Summary of Benefits and Coverage (SBC)

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Medical Care Management: (800) 847-1213
Benefit Beginning and End Date: January 1, 2013 through December 31, 2013

Plan Type: PPO Medical Plan
Plan Name: White Plan

Coverage Tiers

4 tier (5-way)

Common Healthcare Terms for the Summary of Benefits and Coverage

Copayments: Are fixed dollar amounts (for example, $25.00), that you pay for covered health care when you receive a service. This plan does not have office visit copay.

Benefit Percentage: Your share of the costs of covered services, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount is $1,000 for the service and your benefit percentage is 20%, you would be responsible for a $200 payment. This may change if you have not met your deductible.

Plan Allowed Amount: The amount the plan pays for covered services is based on the allowed amount. If an out of network provider charges more than the allowed amount, *Usual and Reasonable (U&R)*, you may have to pay the difference. For example, if an out of network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference.

Provider Network: The plan encourages you to access network providers by charging a lower out-of-pocket network deductible and benefit percentage.

This is only a Summary of Benefits and Coverage. If you want more detail about your coverage and costs, you can get the complete terms of the benefit plan document at www.tmliebp.org or by calling (800) 282-5385.

Frequently Asked Questions	Network Benefit	Non Network Benefit	Limitations and Exceptions
What is my copayment?	Office Visits: N/A Teledoc: $38	N/A	This plan does not have an Office Visit copayment. Teledoc services are subject to a $38 copay.
What is my deductible?	Individual: $1,000 Family: $2,000	Individual: $1,250 Family: $2,250	The Network and Non Network deductible are separate and do not accumulate toward one another. The family deductible is accumulative. Covered expenses incurred during any calendar year and applied toward satisfaction of a covered person's member's individual calendar year deductible will be applied toward the Family Limit. 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.
Are there other deductibles for specific services?	No	Facility Inpatient: Yes $200	In addition to the plan's deductible, there is a hospital admission penalty for non network. An additional $200 per admission penalty will be applied for utilizing a non network facility. This penalty also applies to non network outpatient facility charges.
Is there an out-of-pocket limit on my expenses?	Individual: $3,000 Family: $5,000	Individual: $5,000 Family: $7,000	Covered charges for eligible benefits that are used toward satisfying the out of pocket amount must be incurred during the calendar year. The Network and Non Network out of pocket amounts are separate and do not accumulate towards one another. The Family out of pocket is accumulative. Covered expenses incurred during any calendar year and applied toward satisfaction of a covered family person's individual calendar year out of pocket will be applied toward the Family out of pocket Limit. When the Family out of pocket is satisfied and it will not apply for any other family member's charges. Charges previously applied toward the covered individual's out of pocket amount for other family members will not be recalculated.
What is not included in the out-of-pocket limit?	*See Limitations and Exceptions*	*See Limitations and Exceptions*	The following do not apply to out of pocket maximums: 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, deductibles, copayments, morbid obesity treatment and mental and nervous benefits do not apply to the out of pocket maximum. *Retail prescription copays purchased under the prescription plan (for up to a 34 day supply)* ***will*** *count toward the network out of pocket.*
Is there an overall annual limit on what the plan pays?	No	No	This plan does not have an annual limit for all benefits combined. The plan does have some limits on lifetime and calendar year benefits for specific conditions and/or treatments, as indicated.
Does this plan use a network of providers?	Yes	N/A	Go to www.tmliebp.org or call (800) 282-5385 for a list of participating providers. Your deductible, out-of-pocket expenses, and benefit percentage will be different for Network and Non Network services.
Do I need a referral to see a specialist?	No	No	This plan does not require referrals. You have the option to choose any provider.
Are there services this plan does not cover?	Yes	Yes	Please refer to the General Exclusions or Limitations section and the definition of Unproven Medical Procedures/Treatment in the plan document.

