Event for COBRA Continuation of Coverage purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

In administering this coverage, IEBP will follow the time guidelines of COBRA 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 member must notify IEBP that an employee has been called to active duty and submit a copy of the employer member's active reservist policy to IEBP.

Disability extension of COBRA Continuation of Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify IEBP within sixty (60) days of that determination, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA Continuation of Coverage for a total maximum of twenty-nine (29) months. The disability must start at some time before the sixtieth (60th) day of COBRA Continuation of Coverage and must last at least until the end of the eighteen (18) or twenty-four (24) month period of COBRA Continuation of Coverage. You may contact TML MultiState IEBP about a disability determination at 1820 Rutherford Lane, Suite #300, Austin, Texas 78754 or by telephone (800) 282-5385.

Second Qualifying Event extension of COBRA Continuation of Coverage

If your family experiences another qualifying event while receiving eighteen (18) or twenty-four (24) months of COBRA Continuation of Coverage, the spouse and dependent children in your family can get up to eighteen (18) additional months of COBRA Continuation of Coverage, for a maximum of thirty-six (36) months, if IEBP is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA Continuation of Coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B and/or Part C) gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. This extension is available only if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation of Coverage?

Yes. Instead of enrolling in COBRA Continuation of Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation of Coverage. You can learn more about many of these options at www.healthcare.gov.

Adding Dependents

If you are a COBRA Continuation of Coverage participant, you have the same rights to add dependents to your COBRA Continuation of Coverage as an active covered employee. For example, you may add dependents to your COBRA Continuation of Coverage within thirty-one (31) days of marriage or sixty (60) days of the birth, adoption or placement for adoption of a child. Also, you may add dependents to your COBRA Continuation of Coverage during your employer's open enrollment. However, these dependents who were not covered under the Plan before your qualifying event occurred are not qualified beneficiaries and do not have individual COBRA Continuation of Coverage rights, except for children added within sixty (60) days of birth, adoption or placement for adoption.

Children added to your COBRA Continuation of Coverage within sixty (60) days of birth, adoption or placement for adoption are qualified beneficiaries and have their own COBRA Continuation of Coverage rights.

If you have questions

Questions concerning your Plan or your COBRA 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:

- http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_fact_sheet.html; or
- http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html

OTHER PARTY LIABILITY

OTHER PARTY LIABILITY

This section applies if you:

1. are injured in an accident, regardless of who is at fault;
2. become ill, through the act or omission of another person, company or business and recover money from any source, you must reimburse IEBP for the benefits provided by the Plan whether or not the third party has admitted liability; or
3. For injuries from accidents on or after January 1, 2014, IEBP shall be subject to Chapter 140 of the Texas Civil Practices & Remedies Code.

Contractual Right of Reimbursement

If a Covered Individual:

1. is injured in an accident, regardless of who is at fault; or
2. becomes ill through the act or omission of another person, the Plan shall provide benefits on the condition that the Covered Individual cooperates with IEBP, its agents, subcontractors and attorneys by:
 - a. providing notification of any accidental injury or illness which may involve another individual, business or insurance company;
 - b. providing any information requested that is associated with the injury or illness; and
 - c. filing any claim documentation with an insurance carrier or third party as requested by IEBP.

In addition, the Covered Individual specifically delegates to IEBP the right to make a claim or assert a cause of action on the Covered Individual's behalf against any source of recoveries, and assigns to IEBP the right to any proceeds from the claim or cause of action.

"Source of recovery" shall include, but not be limited to:

1. any third party;
2. any liability or other insurance covering the third party;
3. uninsured motorist, underinsured motorist, no-fault, or medical payments which are paid or payable of a non-immediate family member; or
4. any other responsible party. IEBP may seek direct reimbursement for benefit coverage from any source of recovery.

By enrolling in this Plan, the Covered Individual agrees to abide by the provisions in one (1) through eleven (11) following this paragraph. IEBP may suspend payment of claims for the injury or illness based on the amount of the claim, indication of other insurance, indication there may be another source to pay for the medical services required as a result of the injury or illness, or evidence that the claim may not be covered because it is work-related.

As an additional assurance, payment of the claim(s), and future claims relating to the injury or illness will **only** resume if the Covered Individual:

1. provides any and all information requested by IEBP; and
2. agrees in writing not to settle damages whether by legal action, settlement or otherwise and only after consulting with IEBP to determine the full and potential medical charges; and
3. agrees that should the Covered Individual settle for damages as a result of an injury/illness with a third party or insurer, prior to securing such written permission, IEBP and the employer's health benefits plan is relieved of any liability for medical benefits resulting from the injury/illness; and
4. agrees that IEBP may provide any medical bills or payment information related to the injury/illness to the Covered Individual's attorney, any insurer or any other person who will be reimbursing IEBP for medical benefits; and

5. agrees in writing to reimburse IEBP immediately upon collection of damages whether by legal action, settlement or otherwise including, but not limited to, first party and third party motor vehicle insurance; and
6. agrees in writing to provide IEBP with a first lien on all proceeds recovered for this injury to the extent of benefits provided by the Plan; and
7. agrees in writing that the first lien in 6. above represents the pro rata share of IEBP pursuant to Section 172.015(e), Texas Local Government Code; and
8. agrees in writing that venue for all subrogation disputes shall be in Travis County, Texas; and
9. agrees in writing to provide IEBP with a copy of any settlement agreement relating to this injury/illness if requested; and
10. agrees to cooperate fully with IEBP in asserting its right to subrogate. This means the Covered Individual must supply IEBP with all information and sign and return all documents reasonably necessary to carry out IEBP's right to recover from the third party any benefits paid under the Plan which are subject to this provision; and
11. agrees to all provisions of the benefit plan.

