



CITY OF CARROLLTON

EMPLOYEE DENTAL

PLAN BOOKLET

EFFECTIVE JANUARY 1, 2015

Claims Address:

TML MultiState IEBP
PO Box 149190
Austin, Texas 78714-9190

Customer Care:

English: (800) 282-5385 / Spanish: (800) 385-9952
Professional Health Coach (888) 818-2822

This Plan Booklet summarizes the Dental Plan, which was adopted by the City of Carrollton effective January 1, 1982, and contains amendments through January 1, 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 Dental Plan* are calculated on a “calendar year” period. The benefit period begins on January 1st of each year and extends through December 31st of that year. On January 1st of each year, a new benefit period starts for each eligible person.

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

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

Disclaimer: This book should be used as a guideline for the explanation of your healthcare benefits. Updates and changes to this benefit book may occur during the plan year.

Plan Document

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

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

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

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

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

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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 and dental costs.

The City of Carrollton reserves the right to:

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

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

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

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

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

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

Plan Administration

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

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

How to Enroll in the Plan

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

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

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

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

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 Continuation of Coverage (COC) to be offered to the reservist or guard member.

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

In administering this coverage, 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 IEBP. Furthermore, only those Dependents whose coverage is in effect prior to your retirement may continue coverage. After the effective date of your retirement, you will **not** have the option to add coverage for any Dependents during any annual open enrollment period offered by the City of Carrollton, unless a Retiree's Spouse is employed when the employee retires. In that case, when a retiree's spouse ceases to be employed and

loses coverage, the spouse may enroll as a dependent of the retiree providing that they meet the eligibility requirements of this Plan.

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

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

Termination Date of Coverage

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

Employee Coverage

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

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

Dependent Coverage

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

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

Coverage for a dependent cannot extend beyond the date coverage for the 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.

Other Helpful Claims Information

Assignment of Benefits

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

Appeal of Denied Claims

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

All appeals must be sent in writing to:

IEBP
Claims Appeal
PO Box 149190
Austin, Texas 78714-9190

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

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.

How to File a Dental Claim

Filing Deadline

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

What you need to Submit with your Claim

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

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

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

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

In some instances you may need to obtain a letter of necessity from your Physician for a service. 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 IEBP. Please make copies of any paperwork you are submitting BEFORE sending it in.

How to Avoid Delays in Receiving your Payment

Your claim can only be processed if all paperwork and necessary information is received by 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, 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 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, IEBP will contact you to let you know what information is needed to complete your claim. If 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 IEBP is asking the provider you may contact 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, 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 IEBP's Medical Management staff. The plan's facility guidelines by definition of will not apply if the facility is not located within the United States or its territories.

Legal Actions

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

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

City of Carrollton
Coverage Summary
Schedule of Dental Expense Benefits

Description of Benefits

Benefit Percentage

Preventive Dental	100%
Basic Dental	80%
Major Dental	50%
Orthodontic (no age limit)	50%

Benefit Deductibles and Maximums

Individual Deductible Amount (<i>waived for Preventive</i>)	\$50 per calendar year
Preventive, Basic and Major Dental Expense Benefit	\$1,500 per calendar year
Orthodontic Benefit	\$1,000 per lifetime
All Covered Dental Expenses	Unlimited lifetime benefit while covered under the Plan

Dental Expense Benefits

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

Pre-Treatment Estimate

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

Covered Dental Expenses

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

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

1. Preventive Benefit includes:
 - a. two routine dental examinations per Calendar year;
 - b. two prophylaxis (teeth cleaning) treatments per Calendar year;
 - c. two (2) routine bitewing x-rays (four films) twice each Calendar year; and
 - d. fluoride treatments if less than 18 years old.

2. Basic Benefits includes:
 - a. extractions;
 - b. treatment of tooth pulp, including root canal therapy;
 - c. oral surgery - apicoectomies and extractions of impacted or erupted teeth (including alveolectomy, alveoplasty, and tori removal in connection with extractions);
 - d. local anesthesia or I.V. sedation for covered oral surgery;
 - e. general anesthesia when medically indicated and administered by a Physician other than the operating dentist;
 - f. restorative services (fillings) using amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations, but excluding gold and baked porcelain fillings;
 - g. periodontal scaling, treatment, diagnosis, and surgery;
 - h. full mouth series of x-rays limited to one series in any 36 month period, and other diagnostic x-rays, provided no x-rays are in connection with a program of orthodontics;
 - i. antibiotic injections;
 - j. repair or recementation of crowns, inlays, onlays, bridgework or dentures; and relining or rebasing of dentures 6 months after the denture is installed, limited to one relining or rebasing within any 36 month period;
 - k. initial installation of partial or full removable dentures, including precision attachments and any adjustments during the first 6 month period following installation;
 - l. replacement of an existing full or partial removable denture or fixed bridgework by a new denture or new bridgework due to the extraction of teeth after the denture or bridgework was installed;
 - m. replacement or modification of existing bridgework or denture which cannot be made serviceable, and which are installed more than 5 years prior to replacement or modification;
 - n. space maintainers for missing primary teeth for a Covered Person younger than 14 years of age;
 - o. emergency palliative treatment; and
 - p. sealants
3. Major Benefit includes:
 - a. initial fixed bridgework, including inlays and crowns as abutments;
 - b. initial inlays, onlays, gold fillings or crown restoration; and
 - c. removable mouthguard to alleviate bruxism.
4. Orthodontic Benefit includes:
 - a. essential services required for the straightening of misaligned teeth, by use of braces. Related Covered Expenses are:
 - initial diagnostic procedures;
 - orthodontic diagnostic procedures and treatment, including oral examination, surgery and extractions for Covered Persons;
 - removal of teeth;
 - the first essential appliances;
 - correction of misaligned teeth; and
 - correction of malocclusion by wire appliances, braces and other mechanical aids.