Common Medical Event	Network Benefit	Non Network Benefit	Limitations, Exceptions, and Exclusions
Maximum Lifetime Benefit	N/A	N/A	None
Maximum Lifetime Benefit for treatment of Morbid Obesity	50%	50%	1 treatment episode per lifetime and never pays at 100%. This includes morbid obesity services provided through Satori.
Maximum Lifetime Benefit for treatment of Chemical Dependency	80%	60%	3 treatment episodes per lifetime. Also see Calendar Year Maximums.
Maximum Lifetime Benefit for Custom Molded Foot Orthotics	80%	60%	1 pair per lifetime.
Maximum Lifetime Benefit for Hospice Care	100%	100%	6 month treatment episode per lifetime. The deductible is waived for Network and Non Network.
Maximum Lifetime Benefit for Wigs *(oncology related)*	100%	100%	$250 usual, reasonable & customary maximum per lifetime. The deductible is waived for Network and Non Network.
Maximum Lifetime Benefit for Hearing Appliances	80%	60%	$2,000 usual, reasonable & customary maximum per lifetime.
Calendar Year Maximum for treatment of Chemical Dependency and Mental/Nervous	80%	60%	Treatment of Chemical Dependency and Mental/Nervous conditions are limited to a combined maximum of 26 days per calendar year. Day/Residential treatment will count as a ½ day towards the 26 day maximum. Also see Lifetime Maximums for the treatment of Chemical Dependency.
Calendar Year Maximum for Diabetic Education	80%	60%	$250 usual, reasonable & customary maximum per calendar year.
Calendar Year Maximum for Diabetic Footwear	80%	60%	2 pairs per calendar year.
Calendar Year Maximum for Speech Therapy	80%	60%	12 visits per calendar year. Visits in excess of 12 per calendar year require Notification.
Calendar Year Maximum for Physical Therapy	80%	60%	12 visits per calendar year. Visits in excess of 12 per calendar year require Notification.
Calendar Year Maximum for Occupational Therapy	80%	60%	12 visits per calendar year. Visits in excess of 12 per calendar year require Notification.
Calendar Year Maximum for Aquatic Therapy	80%	60%	12 visits per calendar year. Visits in excess of 12 per calendar year require Notification.
Calendar Year Maximum for Chiropractic Care	80%	60%	10 visits per calendar year for chiropractic services
Calendar Year Maximum for Skilled Nursing Facility	80%	60%	90 days per calendar year
Calendar Year Maximum for Home Health Care	80%	60%	100 days per calendar year
Contraceptive Management	100%	60%	Physician charges for the insertion and/or removal of a physician inserted contraceptive device/implant and the charges for the device/implant. The deductible is waived for Network services. Labs, xrays and all testing will be considered as "Physician Services". Preferred Lab services may also be available.
Physician Office Visit/Consultations to treat an injury or illness	80%	60%	
Physician Services	80%	60%	
Second Surgical Opinions	80%	60%	
Allergy Treatment and Allergy Testing	80%	60%	Preferred Lab benefits are also available for testing.
Teledoc	100% after a $38 copay	N/A	Teledoc can be reached at 1 (800) Teledoc or (800) 835-2362. The deductible is waived for Network services.
Maternity Services	80%	60%	
Preferred Lab Benefit	100%	N/A	Includes laboratory expenses from a Preferred Lab Provider and Preferred Lab drawing site. The deductible is waived for Network services.
Non Preferred Lab	80%	60%	
X-Rays, Major Imaging and Non Preferred Lab	80%	60%	
Pre-Admission Testing	80%	80%	The pre-admission tests must be performed in the hospital where the confinement will take place in lieu of duplicate tests rendered during confinement. You must be admitted to the hospital within seven (7) days of the testing. Preferred Lab Benefits are also available.