If the Covered Individual accepts reimbursement or assigns benefits for an injury or illness for which money or benefits were received or paid by another source, and payment has also been made by IEBP, the Covered Individual must reimburse IEBP the amount paid to the Covered Individual or any provider for services or treatment for the injury or illness. If the Covered Individual does not reimburse IEBP, the amount not reimbursed may be withheld from future benefits.

Automobile/Homeowners Liability and/or Medical Payments Insurance Benefits

Benefits payable under this Plan may be adjusted by IEBP for any first party or third party insurance benefits available for medical benefits, including no-fault medical payments uninsured motorist coverage which are paid or payable by a non-immediate family member whether or not any party has admitted liability.

Right of Recovery

IEBP 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 Individual specifically delegates to IEBP the right to make a claim or assert a cause of action on the Covered Individual's behalf against any source of recovery, and assigns to IEBP the right to any proceeds from the claim or cause of action.

A third party may be liable or legally responsible for expenses incurred by a Covered Individual for an illness, sickness or bodily injury. Subrogation rights may take precedence over a Covered Individual's right to receive payment of the benefits from the third party. The Covered Individual must supply IEBP with all information and sign and return all documents reasonably necessary to carry out IEBP's right to recover from the third party any benefits paid under the Plan which are subject to this provision.

COORDINATION OF BENEFITS

Once a claim or potential claim for benefits has been submitted and there are indications that another source of payment may exist, the Group Benefits Administrator will request further information to confirm or deny the existence of other coverage. A claim is not considered to be complete until all the information needed by the Group Benefits Administrator to make this determination has been received. The Group Benefits Administrator has the authority to determine the form, content and timing of the submission of such information and to resolve any questions with regard to those requirements. This provision is designed to prevent the double payment of medical expenses for the same illness or injury and to manage the high cost of medical coverage by seeking reimbursement from other sources.

COORDINATION OF BENEFITS

When you and/or your dependents are covered under more than one group health plan, the combined benefits payable by this plan and all other plans will not exceed 100% of the eligible expense incurred by the individual. The plan assuming primary payor status will determine benefits first without regard to benefits provided under any other group health plan.

When this plan is the secondary payor or the covered individual accesses benefits through active employee status elsewhere, it will reimburse, subject to all plan provisions, the balance of remaining eligible expenses, not to exceed normal plan liability if this plan had been primary.

For purposes of coordination, eligible expense means usual and customary charge considered in part or full by this plan.

For example:

Charge = \$100 (deductible already satisfied)

The Plan's Allowable Amount = \$100

Primary Carrier Payment = \$75

The Plan's Payment = \$25

DEFINITIONS

Plan

The medical expense benefits provided by your Employer through this Plan.

Plan means any of the following arrangements that provide medical benefits or services:

1. insurance or any arrangement of benefits for groups;
2. prepayment coverage or any coverage toward the cost of which any employer makes contributions;
3. a labor-management trustees plan, union welfare plan, employer organization plan or employee organization plan;
4. any governmental program or coverage required by statute;
5. coverage for students sponsored by, or provided through a school or other educational institution; or
6. coverage for expenses due to accidental bodily injury or disease to the extent to which payment as a settlement, judgment or otherwise is made by any person or their insurers without regard to whether or not liability is admitted.

Primary

A plan that pays eligible expenses without regard to the existence of any other Plans.

Secondary

A plan that coordinates payments so that the total payments from all plans shall not exceed 100% of this Plan's allowable eligible benefits with the exception of an HMO plan.

Application

The Group Benefits Administrator will determine which plan is primary and which plan is secondary. The other plan will always be primary if that plan has no coordination or integration provision. When this Plan is primary, it will pay benefits as if it were the only plan. When this Plan is secondary or the covered individual accesses benefits through active employee status elsewhere, it will pay a reduced benefit, which when added to the benefits paid by all other plans, will not exceed 100% of the total eligible expense covered by this Plan. An Itemized bill and an Explanation of Benefits (EOB) from the primary plan must be provided to the secondary plan to review for payment.

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 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 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.

PRE-EXISTING

Effective January 1, 2014 this plan no longer limits benefits that may be available for pre-existing conditions.

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.

ACTIVE EMPLOYEE – Is an employee who works and is paid by the employer for at least twenty (20) hours per week or is accessing vacation, sick, personal, paid time off, (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. Persons who are receiving long or short term disability payments or workers' compensation income benefits are not otherwise on the payroll of the employer are not active employees, nor do those benefits accrue toward the twenty (20) hour requirement.

