

CITY OF CARROLLTON

EMPLOYEE HEALTH

PLAN BOOKLET

EFFECTIVE JANUARY 1, 2013

Claims Address:

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

English: (800) 282-5385 / Spanish: (800) 385-9952 Professional Health Coach (888) 818-2822 Care Management: (800) 847-1213

NOTICE TO PLAN PARTICIPANTS

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

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

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

Because of this election:

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

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

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

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

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

This Plan Booklet summarizes the Health Plan, which was adopted by the City of Carrollton effective January 1, 1982, and contains amendments through January 1, 2013. This Booklet is provided to you as a guide to assist you in obtaining the benefits contained in that Plan.

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

Throughout this Booklet, "Plan" will mean the City of Carrollton's Health Plan. The City of Carrollton offers the Health Plan described in this Booklet to assist you and your family with access to appropriate healthcare in the event of an illness or injury.

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

HEALTH PLAN DOCUMENT

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

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

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

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

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

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GENERAL PROVISIONS

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

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

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

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

The City of Carrollton reserves the right to:

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

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

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

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

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

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



OUTPATIENT PRESCRIPTION DRUG BENEFIT MAXIMUM ALLOWABLE COST RESTAT CARD PROGRAM ~ MAC C ALIGN/BROAD RETAIL NETWORK AND MAIL SERVICE BENEFIT OPTION

CITY OF CARROLLTON

Effective Date: January 1, 2013

This benefit schedule is made a part of the Plan for the purchase of outpatient prescription drugs. All charges for outpatient prescription drugs are covered under this benefit and are not considered eligible expenses unless purchased through this program.

Generic Prescriptions Could be a Viable Savings Opportunity!

With healthcare costs continuing to rise, generic medicine might be an easy and effective way to minimize out of pocket expenses.

- 1. Generic medications are reviewed by the US Food and Drug Administration (FDA) for safety and efficacy and are manufactured under the strict standards that apply to brand-name drugs and not protected by a trademark.
- 2. Generic medications create competition, which assists in keeping the costs of prescriptions competitive.
- 3. Research shows that plan participants may save an average of 30% to 80% when they fill their prescriptions with a generic instead of a brand-name medication.

Brand Name Drugs

Drugs produced and marketed exclusively by a particular manufacturer. The drug name is usually registered as a trademark.

Maximum Allowable Cost (MAC C)

Covered Individual will pay the appropriate copayment amount of the prescription.

Retail Covered Individual Copayments

Over the Counter Alternates and Prescription Networks	Retail Copayment (34 day supply max unless noted otherwise)	Mail/Maintenance Copayment (84/90 day supply) Biotech/SpecialtyRx Copayment (34 day supply)
Over the Counter Alternates: Non-Sedating Antihistamines (Claritin®, Claritin-D®,	40.00	21/2
Alavert*, Allegra*, Allegra-D*, Zyrtec*, Zyrtec-D*) per prescription. Stomach and Ulcer (Prilosec*, Prevacid*, Zegerid*) per	\$0.00	N/A
prescription. Smoking Cessation (Nicorette Gum) Quantity Limit - 3		
boxes per plan year <u>Aspirin, Folic Acid, Fluoride Chemoprevention</u>		
Supplements and Iron Deficiency Supplements		
Align Network Value Tiered 34 day non Cost Share generic dispensement	\$0.00 (up to 34 days supply)	N/A
Align Network Value Tiered up to 90 day non Cost Share generic dispensement	\$9.00 (35 to 90 days supply)	N/A
Broad Network non Cost Share Generic	\$10.00	\$25.00
Broad and Align Network <u>non Cost Share</u> Best Price Brand List	\$38.00	\$95.00

Over the Counter Alternates and Prescription Networks	Retail Copayment (34 day supply max unless noted otherwise)	Mail/Maintenance Copayment (84/90 day supply) Biotech/SpecialtyRx Copayment (34 day supply)
Broad and Align Network <u>non Cost Share</u> Non-Best Price Brand List	\$60.00	\$150.00
Broad and Align Network Cost Share — see Cost Share Copay Drugs below	\$120.00	\$300.00
SpecialtyRx/Biotech Prescriptions	N/A	\$100.00 for up to 34 day supply

At the time of this printing, the Value Tiered/Align Network Pharmacy Extension includes the following pharmacies:

- Boomtown Drug
- Brookshire Brothers
- Chapel Hill Pharmacy
- City Market Pharmacy
- Cody Drug
- Cody Pharmacy
- Collingsworth Pharmacy
- Cub Pharmacy
- Davis City Pharmacy
- Diamond Pharmacy
- Dillon Stores
- Doc's Drugstore of BrownwoodDoc's Drugstore of Early
- Dominick's
- Eagle Lake Pharmacy
- Farm Fresh
- Fikes Pharmacy
- Fred Meyer

- Fry's Food & Drug
- Graham Pharmacy
- HealthMart Pharmacy (Access Health)
- Hico Pharmacy
- Holmes Pharmacy
- Hughes Pharmacy
- Kenjura Pharmacy
- King Soopers
- Kmart
- Kroger
- Luna's Friendly Pharmacy
- Maloney Pharmacy
- Med Shop Pharmacy
- Medical Arts Drug (Waldie's Pharmacy)
- Medicine Shoppe of Henderson
- Overton Pharmacy
- Plaza Pharmacy

- Quality Food Centers
- Ralph's
- Randall's
- Safeway
- Sam's Club
- Sav-On Pharmacy
- Shopko
- Smiths
- Star Markets
- Super Mercado's Pharmacy
- The Medicine Shoppe of Jasper
- Tom Thumb
- Troup Pharmacy
- Vista Pharmacy
- Vons Companies Inc.
- Waldie's Pharmacy
- Walmart
- Walter's Pharmacy
- Whitehouse Pharmacy

SpecialtyRx/Biotech Prescriptions

The plan offers a Pharmacy Benefit Manager SpecialtyRx service. This service provides a convenient and cost-effective way to order injectable drugs and supplies through Pharmacy Benefit Manager SpecialtyRx. The Specialty/Biotech copay for a 34 day SpecialtyRx/Biotech Prescription is \$100.00. This \$100 will also apply to those prescriptions classified as a Biosimilar.