Common Medical Event	Network Benefit	Non Network Benefit	Limitations, Exceptions, and Exclusions
Facility Charges Inpatient Facility Outpatient Facility & Ambulatory Surgical Centers	 80% 80%	 60% 60%	
Emergency Room Physician Charges – for Emergent/Immediate care Facility Charges – for Emergent/Immediate care Physician Charges – for Non-Emergent/Immediate care Facility Charges – for Non-Emergent/Immediate care	80% 80% 80% 80% after a $200 access fee	60% 60% 60% 60% after a $200 access fee	Out of Network Emergency Room Facility charges are subject to a $200 facility access fee if the claim for Non-Emergent/Immediate care. The Emergency Room Access fee is waived if admitted.
Ambulance Services	80%	80%	Non Network benefit eligible ambulance charges will be subject to the Network deductible and Network out of pocket.
SpecialtyRx/Biotech Medications	80%	60%	SpecialtyRx/Biotech medications are also available under the prescription plan for a fixed copay.
Durable Medical Equipment and Related Supplies	80%	80%	Notification is required for charges in excess of $1,000 per durable medical equipment prior to purchase, lease or rental; limited to the U&R charges of standard models as determined by Medical Care Management.
Sleep Disorders	80%	60%	
Transplant Services	80%	60%	
International Centers of Excellence – Satori Network The treatment of morbid obesity will be covered at 50% and never pays at 100%. All other eligible medical benefits are covered at 100% when using the Satori international network.	100% OR 50%	N/A	The benefit is for approved and eligible medical benefits, and also includes benefits for Travel and Lodging (in connection with an approved International Centers of Excellence treatment during approved and eligible treatment episode), in addition to a Per Diem for Food. The deductible is waived, except for obesity services.
Non-Routine Mammograms	100%	60%	The deductible is waived for Network services. Non-routine mammograms in excess of one per calendar year will be considered at 80% in Network subject to the Network deductible. Non Network will always receive the Non Network benefit.
Other Eligible Major Medical Expenses	80%	60%	

Common Medical Event	Services You May Need	Network Benefit	Non Network Benefit	Limitations & Exceptions
If you have chemical dependency treatment needs.	**Chemical Dependency Benefit** The Plan will pay benefits for treatment of chemical dependency only upon the diagnosis and recommendation of a Physician. Expenses for the treatment of chemical dependency conditions are consider the same as any other illness for the Plan's deductible and out of pocket maximums. *Expenses for the treatment of chemical dependency conditions are considered the same as any other illness. Expenses for the treatment of chemical dependency 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.			
	Chemical Dependency	80%	60%	In addition to the lifetime maximum of 3 treatment series per lifetime, the treatment of Chemical Dependency is subject to the Plan's calendar year combined maximum for Chemical Dependency and Mental/Nervous treatment. The treatment of Chemical Dependency and Mental/Nervous conditions are limited to 26 days per calendar year. This is a combined maximum. Day/Residential treatment will count as a ½ day towards the 26 day maximum. A $200 per admission penalty will apply to all Non Network hospital admissions.
If you have mental health needs.	**Mental/Nervous Conditions** The Plan will pay benefits for treatment of mental/nervous 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/Nervous	80%	60%	The treatment of Chemical Dependency and Mental/Nervous conditions are limited to 26 days per calendar year. This is a combined maximum. Day/Residential treatment will count as a ½ day towards the 26 day maximum. A $200 per admission penalty will apply to all Non Network hospital admissions.
If you have serious mental health needs.	**Serious Mental/Nervous**	80%	60%	Charges for the treatment of a Mental/Nervous illness will be covered the same as any other medical condition or illness. Serious Mental/Nervous is treated as any other medical condition: schizophrenia; paranoia and other psychotic disorders; bipolar disorder (hypomanic, manic depressive, and mixed); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); pervasive development disorders; obsessive compulsive disorder (OCD); and depression in childhood and adolescence.