In order for any form of leave that is not accrued on a weekly, monthly, annual or other periodic basis to be considered as vacation, sick, personal, or paid time off leave under the previous paragraph, the employer's leave policy must be (1) in writing and (2) available uniformly to all employees. This non-accruing leave shall include but not be limited to sick pool leave, catastrophic leave, disability leave, non-FMLA medical leave, workers' compensation injury leave, and emergency leave.

A Family Medical Leave Act (FMLA) certification shall extend the period of coverage for active employee(s) when the FMLA documentation is provided in writing within thirty (30) days of the certification and one hundred and twenty (120) days of the beginning date of the FMLA leave

ADOLESCENT DEPENDENT – An individual thirteen (13) to attained age of eighteen (18) years of age whose disabilities of minority have not been removed by marriage or judicial decree.

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.

ALLERGY IMMUNOTHERAPY – Stimulation of the immune system with gradually increasing doses of the substances to which a person is allergic. The aim is to modify or stop the allergy by reducing the strength of the response.

AMBULATORY SURGICAL CENTER (ASC) – A distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. An ASC is either independent or operated by a hospital (i.e. under the common ownership, licensure or control of a hospital and/or physician), and must be licensed and/or either Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) accredited, Accreditation Association for Ambulatory Health Care (AAAHC) accredited, or accredited by another organization and/or Medicare approved to operate as a Ambulatory Surgery Center.

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.

AMERICAN COLLEGE OF SURGEONS BARIATRIC SURGERY CENTER NETWORK ACCREDITATION PROGRAM (ACS BSCN) – Accredits facilities in the United States.

AQUATIC THERAPY – Services prescribed by a Physician to restore or improve a previous level of body function. Inpatient/Outpatient therapy services must be performed or rendered at a hospital or licensed healthcare facility by a licensed aquatic physical therapist or Physician.

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.

BIRTHING CENTER – A free-standing facility licensed to provide for normal labor and delivery and that employs either a staff obstetrician or certified Nurse-Midwife with an obstetrician consultant.

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

CARDIAC REHABILITATION – A program of clinically supervised exercise designed to strengthen the heart and improve cardiovascular functioning. A Cardiac Rehabilitation program is designed for patients who have experienced a serious cardiac event and whose recovery would benefit from cardiovascular exercise, but the covered individual cannot currently engage in unsupervised exercise without a clear risk to their health.

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, national provider identification 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. A "Clean Claim" does not include a claim where integration/coordination of benefits is actively pursued, medical claims review is necessary, subrogation is pursued or where a work related condition may exist. 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 its 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.
5. Well Conducted Clinical Trials – Trials in which two or more treatments are compared to each other, and the patient or provider is not allowed to choose which treatment is received.

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.

COPAY – A specified amount that is the covered individual's responsibility to pay to a healthcare provider. Copays are usually connected with specific benefits and may be in addition to or in lieu of the Plan deductible.

CONCURRENT REVIEW – A service provided by Medical Intelligence Care Management to review the necessity of continued treatment.

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.

CRISIS STABILIZATION UNIT – A twenty-four (24) hour residential program, usually short-term in nature that provides intensive supervision and highly structured activities to persons who are demonstrating an acute psychiatric crisis of moderate to severe proportions.

CRYOTHERAPY – Cold therapy used to reduce pain and swelling after an injury or surgery.

CUSTODIAL CARE – Care to meet personal needs and daily living activity needs of an individual that could be provided by persons without professional skills, training or a license.

DAY TREATMENT – A psychiatric or Substance Use Disorder treatment facility that meets all of the following requirements:

1. provides treatment for individuals suffering from acute Mental Health disorders and/or Substance Use Disorder in a structured program using individual treatment plans with specific attainable goals and objectives appropriate for the covered individual;
2. clinically supervised by a Physician who is certified in psychiatry by the American Board of Psychiatry and Neurology; and
3. accredited by the Program for Psychiatric Facilities and is licensed by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) or is a community health center, health center or day treatment center which furnishes health services subject to the approval of the Department of Mental Health.

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

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

1. An Employee's lawful Spouse (marriage certificate or a signed affidavit of common law marriage required).
2. 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.

DESIGNATED TRANSPLANT CENTER (CENTERS OF EXCELLENCE) – An OptumHealth network hospital or facility of a particular organ transplant procedure. The hospital or facility selected must meet all of the following requirements:

1. has performed the transplant procedure regularly/periodically for three (3) or more years; and
2. has a twelve (12) month survival rate of at least eighty percent (80%) for the transplant procedure, with the exception of bone marrow/stem cell transplants.

DEVELOPMENTAL DELAY – A delay in achieving skills and abilities usually mastered by children of the same age. Delays may occur in any of the following areas: physical, social, educational, emotional, intellectual, speech and language, and/or adaptive development, sometimes called self-help skills, which include dressing, toileting, feeding, etc.

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 Health conditions; or
6. Substance Use Disorder.

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

DURABLE MEDICAL EQUIPMENT – Equipment that is eligible and appropriate only in the treatment or management of an illness or injury and is accepted in the medical community as safe and effective.

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 – See Active Employee

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 accepted by the employer and received by the Group Benefits Administrator within required timelines.