To see a list of Specialty/Biotech drugs available through the Pharmacy Benefit Manager, please log in to the myTML IEBP web portal and click the "Prescription Benefits" link. SpecialtyRx is the most cost-effective way to purchase medications for Covered Individuals with chronic illnesses requiring life-sustaining medications. SpecialtyRx provides Covered Individuals with a costeffective benefit to purchase specialty prescriptions. With SpecialtyRx, the Covered Individual will receive easy ordering and fast delivery from the Specialty Pharmacy. In addition, the Covered Individual will receive an informative care management packet. The SpecialtyRx prescription may be delivered to the physician's or Covered Individual's address.

The SpecialtyRx plan provides many benefits to Covered Individuals:

- Single reliable source for injectable specialty prescriptions
- For Prior Authorization doctor/prescription prescribers call RxResults (888) 871-4002
- Easy ordering with a toll-free number (877) 408-9742; 7:30am 7:00pm CST M-F
- Express delivery to location of your choice ~ either to the Covered Individual's home or provider's office (Some providers have expressed a strong opinion for the prescription to be delivered to their offices if they are required to administer the prescription.)

Medication Refills

- Retail refills will be approved upon 75% of utilization.
- Mail Service refills will be approved upon 60% of utilization.

Emergencies

On occasion, you may need to get a prescription filled immediately. Ask your physician to write two prescriptions, one for a 21-day supply of medication to be filled locally and the second for the balance (up to 90 days). The 21-day supply prescription filled locally will be covered according to the prescription drug benefit included in your Plan.

Order forms are included in your employee packets and are available from the TML Intergovernmental Employee Benefits Pool or your employer. A re-order form will accompany each order you receive.

Mail Service Prescription Option

Spend Less on Your Prescriptions!

The plan wants to remind you and your covered dependents about an <u>important part of your benefit plan</u> — the CVS/Caremark Mail Service Program. Take advantage of the Caremark Mail Service prescription benefit and you may save time and money on the medications you take each month. Getting your prescription from the mail service pharmacy is simple with FastStart. Easy as 1-2-3!

Call FastStart toll free:

Members - (800) 875-0867 Hearing Impaired - (800) 231-4403 Doctors - (800) 378-5697

2. Call for Refill Mail Service:

Members - (888) 739-7989

- 3. Let the FastStart representative know you wish to fill your prescription order through mail service.
- 4. Provide the information on your benefit ID card, the names of the long-term medications you take, your doctor's name and phone number, and your mailing address.

Identification Cards

Each Covered Individual will be issued an ID card. You must present your ID card to the pharmacist at the time of purchase.

If a Covered Individual does not have the ID card at the time of purchase these steps must be followed:

- Pay for the entire cost of the prescription.
- 2. Obtain and complete a direct prescription drug Restat claim form. These are available from your employer or TML Intergovernmental Employee Benefits Pool.
- 3. Send the Restat drug claim form with the prescription receipt directly to Restat.

Restat will pay the appropriate amount, less the copayment and Maximum Allowable Cost (MAC) differential (if applicable), directly to the Covered employee usually within 30 days.

Medication Therapy Management Program

Note: All clinical programs (Clinical Prior Authorization, Step Therapy, Cost Share Drugs, etc.) are subject to change without notice to accommodate new drug entries to the marketplace and adjustments in established medical and pharmacy practice guidelines.

Important Information

TML IEBP Billing & Eligibility: (800) 282-5385

RxResults (Doctor/Prescription Prescribers Only): (888) 871-4002

TML IEBP Website: http://www.tmliebp.org

Cost Share Copay Drugs

ADHD / CNS Stimulants

Impacts utilization on: <u>Immediate Release Amphetamine Products</u> (Adderall®, Dexedrine®, Dextrostat®),

Immediate Release Methylphenidate Products (Ritalin®, Focalin®),

Extended Release Amphetamine Products (Adderall XR®, Dexedrine Spansules®),

Extended Release Methylphenidate Products (Concerta®, Daytrana®, Metadate CD®, Ritalin LA®,

Intuniv®, Kapvay®, Nuvigil®, Provigil® (brand only)

Alternative Drugs: Generic Methylphenidate®, Amphetamine®, Guanfacine Immediate Release® (for Intuniv®),

Clonidine® (for Kapvay®), Modafinil® (for Provigil®, Nuvigil®)

Brand Strattera®, Vyvanse®, Focalin XR®

Analgesics / Anti-Inflammatory / Pain Agents

Impacts utilization on: Lazanda®, Subsys®

Alternative Drugs: Generic Fentanyl® patch, Fentanyl® lozenge

■ Impacts utilization on: Celebrex®, Naprelan®, Diclofenac ER®, Flector® patch, Solaraze®, Pennsaid®, Zipsor®

Alternative Drugs: Generic Naproxen®, Diclofenac®

Impacts utilization on: Conzip®, Rybix®, Ryzolt®, Tramadol ER®, Ultracet®, Ultram®, Ultram ER®

Alternative Drugs: Generic Tramadol®

Antibiotics: Anti-Infective Agents

Impacts utilization on: Adoxa®, Doryx®, Dynacin®, Monodox®, Periostat®, Solodyn®, Oraxyl®, Oracea®

<u>Alternative Drugs:</u> Generic Minocycline® (for Dynacin®, Solodyn®)

Doxycycline® (for Adoxa®, Doryx®, Monodox®, Periostat®, Oracea®, Oraxyl®)