Common Medical Event	Services You May Need	Network Benefit	Non Network Benefit	Limitations & Exceptions
Wellness Benefit	Colon-Rectal Exam Benefit	100%	60%	**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 schedule of medical expense benefits, subject to usual, reasonable and customary charges, when billed with a routine diagnosis. The deductible is waived for services reimbursed at 100%. 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), routine hearing exams, virtual colonoscopies, vision exams or refractions.* **Colon-Rectal Examination** Coverage for the medically recognized screening examination for the detection of colorectal cancer for covered individuals who are 40 years of age, or have a personal or family history of polyps (or colon cancer), or older and are at normal risk for developing colon cancer for expenses incurred while conducting a medically-recognized screening examination for the detection of colorectal cancer. 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 non-routine colonoscopies, non-routine sigmoidoscopies and non-routine fecal occult blood tests cover covered individuals at any age with no limits. **Tests/Procedures** ▪ Routine Physical ▪ Well Baby and Well Child Visits/Exams ▪ PAP Test and Well Woman Visit/Exam ▪ Routine Venipuncture Urinalysis ▪ (TB) Tuberculosis test ▪ Routine Labs/Xrays ▪ General Health Panel ▪ Routine Mammograms ~ *limit 1 per calendar year* ▪ Prostate Specific Antigen test (PSA) ~ *limit 1 per calendar year* ▪ Coronary Risk Profile (lipid panel) ▪ Digital Rectal Exam ▪ Handling of specimen to/from physician's office to a laboratory ▪ Occult Stool Test ▪ Examination for the detection of skin cancer ▪ Chest X-Ray (front & lateral) ▪ EKG (electrocardiogram) The following network eligible immunizations and administrative fees are reimbursable at 100% of the allowable. Non Network eligible billings will be subject to U&R charges. Allergy injections and expenses related to routine newborn care are not considered as part of this benefit. To be considered under this benefit, the provider's bill must designate a routine diagnosis code. This list is a guideline, but is not an all-inclusive list. **Immunizations/Inoculations** • DT (Diphtheria and Tetanus Toxoids) • MMR (Measles, Mumps, Rubella) • Oral Polio • Pneumococcal (Pneumonia) • HPV (Genital Human Papillomavirus) • DtaP Diphtheria, Tetanus Toxoids and Pertussis • Hepatitis A & Hepatitis B • MMR booster • Varicella Vaccine (Chicken Pox) • Rotovirus • HIB (Hemophilus Influenza B) • Zosatavax (Shingles Vaccine) • Td (Tetanus) booster • Poliomyelitis Vaccine • Influenza • Any other immunization required by federal or state law or regulation • Pediarix (Diphtheria and Tetanus Toxoids and Acellular Pertussis Absorbed, Hepatitis B (Recombinant) and Inactivated Poliovirus Vaccine Combined)
	Routine Mammogram Benefit	100%	60%	
	PSA Exam Benefit	100%	60%	
	Immunizations/Innoculations and all other eligible Preventive Care/Wellness Benefit charges	100%	100%	

Common Medical Event	Prescription Services You May Need	Align Network		Broad Network		Limitations & Exceptions
	MAC: C	**Retail**	**Mail**	**Retail**	**Mail**	
If you need drugs to treat your illness or condition (Refer to Medication Therapy Management Guide for information regarding the Cost Share, Step Therapy, and Prior Authorization prescription requirements.)	Over the Counter/ Behind the Counter	$0	N/A	$0	N/A	**Prescribed Over the Counter Alternates:** Non-Sedating Antihistamines (Claritin®, Claritin-D®, Allegra®, Allegra-D®, Zyrtec®, Zyrtec-D®) per prescription Stomach and Ulcer (Prilosec®, Prevacid®, Zegerid®) per prescription Smoking Cessation (Nicorette Gum) Quantity Limit - 3 boxes per plan year Aspirin, Folic Acid, Fluoride Chemoprevention Supplements & Iron Deficiency Supplements
	Generic	$0/$9	N/A	$10	$25	$0.00 copay up to 34 day supply; $9.00 for 35 to 90 day supply
	Best Brand	$38	N/A	$38	$95	Retail - Up to a 34 day supply; Mail - 35-90 day supply
	Non Best Brand	$60	N/A	$60	$150	Retail - Up to a 34 day supply; Mail - 35-90 day supply
	Cost Share	$120	N/A	$120	$300	Retail - Up to a 34 day supply; Mail - 35-90 day supply
	Biotech/Specialty Prescriptions	N/A	N/A	N/A	$100	Retail - Up to a 34 day supply; Mail - 35-90 day supply
	Biosimilar Prescriptions	N/A	N/A	N/A	$100	Retail - Up to a 34 day supply; Mail - 35-90 day supply

Eligible Covered Individuals, Other Covered & Excluded Services

This is not a complete list. Check your plan document for other excluded and unproven or experimental services.