Exclusions and Limitations Applicable to Dental Benefits

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

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

Ordered means for dentures, that impressions have been taken from which the denture will be prepared; or for the other types of services, that the teeth which will serve as retainers or support or which are being restored have been fully prepared to receive, and impressions have been taken from which the fixed bridgework, restorative crowns, inlays or onlays will be prepared;
9. dental treatment other than by a duly licensed dentist or Physician, except for work done by a dental hygienist, technician, or laboratory that is within the scope of their license and which is performed under the direction of a Dentist or Physician;
10. temporary restorations;
11. any duplicate prosthetic device or any other duplicate appliance;
12. implantology;
13. charges for care or treatment of occlusion by adjustment, appliance, or restorations, except for orthodontics, if provided;
14. any expense incurred prior to becoming covered or any dental work in progress at the time a patient becomes covered under this Plan;
15. any charges in excess of the charges customarily made when alternate services or supplies are customarily available for such treatment, beyond the charge for the least expensive service or supply resulting in professionally adequate treatment, unless alternate services or supplies have previously been utilized and have subsequently proven to be unsuccessful;

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

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/or 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

The City of Carrollton Plan will coordinate with other dental group plans. When coordinating benefits, all of the provisions of the City Plan, including, but not limited to, Reasonable and Customary charges, annual and/or lifetime Maximums, exclusions/limitations, Covered Expenses and Benefit Percentages Payable will apply. The benefits payable under this Plan will not exceed 100% of eligible expenses when combined with all other plans. In other words, as secondary payor the plan will figure what the allowable amount for the service billed would be in the absence of the primary carrier and subtract any payment made by the primary payer from that amount. Any difference would be what the plan would pay as the secondary payer. When coordinating as the secondary payer, the payment under this plan would never exceed our total allowable for the service rendered, or what the plan's normal payment would be.

For example:

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

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

1. Group plans, insured or noninsured; group blanket or franchise insurance coverage; group hospital or medical service plans, and other group pre-payment coverage; any coverage under labor management trusted plans, union welfare plans, employer organization plans or Employee benefit organization plans;
2. Any coverage required or provided by any statute or required by statute;
3. Any plan sponsored by or provided through a school or other educational institution.

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

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

- The plan covering the spouse of the parent who has custody (that is, the step-parent of the child).
- The plan covering the parent without custody.

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

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

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

Definitions

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

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

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

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

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

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

Benefit Percentage – The percentage of Eligible Benefits payable by the Plan after deductible and copay.

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

Clean Claim – A claim for covered services that is received from a network provider that reflects the standard claim format, and accurately contains the following information: patient name, patient’s date of birth, unique identification number, provider’s name, address and tax ID number, 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.

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

Covered Benefits – See Eligible Benefits.

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

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

Dentist – Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is a member or eligible member of the state Dental Association or eligible for membership in such association.

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

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.

Disability – Any of the following conditions:

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

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

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

Emergency Services – See Emergent/Immediate Care.

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

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

Employee – 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.

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.

Group Benefits Administrator – TML MultiState 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), Registered Respiratory Therapist (RRT), 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).

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.

Incapacity – See *Disability*.

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

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.

Open Enrollment – The period as defined by the Employer in which Dependents who are not currently covered by the Plan can be added.

Out of Pocket Amount – The portion of eligible expenses for which a covered individual is responsible to pay.

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

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

Plan Administrator – The City of Carrollton (the Employer).

Plan Sponsor – The Employer.

Plan Year – The 12-month period beginning January 1st through December 31st.

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

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

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

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

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

Spouse – Individual legally married to the Covered Employee under the laws of the State of Texas.

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

www.tmliebp.org
Group#: ACARROL1

Signature Page

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

Title: Workforce Services Director

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