ESSENTIAL BENEFITS –The Patient Protection Affordable Care Act defines essential benefits to include items and services within the following ten (10) benefit categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services (as defined as up to age 21) including oral and vision care.

EVIDENCE BASED MEDICINE (EBM) – Aims to apply the best available evidence gained from the scientific method to medical decision making. It seeks to assess the quality of evidence of the risks and benefits of treatments

(including lack of treatment). EBM recognizes that many aspects of medical care depend on individual factors such as quality and value of life judgments, which are only partially subject to scientific methods. EBM, however, seeks to clarify those parts of medical practice that are in principle subject to scientific methods and to apply these methods to ensure the best prediction of outcomes in medical treatment, even as debate continues about which outcomes are desirable.

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 unless the information is required for contractual prompt pay compliance. 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.

GENETIC TESTING – Involves the examination of human DNA for an anomaly associated with a disease or disorder. DNA is taken from a sample of the covered individual's blood, body fluid or tissue.

GENETIC MARKERS – used to predict an individual's response to drug therapy. Aims to direct specific drug therapy only to individuals who can respond to the therapy and avoid therapy for individuals who cannot benefit. (not for diagnosis).

GROUP BENEFITS ADMINISTRATOR – TML Intergovernmental Employee Benefits Pool (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), Certified Professional Midwife (CPM), Registered Respiratory Therapist (RRT), Certified Respiratory Therapist (CRT), Licensed Physical Therapist (LPT), Licensed Psychologist, Doctor of Chiropractic (DC), Doctor of Podiatry Medicine (DPM), , 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).

HEALTH INSURANCE MARKETPLACE – Health insurance market plan through the Affordable Care Act's Health Insurance Marketplace, www.HealthCare.gov.

HIPAA – A 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.

Title I:

- Refers to healthcare coverage reform and includes provisions for special enrollments and non-discrimination based on Health Status Factors;

- A self-funded, non-federal, governmental plan may exempt itself from HIPAA's provisions for standards relating to benefits for mothers and newborns, parity in the application of certain limits for mental health benefits, coverage for reconstructive surgery following mastectomy/lumpectomy and coverage of dependent students on medically necessary leave of absence. This Plan has opted out of and is exempt from these provisions. However, this Plan may comply voluntarily, in part or in whole, with some of the HIPAA requirements listed.

Title II:

- Effective April 14, 2003, Administrative Simplification guidelines were 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 requirements.

HOMEBOUND – Physician certification that the covered individual is confined to the covered individual's home is required for home health services. Any absence of an individual from the home to receive healthcare treatment including regular absences for the purposes of participating in therapeutic, psychosocial or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited to furnish adult day care services in the State shall not negate the covered individual's homebound status for purposes of eligibility. Any absence for religious service is deemed to be an absence of infrequent or short duration and thus does not negate the homebound status of the beneficiary.

HOME HEALTH CARE AGENCY – A public or private agency or organization licensed by the state in which it is located to provide skilled nursing services and other therapeutic services under the supervision of a Physician or Registered Nurse.

HOME HEALTH CARE PLAN – A program for care and treatment of the covered individual:

1. established, approved and reviewed in writing at thirty (30) day intervals by the attending Physician; and
2. certified by the attending Physician that the proper treatment of the disability would require confinement as an inpatient in a hospital, rehabilitative hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the home health care plan.

HOSPICE – An interdisciplinary group of personnel which includes at least one (1) Physician and one (1) Registered Nurse and which maintains central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPICE CARE – A coordinated, interdisciplinary program approved by a terminally ill individual's attending Physician for meeting the special physical, psychological and social needs of an individual who has a life expectancy of less than six (6) months. The program provides palliative and supportive medical, nursing and other healthcare services through home or inpatient care for a period not to exceed six (6) months.

HOSPITAL – An institution constituted and operated according to law which meets all of the following requirements:

1. is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) and/or approved by Medicare and/or Texas Commission on Alcohol and Drug Abuse (TCADA);
2. maintains permanent and full-time facilities for care of five (5) or more patients;
3. provides diagnostic and therapeutic services and medical care and treatment to sick and injured persons on an inpatient basis; and
4. provides care and treatment at the covered individual's expense.

The term hospital DOES NOT INCLUDE an institution or any part of one which is used primarily as:

1. a rest facility;
2. a facility for the aged; or
3. a place for custodial care.

ILLNESS – Sickness or disease which requires treatment by a licensed Healthcare Provider.

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 Health/Substance Use Disorder treatment of high frequency over a short period of time.

LATE ENTRANT – A person who makes application for coverage more than thirty-one (31) days after the person's initial eligibility date. Late Entrants will only be accepted for coverage during the Plan's annual open enrollment, within thirty-one (31) days of a qualifying event.

LONG TERM ACUTE CARE (LTAC) FACILITY - A long-term acute care hospital that provides extended, intensive medical care to patients who are clinically complex and suffering from multiple acute or chronic conditions. Such patients typically require a longer than usual hospital stay because of the severity of illness or the chronic nature of the disease process.