Anticonvulsants

■ Impacts utilization on: Gralise®, Lamictal XR®

Alternative Drugs: Generic Gabapentin (PHN)® (for Gralise®), Lamotrigine® (for Lamictal XR®)

Antidepressants

Impacts utilization on: Viibryd®, Cymbalta®

Alternative Drugs: Generics Citalopram®, Escitalopram®, Fluoxetine®, Paroxetine®, Sertraline®, Venlafaxine®,

(Multiple) Buproprion®

Antihypertensive Agents

Impacts utilization on: Dutoprol®, Amturnide®, Atacand®/Atacand HCT®, Avapro®/Avalide®, Azor®, Benicar®/Benicar HCT®, Cozaar®/Hyzaar® (brand only), Diovan®/Diovan HCT® (brand only), Edarbyclor®, Exforge®/Exforge HCT® (brand only), Micardis®/Micardis HCT®, Tekamlo®, Tekturna®/Tekturna HCT®, Teveten®/Teveten HCT®, Tribenzor®,

Twynsta®, Valturna®

Alternative Drugs: Generic Metroprolol-Hydrochlorothiazide® (for Dutoprol®), Any Generic ACE Inhibitor,

Losartan®/Losartan HCTZ® (for Cozaar®/ Hyzaar®), Irbesartan®/Irbesartan HCTZ® (for Avapro®/ Avalide®), Eprosartan®/Eprosartan HCTZ® (for Teveten®/ Teveten

HCT®), Valsartan®/Valsartan HCTZ® (for Diovan®/Diovan HCT®)

Central Nervous System: Sedative Hypnotics

■ Impacts utilization on: Ambien®, Ambien CR®, Edluar®, Lunesta®, Rozerem®, Sonata®, Zolpidem ER®, Intermezzo®,

Silenor®, Zolpimist®

Alternative Drugs: Generic Zolpidem® Immediate Release (for Ambien®), Zaleplon® (for Sonata®), Doxepin®

(for Silenor®), Zolpidem® (for Intermezzo®, Zolpimist®)

Migraine Headaches

■ Impacts utilization on: Amerge®, Axert®, Frova®, Imitrex® (brand), Relpax®, Treximet®, Zomig®, Zomig ZMT®

<u>Alternative Drugs:</u> Generic Sumatriptan® (for Imitrex®)

Brand Maxalt®

Nasal Steroids

Impacts utilization on: Beconase AQ®, Flonase® (brand), Nasacort AQ®, Nasalide® (brand), Nasarel®, Nasonex®,

Omnaris®, Rhinocort AQ®, Veramyst®, Qnasl®, Zetonna®

Alternative Drugs: Generic Fluticasone® (for Flonase®), Flunisolide® (for Nasalide®)

Osteoporosis Drugs

Impacts utilization on: Actonel®, Actonel® w/Calcium, Atelvia®, Boniva®, Fosamax®, Fosamax-D®

Alternative Drugs: Generic Alendronate® (for Fosamax®)

Otic Products

■ Impacts utilization on: Auralgan®

Alternative Drugs: Generic Benzocaine-Antipyrine®

Overactive Bladder Drugs

■ Impacts utilization on: Detrol®, Detrol LA®, Ditropan® (brand), Ditropan XL®, Gelnique®, Enablex®, Oxytrol® patches,

Sanctura®, Toviaz®, Vesicare®

Alternative Drugs: Generic Oxybutynin® Immediate Release (for Ditropan®)

Respiratory / Allergy / Asthma: Antihistamines

■ Impacts utilization on: Fexofenadine®, Clarinex®, Xyzal®

Alternative Drugs: Generic Loratidine®, Cetirizine®

OTC Alavert®, Allegra®, Zyrtec®, Claritin®

Respiratory / Allergy / Asthma: Antihistamines-Decongestants

■ Impacts utilization on: Fexofenadine-D®, Clarinex-D®

Alternative Drugs: Generic Loratidine-D®, Cetirizine-D®

OTC Allegra-D[®], Zyrtec-D[®], Claritin-D[®]

Skeletal Muscle Relaxants

Impacts utilization on: Lorzone®

Alternative Drugs: Generic Chlorzoxazone®

Stomach Ulcer / Reflux Drugs / Gastrointestinal / Stomach: Proton Pump Inhibitors

Impacts utilization on: Aciphex®, Dexilant® (formerly Kapidex®), Nexium®, Lansoprazole®, Prevacid®, Prilosec®,

Protonix®, Vimovo®, Duexis®

Alternative Drugs: Generic Omeprazole®, Pantoprazole®, Ibuprofen and Famotidine® separately (for Duexis®)

OTC Prevacid®, Prilosec®, Zegerid®

Topical Antifungal Agents

■ Impacts utilization on: Pedipirox-4®

<u>Alternative Drugs:</u> Generic Ciclopirox®

Clinical Prior Authorization

The list of conditions below may change as appropriate for the plan. For prior authorization requests, please have your **doctor/prescription prescriber** call **RxResults at (888) 871-4002**. Your doctor/prescription prescriber will be asked a series of questions and RxResults will then approve or deny the authorization request.