Pre-Existing Conditions

A pre-existing condition is any medical condition, regardless of the cause of the condition for which medical advice, diagnosis, care, or treatment was recommended or received by a licensed health care provider, or for which drugs were prescribed during the six (6) month period immediately preceding an individual's enrollment date under this Plan. Pregnancy does not constitute a pre-existing condition for the purpose of this section. The Pre-Existing condition limitations do not apply to covered individuals less than nineteen (19) years of age. A condition will no longer be considered pre-existing on the date you or your Dependent(s) complete 12 consecutive months of coverage under the Plan. The maximum benefit available for pre-existing conditions will not exceed $5,000 for the first 12 months.

A covered individual may be able to reduce the pre-existing limitation period if the covered individual can show proof of other coverage. To receive this credit for prior coverage, the covered individual must not have a break in coverage (that is, a period without coverage) of 63 consecutive days or more. The covered person will not get credit for any coverage prior to any 63-day break in the coverage period. If the covered individual provides false or misleading information regarding prior coverage or about the status of other individuals for whom dependent coverage is elected they may lose all coverage under the plan. The covered individual may also be subject to civil and criminal enforcement action including monetary penalties and imprisonment.

General Exclusions or Limitations

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. for reconstructive and cosmetic surgery or any charges which are the result of cosmetic surgery, including any charges for a condition whose diagnosis is different from cosmetic surgery but which has been adversely affected by or caused by cosmetic surgery, except for treatment in connection with:
   a. an accidental bodily injury which occurred while covered under the Plan and the cosmetic surgery is performed within 90 days of such injury;
   b. a congenital anomaly in a newborn who has been covered under the Plan since birth; or

c. reconstructive procedure, which is necessary for post-oncology treatment, provided the original condition necessitating such treatment occurred while the patient was covered under the Plan.

9. incurred in connection with remedying a condition by means of cosmetic surgery or non-mastectomy reconstructive surgery, or a non-lumpectomy reconstructive surgery, or in connection with a prophylactic mastectomy without a cancer diagnosis, or in connection with a primary prophylactic oophorectomy without an appropriate bilateral diagnosis (the Plan will however pay for the treatment of the unaffected breast following a mastectomy or cancer diagnosis). In addition, this exclusion will not apply when evidence based BRCA testing is positive;
10. prophylactic procedures due to family history, unless otherwise specifically covered under this plan;
11. for custodial or sanitary care and service, or for maintenance care or rest care;
12. for care and treatment of Mental/Nervous Disorders in excess of the specified Covered Expenses and in excess of the limitations shown in the Schedule of Medical Expense Benefits;
13. for treatment by hypnosis, except as part of the Physician's treatment of a mental illness or when hypnosis is used in lieu of an anesthetic;
14. 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;
15. for rhinoplasty, blepharoplasty or brow-lift due to a nonfunctional condition;
16. 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;
17. 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;
18. for dentistry of any kind as a medical, rather than a dental benefit, except where specifically provided as a Covered Medical Expense;
19. 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);
20. for treatment, non-surgical and surgical procedures to reverse sterilization;
21. for sex therapy, marriage counseling or other social services unless specified otherwise;
22. for unproven drug therapy or any health procedures not approved by the Food and Drug Administration;
23. 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 Restat and is only covered only for hormone replacement not for erectile dysfunction) or SpecialtyRx/Biotech medications, which are eligible under the Medical plan;
24. for a sex change, gender reassignment or treatment for transsexual purposes;
25. 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);
26. for Diabetic equipment and/or supplies used for testing blood and urine samples at home. (These are covered under the Prescription plan);
27. for chelation therapy, unless blood poisoning;