MAINTENANCE CARE – All services, equipment and supplies which are provided solely to maintain a covered individual's condition and from which no functional improvement can be expected.

MEDICAL INTELLIGENCE CARE MANAGEMENT – Large Medical Intelligence 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 Medical Intelligence 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.

MEDICAL SUPPLIES – Benefit eligible medical supplies provided on an outpatient basis.

MEDICALLY JUSTIFIED – A service that falls under the plan definition of UNPROVEN MEDICAL PROCEDURES/THERAPY, but that can be justified for an individual patient due to:

1. A rare/orphan disease (a rare/orphan disease is one that affects fewer than 200,000 people, according to the U.S. Rare Disease Act of 2002).
2. A unique co-morbidity, or complication that precludes treatment with a proven medical procedure or therapy.
 - a. No other treatment available due to co-morbidities
 - b. Co-morbid Disease State Risk
3. Continuation and/or repeat of a previously approved successful treatment plan.
4. Concern for Complications due to treatment area.
5. Repeat of prior successful treatment intervention and disease state; disease state put in remission.
6. Treatment dose should be in compliance for best outcome.
7. Severity of illness defined as ongoing intensity and complication of disease state with lab value concerns.

MEDICARE – Title XVIII (Health Insurance for the Aged) of the United States Social Security Act or as later amended.

MENTAL HEALTH CONDITIONS – Those conditions or illnesses that are classified by the most recent edition of either a DSM (Diagnostic & Statistical Manual of Mental Disorders) diagnostic code or an ICD (International Classification of Disease) code for mental disorders.

MENTAL NERVOUS/SUBSTANCE USE DISORDER INTENSIVE OUTPATIENT TREATMENT – Conditions that require more frequent outpatient services in a short period of time.

MENTAL HEALTH TREATMENT FACILITY – A facility constituted and operated under law which includes all of the following:

1. is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO);
2. maintains permanent and full-time facilities for care of five (5) or more patients;
3. provides a program for diagnosis, evaluation and effective treatment of Mental Health conditions;
4. complies with all licensing and other legal requirements;
5. has a Physician, Registered Nurse (RN) and a medical staff responsible for execution of all policies and procedures;
6. provides twenty-four (24) hour skilled nursing care by nurses under the supervision of a registered nurse (RN);
7. provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
8. has an established protocol for medical emergencies; and
9. is not, other than incidentally, a place for custodial care or for care of the aged and senile.

MORBID OBESITY – is defined as a condition for which a Covered Person is 200% over ideal weight or 100 pounds overweight with a Body Mass Index (BMI) of greater than 40.

NETWORK – Treatment or services rendered by providers that are included as contracted providers in the preferred provider network.

NON-MORBID OBESITY TREATMENT CENTER – A non-accredited, non-network UnitedHealthcare Choice Plus, and non-designated Center of Excellence facility will not be eligible for benefit plan consideration.

NON-NETWORK – Treatment or services rendered by providers that are not included as contracted providers in the preferred provider network.

NOTIFICATION – The process for notifying Medical Intelligence Care Management of the need for medical treatment or services.

NURSE – A Registered Nurse (RN), Licensed Vocational Nurse (LVN), Licensed Practical Nurse (LPN), Advanced Nurse Practitioner (ANP) or Registered Nurse First Assistant (RNFA).

NURSE MIDWIFE/CERTIFIED PROFESSIONAL MIDWIFE (CPM) – A licensed registered nurse (RN) who is certified as a nurse midwife by the American College of Nurse-Midwives and is authorized to practice as a nurse midwife under state regulations.

Certified Professional Midwife (CPM) who is a knowledgeable, skilled and a professionally independent midwifery practitioner and has met the standards for certification set forth by the North American Registry of Midwives (NARM). Graduate programs must be accredited by the Midwifery Education and Accreditation Council (MEAC); or certified by the American Midwifery Certification Board (AMCB) as a CNM/CM.

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 AREA – If a covered individual requires immediate care at an Non Network provider, the Plan will pay eligible expenses at the benefit percentage referenced on the Summary of Benefits and Coverage, subject to the deductible, out of pocket and usual, reasonable & customary.

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

OUTPATIENT – Treatment or confinement in a medical facility where the covered individual has not been admitted as inpatient. If you notify Medical Intelligence Care Management within forty-eight (48) hours of an outpatient surgery that exceeds the twenty-three (23) hour limit it will be considered an admission and a late review will be performed.

OUTPATIENT OBSERVATION – Treatment or confinement in a medical facility with the purpose of observing the covered individual to determine the need for further outpatient treatment or for inpatient admission.

OUT OF NETWORK – See Non Network.

PHARMACY BENEFIT MANAGER – The Plan’s prescription drug carrier.

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.

GROUP BENEFITS ADMINISTRATOR – The City of Carrollton (the Employer).

PLAN SPONSOR – The Employer.

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

PREDETERMINATION – Process of reviewing provider-submitted clinical information supporting the eligibility of a planned procedure/treatment or device(s). A pre-determination is done in advance of a procedure/treatment or device(s) and is subject to plan benefits and limitations.