ANTIBIOTICS	✓ ZYVOX®	HEPATITIS C	✓	INCIVEK®
		THERAPY -	V	VICTRELIS®
<u>ASTHMA</u>	Requests may be granted to patients who have	<u>ANTIVIRAL</u>		
<u>INHALERS</u>	demonstrated compliance to an inhaled steroid			
	and/or satisfied additional clinical criteria as	MAJOR BIOTECH		Blood Cell Deficiency
	determined by the prior authorization review.	<u>PRESCRIPTION</u>	✓.	Crohn's Disease
	Treatment Plan Adherence is required for	<u>CATEGORIES</u>	✓	Cystic Fibrosis
	authorization to be approved.		✓	Growth Hormones
	✓ ADVAIR®		✓	Hemophilia Hepatitis C
	✓ ARCAPTA®		\checkmark	HIV/Immune Deficiency Medications
	✓ BROVANA®		✓	Multiple Sclerosis
	✓ DULERA®		\checkmark	Oncology Oral
	✓ FORADIL®		✓	Osteoarthritis
	✓ PERFOROMIST®		\checkmark	Psoriasis
	✓ SEREVENT®		✓	Pulmonary Arterial Hypertension
	✓ SYMBICORT®		✓	Renal Disease
			✓	Rheumatoid Arthritis
ASTHMA	✓ XOLAIR® Injection		✓	All Others
NON INHALERS	•			
	Requests may be granted to patients who have	TESTOSTERONE	√	ANDROGEL® (covered only for hormone
	demonstrated compliance to clinical criteria as	ALL PRODUCTS		replacement not for erectile dysfunction)
	determined by the prior authorization review.		✓	ANDRODERM®
	Treatment Plan Adherence is required for		✓	TESTIM®
	authorization to be approved.			Actual lab results defining the testosterone
				level will be required. The lab report will
GENERAL	✓ Attention Deficit Disorder ADHD (For			indicate whether the level is low or within
GLIVLINAL	individuals 17 years of age or older)			normal ranges.
	These medications may be reimbursed			normar ranges.
	following satisfaction of clinical criteria as	DIABETES	√	JANUVIA®/JANUMET®, JANUMET XR®
	determined by prior authorization review.	DIABETES	٧	· · · · · · · · · · · · · · · · · · ·
	✓ Narcolepsy Medications (For individuals 17		✓	(covered for diabetes only)
			∨	SYMLIN®
	years of age or older)			BYETTA®
	✓ Acne Medications (For individuals 26 years		√	VICTOZA®
	of age and older)		√	ONGLYZA®
			√	KOMBIGLYZE®
			√	TRAJENTA®
			√	BYDUREON®
			✓	JENTADUETO®
			✓	JUVISYNC
				These medications may be reimbursed
				These medications may be reimbursed

Note: All clinical programs (Clinical Prior Authorization, Step Therapy, Cost Share Drugs, etc.) are subject to change without notice to accommodate new drug entries to the marketplace and adjustments in established medical and pharmacy practice guidelines.

Step Therapy

- For Clinical Authorization, doctor/prescription prescribers should call RxResults at (888) 871-4002. Your doctor/prescription prescriber will be asked a series of questions and RxResults will then approve or deny the authorization request.
- Sample of what will occur at pharmacy

Claim is processing for Advair® & the following message will alert the pharmacist: Step Therapy after inhaled steroid 1st or Prior Authorization call (888) 871-4002.

Step Therapy Drug Categories

ASTHMA

Required for <u>members <40 years of age</u> who have not demonstrated adherence to an inhaled corticosteroid (ICS) (90 days of therapy in the past 120 days).

If the member is beginning therapy (regardless of age), only an inhaled steroid will be approved unless otherwise approved by RxResults.

Category A

✓ Inhaled Corticosteroid (ICS) - Member must demonstrate adherence to an inhaled steroid and/or satisfy specific clinical criteria as determined by RxResults prior to obtaining a Category B medication.

Category B (Only after failure with a Category A medication)

- ✓ ADVAIR®
- ✓ ARCAPTA®
- ✓ BROVANA®
- ✓ DULERA®
- ✓ FORADIL®
- ✓ PERFOROMIST®
- ✓ SEREVENT®
- ✓ SYMBICORT®

Treatment Plan Adherence is required for authorization to be approved.

Drugs Covered Under This Benefit

- 1. Legend Drugs;
- 2. Insulin or oral diabetic prescription;
- Disposable insulin needles/syringes and physician prescribed needles/syringes;
- Disposable blood/urine/glucose/acetone testing agents (e.g. Acetest Tablets, Clinitest Tablets, Glucometer (one per calendar year), Lancets, Diastix Strips, Tes-Tape and Chemstrips;
- Diabetic supplies will be purchased with order for oral diabetic prescription. The plan will allow needles, syringes, lancets and testing strips at no charge if ordered within 30 days of a prescription at the same pharmacy;
- Tretinoin all dosage forms (e.g. Retin-A, Differin, Tazorac) for Individuals through the age of 25 years;
- Compound medication of which at least one ingredient is a legend drug;
- 8. Any other drug which under the applicable State Law may only be dispensed upon the written prescription of a physician or other lawful prescriber;
- Contraceptives: Oral, Extended cycle (mail order only), Transdermal patches, Contraceptive devices, Levonorgestrel (Norplant), Prescription Strength Only;
- 10. Depo Provera;
- 11. Central Nervous System Stimulants (e.g. Adderall, Adderall XR, Focalin, Focalin XR, Ritalin, Dexedrine, etc) will be covered for individuals through age 16. (Individuals 17 years and older will require prior authorization through RxResults.)
- Prescribed smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms;
- 13. Growth hormones through age 15;
- Extended Release anti-depressive agents: Wellbutrin XL, Effexor XR:
- Extended Release migraine prophylactic agents: Depakote ER;
- 16. Single entity legend vitamins;
- 17. Prescribed Prenatal vitamins;
- 18. Immunization agents.