28. for air purification, humidifying, cooling or heating equipment;
29. for exercising equipment, vibratory equipment, swimming or therapy pools, health club memberships, massage therapy or hippo therapy;
30. incurred in connection with acupuncture or acupressure;
31. 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;
32. 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);
33. for speech therapy except for covered services as listed under Major Medical Expenses Item #8;
34. for hospital room and board charges when admission occurs one or more nights before a surgery, unless such admission is an eligible benefit;
35. expenses for appointments made but not kept or for completion of claim forms or pre-treatment forms required by your Employer;
36. any care or services covered in whole or in part under any other section of this Plan, unless specified otherwise;
37. 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;
38. for any condition, illness, injury or complication thereof arising out of or in the course of employment;
39. 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;
40. 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;
41. 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;
42. the result of intentionally self-inflicted injuries or illnesses, whether inflicted while sane or insane;
43. 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;
44. in connection with participation in a civil disturbance or insurrection;
45. 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;
46. rendered on an unproven, research basis when not generally accepted medical or dental practice;
47. not actually rendered;
48. 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;
49. rendered by a member of your family or close relative, including a person related by blood or marriage;
50. for travel or accommodations (expect in connection with a covered transplant or services through the International Centers of Excellence), whether or not recommended by a Physician;
51. in excess of the reasonable and customary allowances for non-negotiated services;
52. 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;

53. filed later than or information received later than twelve (12) months from the date the expense was incurred;
54. for elective abortions for covered persons except in the case of incest, rape or situations which are life threatening to the mother;
55. for services related to intersex surgery (transsexual operations) and any resulting complications;
56. 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, including lifts; elevators; escalators; or ramps;
57. congenital or developmental malformation existing when the person became covered under this Plan;
58. for genetic testing, except for amniocentesis and/or once a diagnosis is established and the result of the genetic marker test will directly impact the treatment being delivered to the covered individual;
59. for penile implants and/or devices (including external);
60. for cosmetic hair loss treatment (except as covered under the Wig benefit);
61. for cryotherapy;
62. for employer-mandated immunizations, medical services, medical testing;
63. 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;
64. for virtual colonoscopies; and
65. items not specifically listed as a Covered Expense.

Filing Deadline

No benefits are payable for claims or additional information submitted by the employee, covered individual or a provider more than twelve (12) months after the date incurred (or within 90 days after a non-compensable claims decision by Workers' Compensation).

Subrogation

The plan pursues subrogation pursuant to (1) Section 172.015 of the Texas Local Government Code, (2) contractual plan provisions, and (3) common law. The plan language grants to the plan a first lien on any accident-related reimbursements that the plan participant may receive from any source. These sources include, but are not limited to any responsible third parties, third party liability insurance, and the participant's own insurance, such as med-pay, personal injury protection, or uninsured/underinsured motorist coverage. The plan participant will be asked to complete an Accident/ Injury Questionnaire prescribed by the plan. Payment on any accident-related claims may be withheld pending the completion of the questionnaire.

Unproven Medical Procedures/Treatment

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.

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.
3. Continuation and/or repeat of a previously approved successful treatment plan.

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.

Usual and Reasonable (U&R)

Charges incurred using Non Network providers are subject to the usual and customary allowable amount.

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 (TML 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 Out of Pocket Maximum, which resulted from your audit of the hospital or doctor bill.

Extenuating Circumstances

If a Covered Individual requires emergent/immediate care until stabilized or if a specialist care provider is required but there is not a Network specialist care provider within a seventy-five (75) mile radius from the employee's place of business, the provider would be paid at 80% subject to the Network deductible and Network Out of Pocket, subject to usual, reasonable and customary allowable amounts.

Note: When a Covered Individual uses a Network facility, all ancillary providers and specialists, including, but not limited to, surgeons, emergency room physicians, anesthesiologist, pathologist, and radiologist will be paid at the Network benefit percentage and subject to the Network out of pocket, the Network deductible and Usual, reasonable and customary amounts.