PREGNANCY – Under the terms of this Plan, pregnancy includes one or more of the following:

1. period from conception through childbirth;
2. miscarriage;
3. any complications arising wholly from pregnancy, childbirth or miscarriage;
4. any pregnancy complications arising from any trauma; and/or
5. extra-uterine pregnancies are considered to be genitourinary conditions.

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 MultiState 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.

RECONSTRUCTIVE SURGERY – A procedure performed incidental to an injury, sickness, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that

physical appearance may change or improve as a result of reconstructive surgery does not classify such surgery as cosmetic when a functional impairment exists, and the surgery restores or improves function.

REHABILITATIVE HOSPITAL – An institution constituted and operated under law which:

1. is primarily engaged in providing rehabilitation services for sick or injured persons and meets the definition of a Hospital; and
2. is not, other than incidentally, a place for custodial care, for care of the aged or senile, for treatment of Mental Health conditions or of substance abuse or a school or similar institution.

RESIDENTIAL TREATMENT CENTER – The term residential treatment center for children and adolescents means an accredited child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission for the Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children.

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.

ROUTINE – Being in accordance with an established procedure.

SEMI-PRIVATE ROOM – A hospital room containing two (2) beds, but does not include an intensive care unit room.

SKILLED NURSING FACILITY – An institution or a distinct part of an institution which meets all of the following criteria:

1. is primarily engaged in providing for inpatient skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation service for the rehabilitation of injured or sick persons;
2. has policies which are developed with the advice of (and with provision for review of such policies from time to time) a group of professional personnel, including one or more Physicians and one or more Registered Nurses, to govern the skilled nursing care and related medical care or other services provided;
3. has a Physician, a Registered Nurse (RN) and a medical staff responsible for the execution of such policies;
4. has a requirement that the healthcare of every patient must be under the supervision of a physician and provides for having a Physician available to furnish necessary medical care in case of emergency;
5. maintains clinical records on all patients;
6. if required, provides twenty-four (24) hour nursing care under the supervision of a Registered Nurse (R.N.);
7. provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
8. has in place a utilization review plan which provides for the review of admissions to the institution, the duration of stays and the professional services furnished with respect to eligibility;
9. is licensed by the appropriate state or local agency; and
10. is Medicare or Medicaid eligible.

A skilled nursing facility meets the definition of an extended care facility but does not include any institution which is primarily for custodial care or for care of the aged or senile.

SKILLED NURSING SERVICES – Nursing services performed by a RN, LVN or LPN for health services.

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 USE DISORDER – Habituation, abuse and/or addiction to alcohol or other chemical substance not including nicotine. This includes physiological and/or psychological dependence.

SUBSTANCE USE DISORDER OR SUBSTANCE ABUSE TREATMENT FACILITY – A facility which provides a program for the treatment of Substance Use Disorder pursuant to a written treatment plan approved and monitored by a physician and which facility meets the requirements under #1, #2 and #3 or the requirements under #4:

1. affiliated with a hospital under a contractual agreement with an established system for covered individual referral;
2. accredited as such a facility by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO); and
3. licensed as a Substance Use Disorder treatment program by the Texas Commission on Alcohol and Drug Abuse (TCADA); or
4. licensed, certified or approved as a Substance Use Disorder treatment program or center by any other state agency having legal authority to so license, certify or approve and is also an approved healthcare facility.

TELEMEDICINE – 1. Medical information that is communicated in real-time with the use of interactive audio and video communications equipment, and is between the performing physician and a distant physician or health care specialist with the patient present during the communication.

2. TML MultiState IEBP's contracted telemedicine services via the convenience of phone or online, video consultation, diagnostic and/or medication management services for many conditions including allergies, cold and flu symptoms, ear infection and other minor medical conditions.

TRANSPLANT – The removal and replacement of human tissue and/or organ.

TREATMENT – Any specific procedure or service, which is eligible and used for the cure or improvement of an illness, disorder or injury.

UNITED STATES PREVENTIVE SERVICES TASK FORCE (USPSTF) – Quality Improvement preventive services task force that works with other national organizations.

PHS Act section 2713 and the interim final regulations require non-grandfathered group health plans in the individual or group benefits prohibit the cost-sharing requirements with respect to, the following:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the covered individual;
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the covered individual;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
4. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

UNPROVEN MEDICAL PROCEDURES/TREATMENT – Means experimental/Investigational/Unproven Services: medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Any drug not approved by the U.S. Food and Drug Administration (FDA) for marketing; any drug that is classified as IND (Investigational new drug) by the FDA;
- Determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials;
- Not consistent with the standards of good medical practice in the United States as evidenced by endorsement by national guidelines;

- Exceeds (in scope, duration, or intensity) that level of care which is needed - Given primarily for the personal comfort or convenience of the patient, family member(s) or the provider;
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered Experimental or Investigational.); or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1 or 2 clinical trial, or is the experimental arm of a Phase 3 or 4 clinical trial as set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

URAC (UTILIZATION REVIEW ACCREDITATION COMMISSION) – An independent organization, known as a leader in accreditation, education and measurement programs. URAC offers quality benchmarking programs and services to validate quality and accountability. URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry.