Drugs Not Covered Under This Benefit

- 1. Dietary supplements, vitamins or formulas;
- Growth hormones after age 15;
- 3. Biological sera blood or blood plasma;
- Male pattern baldness medications; hair growth stimulants;
- Tretinoin, all dosage forms (e.g. Retin-A, Differin, Tazorac) for individuals 26 years of age or older; cosmetic agents including anti-wrinkle, Botox and skin depigmenting agents;
- 6. Vitamins individually or in combination;
- Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use;
- 8. Charges for the administration or injection of any drug;
- Drugs labeled "Caution limited by Federal Law to investigational use" or experimental drugs even though a charge is made to the individual;
- 10. Medications which are to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar premises which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- 11. Emergency contraceptives;
- 12. Fertility medications;
- Any prescription refilled in excess of the number specified by the physician or any refill dispensed after one year from the physician's original order;
- 14. Prescription which an eligible individual is entitled to receive without charges from any Workers' Compensation Laws or which is prescribed for an injury or illness which is excluded from any medical coverage which is provided in conjunction with this prescription benefit;
- 15. Anti-obesity medications;
- 16. Non-legend drugs other than those listed above;
- 17. Lifestyle convenience prescriptions (ie: erectile dysfunction prescriptions).

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

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

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

If you do not notify the Workforce Services Department and return the appropriate completed change form(s) and proof within thirty (30) days of the date that you experience a family status change, with the exception of loss of

Dependent(s) eligibility, then you may not add, change, or drop coverage on yourself or your Dependent(s) until the next annual open enrollment period.

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

COVERAGE OF NEWBORNS

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

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

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

MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

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

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

ACTIVE DUTY RESERVISTS

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

If a fire fighter or police officer is called to active duty for any period, the employing municipality must continue to maintain any health, dental or life coverage received on the date the fire fighter or police officer was called to active military duty until the municipality receives written instructions from the fire fighter or police officer to

change or discontinue the coverage. Such instruction shall be provided no later than 60 days following the Qualifying Event. If no such instruction is given, then coverage will terminate on the 61st day, which shall then become the Qualifying Event for COC purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

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

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

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

For the Employee to return to the Employer's plan and continue their benefits with no waiting period or preexisting condition the Employee must return to work within the time period required by state and federal law for such return. The additional 2% of contribution is not charged for an Employee called to active duty.

COVERAGE FOR ACTIVE EMPLOYEES AGE 65 OR OLDER

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

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

RETIREE COVERAGE

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

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

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

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

TERMINATION DATE OF COVERAGE

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

EMPLOYEE COVERAGE

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

- 1. to the end of the month in which your employment terminates;
- 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:

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

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

RETIREE COVERAGE

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

- 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.

CARE MANAGEMENT FEATURES

DISCUSSING YOUR CHARGES

In the case of an elective admission, you have time to make sure that you will receive quality care at a reasonable price. Take the time to discuss the care you will be receiving with your Physician and the hospital.

Most important, be sure to discuss the charges for the treatment. Your Plan does not cover charges in excess of the amount generally charged for the same services in your area. You will have to pay the difference between what the Plan approves and what your Physician charges from your own pocket, and those payments by you (for higher than average charges) will not count towards your Deductible (if applicable) or Out of Pocket.

What can you do to avoid this situation? See an in network Physician OR ask your non network Physician to explain to you the different services that are included in the care that you need. Make sure that the services are necessary. Remember, the Plan will not pay for services that are not eligible benefits.

If you have any questions about the charges or services your Physician discusses with you, please feel free to consult Workforce Services, or call TML IEBP. Taking the time to ask a few questions now can mean less cost to you later on.

The Group Benefits Administrator shall retain final authority for interpretation of plan language and administration. When such exceptions are recommended by case management and industry consultants as reasonable and prudent for the patient and plan's financial viability.

CARE MANAGEMENT

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

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

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

HOW THE NOTIFICATION PROCESS WORKS

The 23-Hour Rule

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

What is an admission?

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

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

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

Responsibilities of the Covered Person

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

Responsibilities of Care Management

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

What Happens on Inpatient Treatment?

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

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

Outpatient Surgery not on the Outpatient Surgery List

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

Outpatient Surgery on the Outpatient Surgery List

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

Immediate Care (Emergency) Medical Admission

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

CONTINUED STAY REVIEW

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

LARGE CARE MANAGEMENT

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

Large Care Management is an option. However, should Large Care Management be refused by the covered person or physician, benefits will pay at the non network benefit percentage and will not, at any time, pay at 100% for any medical services under the out of pocket provision of the Plan. If Large Care Management is refused, all future payments for any medical services will be paid at the reduced benefit. The individual out of pocket amount must be met each calendar year.

POPULATION HEALTH ENGAGEMENT

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

HEALTHY LIVING GUIDES

TML IEBP offers Healthy Living Guides to Covered Individuals to assist them with managing their disease states, maintaining good health and supporting healthy lifestyle choices. Below is a list of the guides currently available. To request a Healthy Living Guide, contact a Professional Health Coach at (888) 818-2822.

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

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

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

TML Intergovernmental Employee Benefits Pool's phone number to provide Notification is: **Toll free: (800) 847-1213**

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

NOTIFICATION REQUIREMENTS

Notification enables clinical support and educations, such as:

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

SERVICE	NOTIFICATION REQUIRED	LATE NOTIFICATION PENALTY
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 fortyeight (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
Dialysis for End Stage Renal Disease (ESRD)	Prior to commencement	\$500

Service	Notification	LATE
	REQUIRED	NOTIFICATION
		PENALTY
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

MAJOR MEDICAL EXPENSE BENEFITS

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

Inpatient hospital (See Notification requirements):

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

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

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

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

Charges for physical therapy, including related office visits and tests, when such services are prescribed by a Physician and performed by a Licensed Professional Physiotherapist or Licensed Professional Occupational Therapist. Outpatient charges are subject to the Calendar Year Maximum. Outpatient visits in excess of twelve require Notification for review of benefit eligibility;

Charges for occupational therapy, including related office visits and tests, when such services are prescribed by a Physician and performed by a Licensed Professional Physiotherapist or Licensed Professional Occupational Therapist. Outpatient charges are subject to the Calendar Year Maximum. Outpatient visits in excess of twelve require Notification for review of benefit eligibility;