Notification Requirements

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 Care Management nurse 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 Psychiatric/Chemical Dependency Admissions Psychiatric/Chemical Dependency 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
Outpatient Physical Therapy	When in excess of 12 visits per cal. year	$500
Outpatient Occupational Therapy	When in excess of 12 visits per cal. year	$500
Outpatient Speech Therapy	When in excess of 12 visits per cal. year	$500
Outpatient Aquatic Therapy	When in excess of 12 visits per cal. year	$500

Service	Notification Required	Late Notification Penalty
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
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	Prior to commencement	$500
Cardiac Rehabilitation	Prior to commencement	$500
Prior to administering Chemotherapy	Prior to commencement	$500
Radiation therapy	Prior to commencement	$500
Genetic markers for treatment (not for diagnosis)	Prior to commencement	$500
Evidence Based BRCA Testing	Prior to commencement	$500

Population Health Engagement

Population Health Engagement 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, counselors, behaviorists, registered dietitians and certified diabetes educators. To contact a Professional Health Coach, call (888) 818-2822.

Medical Intensive Care Management

Medical Intensive 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 care management, followed by on-going work with you and your provider to plan health care alternatives to meet your needs. The Care Manager will try to conserve your benefits by making sure that your care is handled as efficiently as possible. Intensive Case Management is an option and is not a requirement of the plan.

The Care Management staff consists of licensed, professional nurses. The Nurses have years of experience in health care. They know the importance of not intruding in the doctor/patient relationship. By promoting health care alternatives that are acceptable to you, your doctors and your employer, Care Management helps to control health care costs and use your benefits wisely. The Medical Intensive Care Management Team will coordinate care and document Notification communication.

What Happens on Inpatient Treatment?

The Covered Individual must notify Medical Care Management per the Notification Requirements. Concurrent stay review requirements apply to all inpatient confinements. No benefits will be paid for any charges related to non-notified days or services.

Continuation of Coverage (COC)

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

YOUR GRIEVANCE AND APPEAL RIGHTS

Claims Appeals

TML IEBP will conduct a full and fair review of your appeal. The appeal will be reviewed by appropriate individual(s) on the TML IEBP staff for internal review; or a health care professional with appropriate expertise during the initial benefit determination process. The appellant may request an independent review from an independent state licensed external review organization that is credentialed under URAC. 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 of Emergent Care Request for Benefits (Adverse Notification Determination Prior to Claim Submission)

	Appeal of Urgent/Emergent Request for Benefits (Adverse Pre-Determination/Notification Request)	
Type of Request for Benefits or Appeal	**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 IEBP will send the ***urgent/emergent incomplete pre-determination/notification information declination letter*** 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 IEBP declination due to incomplete information
If the request for urgent/emergent benefits is complete and not approved, TML IEBP will send an ***urgent/emergent pre-determination/notification denial letter*** within:	**Internal**	**seventy-two (72) hours**
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 IEBP will submit the response of ***an expedited urgent/emergent pre-determination/notification*** of a benefit appeal within:	**External**	**seventy-two (72) hours**

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

	Appeal of Non-Emergent Request for Benefits (Adverse Pre-Determination/Notification Request)	
Type of Request for Benefits or Appeal	**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 ***benefit information incomplete***, TML IEBP will notify the appellant within:	**Internal**	**five (5) days**

	Appeal of Non-Emergent Request for Benefits (Adverse Pre-Determination/Notification Request)	
Type of Request for Benefits or Appeal	**Internal/External Appeal Process**	**Business Hours/Days**
If the **request for pre-determination/notification** is ***clinical information incomplete***, TML 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 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 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 ***non emergent claim or benefit appeal*** within:	**External**	**forty-five (45) days**

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

Post Service Claims Appeal

	Post-Service Claims	
Type of Claim or 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 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 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
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**	**forty-five (45) 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 Plan Administrator's address printed on the Medical/Prescription ID cards or complete the appeal form online at www.tmliebp.org. Your request must contain the employee's name, social security or employee ID number and the exact reason(s) for requesting the appeal and include any supporting documentation. TML IEBP will notify you of the results of the review within thirty (30) days, unless TML 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 Plan 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.