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.cityofcarrollton.com

Group Benefits Administrator

TML Intergovernmental Employee Benefits Pool (IEBP)
PO Box 149190
Austin, TX 78714-9190
(800) 282-5385

www.iebp.org
Group#: ACARROL1

Medical Intelligence Care Management

TML MultiState IEBP – Medical Intelligence Care Management
PO Box 149190
Austin, TX 78714-9190
(800) 847-1213

www.iebp.org
Group#: ACARROL1
(800) 847-1213

Professional Health Coach Services

(888) 818-2822

EAP

Deer Oaks
2501 Oak Lawn, Suite 201
Dallas, Texas 75203
(866) 327-2400

www.deeroaks.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The City of Carrollton's Employee Health Plan ("Plan") is required by law to keep your health information private and to notify you if the Plan, or one of its business associates, breaches the privacy or security of your unsecured, identifiable health information. This notice tells you about the Plan's legal duties connected to your health information. It also tells you how the Plan protects the privacy of your health information. The Plan must use and share your health information to pay benefits to you and your healthcare providers. The Plan has physical, electronic and procedural safeguards that protect your health information from inappropriate or unnecessary use or sharing.

Is all my health information protected?

Your individually identifiable health information that the Plan transmits or maintains in writing, electronically, orally or by any other means is protected. This includes information that the Plan creates or receives and that identifies you and relates to your participation in the Plan, your physical or mental health, your receipt of healthcare services and payment for your healthcare services.

How does the Plan use and share my health information?

The Plan's most common use of health information is for its own treatment, payment and healthcare operations. The Plan also may share your health information with healthcare providers, other health plans and healthcare clearinghouses for their treatment, payment and healthcare operations. (Healthcare clearinghouses are organizations that help with electronic claims.) The Plan also may share your health information with a Plan business associate if the business associate needs the information to perform treatment, payment or healthcare operations on the Plan's behalf. For example, your health benefits include a retail and mail order pharmacy network, the Plan must share information with the pharmacy network about your eligibility for benefits. Healthcare providers, other health plans, healthcare clearinghouses and Plan business associates are all required to maintain the privacy of any health information they receive from the Plan. The Plan uses and shares the smallest amount of your health information that it needs to administer your health plan.

What are treatment, payment and healthcare operations?

Treatment is the provision, coordination or management of healthcare and related services. For example, your health information is shared for treatment when your family doctor refers you to a specialist.

Payment includes Plan activities such as billing, claims management, subrogation, plan reimbursement, reviews for appropriateness of care, utilization review and prior notification of healthcare services. For example, the Plan may tell a doctor if you are covered under the Plan and what part of the doctor's bill the Plan will pay.

Healthcare operations include quality assessment and improvement, reviewing competence or qualifications of healthcare professionals, underwriting and other activities necessary to create or renew health plans. It also includes disease management, care management, conducting or arranging for medical review, legal services, auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information from your claims to contact you about treatment alternatives or other health-related benefits and services that may be of interest to you. Please note that while TML MultiState IEBP may use and share your health information for underwriting, TML MultiState IEBP is prohibited from using or sharing any of your genetic information for underwriting.

How else does the Plan share my health information?

The Plan may share your health information, when allowed or required by law, as follows:

- Directly with you or your personal representative. A personal representative is a person who has legal authority to make healthcare decisions for you. In the case of a child under 18 years of age, the child's personal representative may be a parent, guardian or conservator.

In the case of an adult who cannot make his own medical decisions, a personal representative may be a person who has a medical power of attorney.

- With the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Plan's compliance with federal regulations on protecting the privacy and security of health information.
- With your family member, other relative, close personal friend or other person identified by you who is involved directly in your care. The Plan will limit the information shared to what is relevant to the person's involvement in your care and, except in the case of an emergency or your incapacity, you will be given an opportunity to agree or to object to the release of your health information.
- For public health activities.
- To report suspected abuse, neglect or domestic violence to public authorities.
- To a public oversight agency.
- When required for judicial or administrative proceedings.
- When required for law enforcement purposes.
- With organ procurement organizations or other organizations to facilitate organ, eye or tissue donation or transplantation.
- With a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties required by law.
- With a funeral director when permitted by law and when necessary for the funeral director to carry out his duties with respect to the deceased person.
- To avert a serious threat to health or safety.
- For specialized government functions, as required by law.
- When otherwise required by law.
- Information that has been de-identified. This means that the Plan has removed all your identifying information and it is reasonable to believe that the organization receiving the information will not be able to identify you from the information it receives.

Can I keep the Plan from using or sharing my health information for any of these purposes?

You have the right to make a written request that the Plan not use or share your health information, unless the use or release of information is required by law. However, since the Plan uses and shares your health information only as necessary to administer your health plan, the Plan does not have to agree to your request.

Are there any other times when the Plan may use or share my health information?

The Plan may not use or share your health information for any purpose not included in this notice, unless the Plan first receives your written authorization. To be valid, your authorization must include: the name of the person or organization releasing your health information; the name of the person or organization receiving your health information; a description of your health information that may be shared; the reason for sharing your health information; and an end date or end event when the authorization will expire.