Aquatic Therapy charges for evidence based aquatic services, when prescribed by a Physician. Must be direct, one-on-one treatment; by a licensed Physical Therapist. Outpatient charges are subject to the Calendar Year Maximum. Outpatient visits in excess of twelve require Notification for review of benefit eligibility;

Charges of a Licensed Speech Therapist for restoratory or rehabilitory speech therapy, provided the therapy is for speech loss or impairment due to an illness or accidental bodily injury, surgery on account of illness or accidental bodily injury, or impairment due to a congenital anomaly, provided such loss or impairment is not due to a functional nervous disorder. Outpatient charges are subject to the Calendar Year Maximum. Outpatient visits in excess of twelve require Notification for review of benefit eligibility;

Charges for services of a Nurse as follows:

- 1. in a hospital, services of a Registered Professional Nurse (R.N.), services of a Licensed Practical Nurse (L.P.N.), Registered Nurse First Assistant (RNFA) if medically necessary, Advanced Nurse Practitioner (ANP)or services of a Licensed Vocational Nurse (L.V.N.), and
- 2. other than in a hospital, services of a Registered Professional Nurse (R.N.); Licensed Practical Nurse (L.P.N.); or the services of a Licensed Vocational Nurse (L.V.N.).

Charges for Mental and Nervous Disorders and Serious Mental Illness are covered as follows, subject to the limitations stated in the Schedule of Medical Expense Benefits:

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

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

Professional licensed ambulance service as follows:

- 1. ground transportation when deemed an eligible benefit and used locally to or from the nearest hospital qualified to render treatment,
- 2. transportation from one hospital to another in order to provide benefit eligible care that is unavailable at the first hospital,
- 3. transportation to an in network hospital following an emergency admission at a non network hospital, and
- 4. air transportation when the use of air transportation is necessary because of a life-threatening situation.

Charges for drugs and medications:

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

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

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

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

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

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

Cornea Transplants are eligible as a medical expense.

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

The first pair of eyeglasses or contact lenses prescribed as part of postoperative treatment for intra-ocular surgery or due to accidental bodily injury shall be included as a Covered Expense provided such treatment is received within six (6) months of the accident or date of surgery. Replacement of such appliances shall not be a Covered Expense;

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

Radiation services, including diagnostic x-rays and interpretation, x-ray therapy, radiation therapy and treatment; Clinical and pathological laboratory examinations and professional interpretation of their results;

Electrocardiograms and electroencephalograms

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

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

Surgical Sterilizations

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

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

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

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

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

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

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

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

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

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

Charges for Custom Molded Foot Orthotics, limited to:

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

SECOND SURGICAL OPINIONS

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

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

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

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

PREVENTIVE CARE/WELLNESS BENEFIT

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

Tests/Procedures

Routine Physical
Well Baby/Child Exams
Well Woman Exam
Prostate Specific Antigen (PSA) exam ~ limit one per calendar year
PAP Test
Routine Venipuncture
Routine Mammograms ~ limit one per calendar year
General Health Panel
Coronary Risk Profile (lipid panel)
Urinalysis
(TB) Tuberculosis test
Handling of specimen to/from physician's office to a laboratory

Recommended, at and after age 40:

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

Occult Stool Test

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.

IMMUNIZATIONS/INOCULATIONS — ALL AGES

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

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

- DT (Diphtheria and Tetanus Toxoids)
- DtaP Diphtheria, Tetanus Toxoids and Pertussis

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

PRE-ADMISSION TESTING

One set of laboratory tests and x-ray examinations will be paid by the Plan at the in network benefit percentage of eligible charges if such tests are related to the performance of scheduled surgery or treatment, and are performed before your admission to the hospital. These benefits will be paid according to the Schedule of Medical Expense Benefits.

The 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. Also, non-emergency lab work sent to a Preferred Lab will be paid at 100%.

For example:

Suppose that you have been having abdominal pains and nausea following your meals. When you go to the Physician's office to have the problem checked, your Physician tells you that you need to have gallbladder surgery, and schedules you for inpatient surgery 6 days later. From reading this Booklet, you know that you must notify TML IEBP in advance of any hospital stay.

As with any hospital confinement, the hospital requires that a series of tests (blood work, urinalysis, etc.) be performed before your surgery takes place. To save you the expense and inconvenience of an additional day of confinement just for routine tests, you and your Physician decide to have these tests performed in the outpatient department of the hospital the day before you're scheduled to be admitted to the hospital for your surgery. Having these tests performed before your admission to the hospital is what Pre-Admission Testing means.

Back home again once your operation is successfully completed, you go through your bills and find that the Physician's visit and any drug expenses have been covered as other medical expenses, payable at the in network percentage of charges in excess of the Deductible (if applicable). The hospital expenses were paid at the percentage shown in the Schedule of Medical Expense Benefits after the application of any Deductible amount.

The charges for the Second Opinion and the Pre-Admission Testing have been paid at the benefit percentage. If your portion of Covered Expenses in excess of any Deductible amount were to exceed the Out of Pocket Maximum, Covered Expenses in excess of that maximum would be payable at 100%.

HOME HEALTH CARE

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

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

- 1. skilled nursing care under the supervision of a Physician or registered nurse (R.N.);
- 2. rehabilitative therapy and respiratory therapy provided by the home health care agency;
- 3. social worker to assess and identify community resources; and
- 4. Physician services if the covered individual is homebound and Physician homebound intervention is appropriate.

HOSPICE CARE

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

Hospice care must be established, approved and reviewed in writing by the attending physician and documented by the attending physician that proper treatment of the disability would otherwise require confinement as an inpatient in a hospital or Skilled Nursing Facility in the absence of the services and supplies provided by the hospice care program.