Ombudsman Services

Availability of Consumer Assistance/Ombudsman Services: There may be other resources available to help you understand the appeals process. For questions about your appeal rights, an adverse benefit determination, or for assistance, you can contact the Employee Benefits Security Administration at (866) 444-EBSA (3272). Your state consumer assistance program may be able to assist you at the Texas Consumer Health Assistance Program Texas Department of Insurance (855) TEX-CHAP (839-2427).

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

Title I:

- Refers to healthcare coverage reform and includes provisions for creditable coverage, restrictions on pre-existing condition exclusions, 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 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 have been mandated. The administrative simplification process includes standards for electronic transactions and code sets, national identifiers (for employers, health plan and providers), Security and Electronic Signature Standards (Security Rule) and Standards for Privacy of Individually Identifiable Health Information (Privacy Rule);
- A self-funded, non-federal, governmental health plan cannot exempt itself from the Title II requirements.

Privacy of Your Health Information

A Federal regulation, called the "Privacy Rule," requires TML Intergovernmental Employee Benefits Pool to protect the privacy of each Covered Individual's identifiable health information. Under the Privacy Rule, TML Intergovernmental Employee Benefits Pool 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 TML Intergovernmental Employee Benefits Pool needs to use or disclose a Covered Individual's health information for a purpose not permitted under the Privacy Rule, TML Intergovernmental Employee Benefits Pool must first obtain a written authorization signed by the Covered Individual.

In addition to restrictions on how TML Intergovernmental Employee Benefits Pool 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.

TML IEBP's Notice of Privacy Practices explains fully how TML IEBP may use and disclose a Covered Individual's identifiable health information and a Covered Individual's rights under the Privacy Rule. TML IEBP's Notice of Privacy Practices is included with each Covered Individual's enrollment information. TML IEBP's Notice of Privacy Practices also is available on TML IEBP's website at www.tmliebp.org, or an individual may request a paper copy of the notice by calling TML IEBP's customer service number at (800) 282-5385.

Security of Your Health Information

A Federal regulation, called the "Security Rule", requires TML IEBP to ensure the confidentiality, integrity and availability of a Covered Individual's identifiable health information that TML IEBP receives, creates, maintains or transmits electronically. TML IEBP has implemented administrative, physical and technical safeguards that meet both Federal requirements and industry standards for the security of electronic health information.

Important Disclaimer

The information presented in this Summary of Benefits and Coverage (SBC) **IS NOT** a guarantee of payment. The benefits described are subject to all plan limitations, pre-existing information, late entrants, filing deadlines, exclusions and eligibility requirements. All benefits are based on the plan document language.

If a Covered Individual is on continuation of coverage (COC), coverage could terminate retroactively if the individual's contribution is not made within the COC payment timeframe.

If a Covered Individual is receiving care or about to receive care and is identified as not actively at work, continuation of coverage benefits may be offered, but must be accepted and paid per the continuation of coverage time guidelines for provider services to be considered for eligible benefit payment.

Requests for reimbursement for a covered benefit should be sent to the Group Benefits Administrator within ninety (90) days of the date of service but not later than twelve (12) months.

All inpatient and outpatient facilities are required to be licensed and/or accredited by Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), Medicare, Texas Commission on Alcohol and Drug Abuse (TCADA), or Accreditation Association for Ambulatory Health Care (AAAHC) for the bill to be considered for payment.

You may be responsible for payment of all or part of any fees for healthcare services not covered by your Health Benefit Plan because the services received are provided by health care providers who are not members of the plan's provider network.

Notification is required prior to receiving certain types of health care services:

1. eligibility of any individual for coverage;
2. benefit coverage for services rendered pursuant to the Notification; or
3. network status of the provider(s).