You may revoke or take back any authorization that you make. Your request to revoke your authorization must be in writing and will not apply to any information shared before the Plan receives your request.

The plan must always have your written authorization to:

- Use or share psychotherapy notes, unless the Plan is using or sharing the psychotherapy notes to defend itself in a legal action or other proceeding brought by you.
- Use or share your identifiable health information for marketing, except for: (1) a face-to-face communication from the Plan, or one its business associates, to you; or (2) a promotional gift of nominal value given by the Plan, or one its business associates, to you.
- Sell your identifiable health information to a third party.

You may revoke or take back any authorization that you make. Your request to revoke your authorization must be in writing and will not apply to any information shared before the Plan receives your request.

Can I find out if my health information has been shared with anyone?

You may make a written request to the Plan's Privacy Officer for a list of any disclosures of your health information made by the Plan during the last six years. The list will not include any disclosures made for treatment, payment or healthcare operations; any disclosures made directly to you; any disclosures made based upon your written authorization; any disclosures reported on a previous list; or any disclosures reported on a previous list.

Generally, the Plan will send the list within 60 days of the date the Plan receives your written request. However, the Plan is allowed an additional 30 days if the Plan notifies you, in writing, of the reason for the delay and notifies you of the date by which you can expect the list.

If you request more than one list within a 12-month period, the Plan may charge you a reasonable, cost-based fee for each additional list.

Can I view my health information maintained by the Plan?

You may make a written request to inspect, at the Plan's offices, your enrollment, payment, billing, claims and case or medical management records that the Plan maintains. You also may request paper copies of your records. If you request paper copies, the Plan may charge you a reasonable, cost-based fee for the copies. Requests to view your health information should be made in writing to:

City of Carrollton
Attn: Human Resources
1945 Jackson Road
Carrollton, TX 75006

If I review my health information and find errors, how do I get my records corrected?

You may request that the Plan correct any of your health information that it creates and maintains. All requests for correction must be made to the Plan's Privacy Officer, must be in writing and must include a reason for the correction. Please be aware that the Plan can correct only the information that it creates. If your request is to correct information that the Plan did not create, the Plan will need a statement from the individual or organization that created the information explaining an error was made. For example, if you request a claim be corrected because the diagnosis is incorrect, the Plan will correct the claim if the Plan (or its business associate) made an error in the data entry of the diagnosis.

However, if your healthcare provider submitted the wrong diagnosis to the Plan, the Plan cannot correct the claim without a statement from your healthcare provider that the diagnosis is incorrect.

The Plan has 60 days after it receives your request to respond. If the Plan is not able to respond, it is allowed one 30-day extension. If the Plan denies your request, either in part or in whole, the Plan will send you a written explanation of its denial. You may then submit a written statement disagreeing with the Plan's denial and have that statement included in any future disclosures of the disputed information.

I'm covered as a dependent and do not want any of my health information mailed to the covered employee's address. Will you do that?

If mailing communications to the covered employee's address would place you in danger, the Plan will accommodate your request to receive communications of health information by alternative means or at alternative locations. Your request must be reasonable, must be in writing, must specify an alternative address or other method of contact, and must include a statement that sending communications to the covered employee's address would place you in danger. Please be aware that the Plan is required to send the employee any payment for a claim that is not assigned to a healthcare provider, except under certain medical child support orders.

If I believe my privacy rights have been violated, how do I make a complaint?

If you believe your privacy rights have been violated, you may make a complaint to the Plan.

In writing:
City of Carrollton
Attn: Human Resources
1945 Jackson Road
Carrollton, TX 75006

Also, you may file a complaint with the U.S. Department of Health and Human Services. The Plan will not retaliate against you for filing a complaint.

When were the privacy practices described in this notice effective?

This privacy notice has an effective date of September 1, 2013, and it replaced any privacy notice issued by the Plan before that date.

Can the Plan change its privacy practices?

The Plan is required by law to follow the terms of its privacy notice currently in effect. The Plan reserves the right to change its privacy practices and to apply the changes to any health information the Plan received or maintained before the effective date of the change. The Plan will distribute any revised notice to covered employees, either by hand or by mail, before the effective date of the revised notice. The Plan and TML MultiState IEBP (the Plan's Group Benefits Administrator) will maintain their current privacy notice's on TML MultiState IEBP's website at: www.iebp.org. If a revision is made during your plan year, TML MultiState IEBP will post the revised notices to the website on the date the new notice goes into effect.

What happens to my health information when I leave the plan?

The Plan is required to maintain your records for at least six years after you leave the Plan. However, the Plan will continue to maintain the privacy of your health information even after you leave the Plan.

How can I get a paper copy of this notice?

Write to: City of Carrollton
 Attn: Human Resources
 1945 Jackson Road
 Carrollton, TX 75006

Who can I contact for more information on my privacy rights?

Write to: City of Carrollton
 Attn: Human Resources
 1945 Jackson Road
 Carrollton, TX 75006

SIGNATURE PAGE

The effective date of the City of Carrollton Group Benefit Plan January 1, 1982, as amended through January 1, 2015.

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 4th day of December, 2014

By: Crystal Savas

Title: Workforce Services Director

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