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

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

EXTENDED CARE FACILITY

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

MORBID OBESITY

Morbid Obesity is defined as a condition for which a Covered Individual is 200% over ideal weight or 100 pounds overweight with a Body Mass Index (BMI) of greater than 40. A Notification Review is required to review the eligibility prior to any surgical procedure. This review requires documentation of six (6) consecutive months of physician-supervised weight management program that may include but is not limited to nutritional education and a physical activity program. The covered individual, treating physician or family member must provide Notification to Medical Care Management for review prior to any surgical treatment. Failure to do so will result in no benefit coverage for morbid obesity services.

Eligible Morbid Obesity expenses incurred will be covered subject to Medical Care Management's approval and Plan limitations. Under this provision, Morbid Obesity includes the pre-obesity evaluation, medical and surgical treatment for post obesity follow-up care including but not limited to the eligible body sculpting services and/or treatment of any complications. The Morbid Obesity benefits are paid at the benefit percentage/lifetime maximum documented on the Schedule of Medical Expense Benefits for covered persons twenty-one (21) and older. The Morbid Obesity treatment must be performed at a Plan-Designated Morbid Obesity Treatment Center.

Non-Designated Morbid Obesity Center

If the Morbid Obesity treatment is performed at a Non-Designated Morbid Obesity Treatment Center of if the Care Management is refused, the obesity care <u>will not be covered</u>. Morbid Obesity treatment procedures will not be paid if the procedure is an Unproven Medical Procedure as defined in this booklet.

This will not pay for commercial weight management programs or health club memberships.

TRANSPLANT BENEFIT

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

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

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

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

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

Non-Designated Transplant Center

If the organ transplant is performed at a Non-Designated Transplant Center will be considered at the Non Network benefit percentage, as shown on the Schedule of Medical Expense Benefits.

Transplant Center

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

This benefit will cover charges resulting from organ transplantation at a Plan-Designated Transplant Center plus charges for:

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

Reimbursement

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

Travel

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

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

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

Lodging

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

Food

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

INTERNATIONAL CENTERS OF EXCELLENCE

The International Care must be performed at a hospital or facility designated by the Plan as an International Center of Excellence. A list of such hospitals may be obtained from Medical Care Management. This benefit will cover the following designated charges:

Approved eligible medical services per this Plan

Contact the TML IEBP Medical Care Management Team at 800-847-1213 to coordinate your request to access International Centers of Excellence for medical care.

Travel and Lodging

The benefit includes concierge services, airfare, hotel accommodations and ground transportation. These expenses are included in the International Medical Case Rate for the patient and eligible companion. Eligible companion is a person of the covered individual's choice age eighteen (18) or older.

Food

The benefit includes a Per Diem for the patient and their eligible companion to use for their food expenses during the eligible International Centers of Excellence treatment episode.

EMPLOYEE ASSISTANCE PROGRAM

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

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

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

An "episode of care" is defined as an uninterrupted course of EAP counseling, mental health treatment or chemical dependency treatment.

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

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

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

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

CHEMICAL DEPENDENCY AND MENTAL/NERVOUS DISORDERS

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 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.

SERIOUS MENTAL/NERVOUS DISORDER

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

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

MENTAL/NERVOUS DISORDERS

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 AND CHEMICAL DEPENDENCY CATEGORIES OF TREATMENT

The categories of treatment for Mental/Nervous and Chemical Dependency are as follows:

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

MAIL ORDER AND RETAIL PRESCRIPTION DRUG PROGRAM

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

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

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

OTHER HELPFUL CLAIMS INFORMATION

ASSIGNMENT OF BENEFITS

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

CLAIMS AUDIT REIMBURSEMENT PROGRAM

The City of Carrollton has implemented a claims audit reimbursement program as an incentive for you and your Dependent(s) to audit your hospital and doctor bills in order to detect incorrect charges made by the provider. Detecting such a charge on your hospital or doctor bill for a service that you did not receive could result in the provider reducing the total charge on your bill, thereby reducing the total cost of your claim for both you and the City of Carrollton. Under this bonus program, you or your Dependent(s) must detect such errors on your hospital and doctor bills **before** your claim is paid by the Group Benefits Administrator (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.

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.

CLAIM APPEALS

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

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

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

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

	Appeal for Urgent Care 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 <u>urgent care incomplete predetermination/notification information declination letter</u> within:	Internal	twenty-four (24) hours of receipt of appellant's information
The appellant must provide a completed information request within:	Internal	forty-eight (48) hours after receiving the TML IEBP declination due to incomplete information
If the request for urgent/emergent benefits is complete and not approved, TML IEBP will send an <u>urgent care pre-determination/notification denial letter</u> 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 <u>an expedited urgent care pre-determination/notification</u> of a benefit appeal within:	External	seventy-two (72) hours

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

	Appeal of Non-Urgent Care Request for Benefi (Adverse Pre-Determination/Notification Reque	
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 <u>benefit</u> <u>information incomplete</u> , TML IEBP will notify the appellant within:	Internal	five (5) days
If the request for pre-determination/notification is <u>clinical</u> <u>information incomplete</u> , 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*

	Appeal of Non-Urgent Care Request for Benefits (Adverse Pre-Determination/Notification Request)	
Type of Request for Benefits or Appeal	Internal/External Appeal Process	Business Hours/Days
The appellant may request the appeal be submitted to an Independent Review Organization, (IRO). The External Review Request must be submitted within:	External	one hundred twenty (120) days of receipt of the original denial or response to your appeal
The IRO must complete the review of a <u>non urgent care claim or</u> <u>benefit appeal</u> within:	External	forty-five (45) days

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

Post Service Claims Appeal

	Post Service Claims Appeal		
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 Group Benefits 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 unique 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 Group Benefits Administrator shall be under no obligation to respond to an appeal of a claim based upon complaints that have previously been addressed by a prior appeal.

PROTECTED HEALTH INFORMATION

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

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

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

EXCLUSIONS AND LIMITATIONS APPLICABLE TO MEDICAL BENEFITS

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

- 1. the result of:
 - a. mandibular or maxillofacial surgery to correct growth defects, jaw disproportions or malocclusions, except for correction of a congenital anomaly in a child who was covered under this Plan from birth, or
 - 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;
- 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;
- 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;
- 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;
- 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;
- 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.

HOW BENEFITS ARE PAID

DEDUCTIBLE AND OUT OF POCKET

Meeting the Annual Deductible

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

Meeting the Annual Out Of Pocket Maximums

When a Covered Person meets their individual annual Out of Pocket maximum, or when the family annual Out of Pocket maximum has been met for in network services, all remaining Covered Expenses are payable at 100% for the remainder of that same calendar year.

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.

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

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

HOW TO FILE A MEDICAL CLAIM

FILING DEADLINE

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

WHAT YOU NEED TO SUBMIT WITH YOUR CLAIM

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

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

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

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

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

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

HOW TO AVOID DELAYS IN RECEIVING YOUR PAYMENT

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

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

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

FOREIGN PROVIDERS

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

CONTINUATION OF COVERAGE (COC) RIGHTS UNDER COBRA

Introduction

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

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

What is Continuation of Coverage?

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

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

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

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

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

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

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

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

When is Continuation of Coverage available?

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

You must give notice of some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Group Benefits Administrator within sixty (60) days after the qualifying event occurs. The City of Carrollton is the Group Benefits Administrator.

When are Continuation of Coverage Payments due?

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

How is Continuation of Coverage provided?

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

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

Disability extension of 18-month period of Continuation of Coverage

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

Second Qualifying Event extension of eighteen (18) month period of Continuation of Coverage

If your family experiences another qualifying event while receiving eighteen (18) months of Continuation of Coverage, The spouse and dependent children in your family may get up to eighteen (18) additional months of Continuation of Coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan.

This extension may be available to the spouse and any dependent children receiving Continuation of Coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B and/or Part C) or gets divorced or legally separated, of if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions

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

- <u>www.cciio.cms.gov/programs/protections/cobra_fact_sheet.html;</u> or
- www.cciio.cms.gov/programs /protections/cobra/cobra gna.html.

Keep Your Plan Informed of Address Changes

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

RIGHT OF RECOVERY

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

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

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

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

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

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

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

Right of Recovery

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

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

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

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

COORDINATION OF BENEFITS

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

For example:

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

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

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

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

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

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

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

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

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

PRE-EXISTING

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 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.

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.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1. affiliated with a hospital under a contractual agreement with an established system for covered individual referral;
- 2. accredited as such a facility by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO); and

- 3. licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse (TCADA); or
- 4. licensed, certified or approved as a Chemical Dependency treatment program or center by any other state agency having legal authority to so license, certify or approve and is also an approved healthcare facility.

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

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

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

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

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

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

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

COVERED BENEFITS – See Eligible Benefits.

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

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

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

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

DAY TREATMENT – A psychiatric or Chemical Dependency treatment facility that meets all of the following requirements:

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

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

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

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

DESIGNATED TRANSPLANT CENTER – A hospital or facility selected by the Group Benefits Administrator to be a preferred provider of a particular organ transplant procedure. The hospital or facility selected must meet all of the following requirements:

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

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

DISABILITY – Any of the following conditions:

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

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

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

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

EMERGENCY SERVICES – See Emergent/Immediate Care.

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

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

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

EMPLOYER OR EMPLOYER MEMBER – The City of Carrollton.

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

EVIDENCE BASED MEDICINE (EBM) – Aims to apply the best available evidence gained from the scientific method to medical decision making. It seeks to assess the quality of evidence of the risks and benefits of treatments (including lack of treatment). EBM recognizes that many aspects of medical care depend on individual factors such as quality and value of life judgments, which are only partially subject to scientific methods. EBM, however, seeks to clarify those parts of medical practice that are in principle subject to scientific methods and to apply these methods to ensure the best prediction of outcomes in medical treatment, even as debate continues about which outcomes are desirable.

EXCLUSIONS – Those charges for which benefits are not provided.

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

medical expense sought to be claimed is due to an injury that is non-compensable, whichever is later. Determination of "reasonably possible" is at the sole discretion of the Group Benefits Administrator.

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

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

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

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

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

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

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

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

HIPAA Title I:

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

HIPAA Title II:

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

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

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

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

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

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

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

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

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

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

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

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

INCAPACITY – See Disability.

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

INFUSION THERAPY – Medications administered intravenously (IV).

INJURY – See Accidental Injury.

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

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

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

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

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

MAINTENANCE CARE – All services, equipment and supplies which are provided solely to maintain a covered individual's condition and from which no functional improvement can be expected or is not life sustaining treatment for a medical condition.

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

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

- 1. A rare/orphan disease (a rare/orphan disease is one that affects fewer than 200,000 people, according to the U.S. Rare Disease Act of 2002).
- 2. A unique co-morbidity, or complication that precludes treatment with a proven medical procedure or therapy.
- 3. Continuation and/or repeat of a previously approved successful treatment plan.

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

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

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

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

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

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

MORBID OBESITY TREATMENT CENTER – A hospital or facility selected by the Group Benefits Administrator to be a preferred provider of a particular Morbid Obesity treatment.

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

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

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

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

NURSE MIDWIFE – A licensed registered nurse (RN) who is certified as a nurse midwife by the American College of Nurse-Midwives and is authorized to practice as a nurse midwife under state regulations. This does not include midwives who are not also licensed registered nurses (RN).

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

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

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

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

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

OUT OF NETWORK – See Non Network.

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

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

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

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

PLAN SPONSOR – The Employer.

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

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

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

- 1. period from conception through childbirth;
- miscarriage;

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

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

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

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

RECONSTRUCTIVE SURGERY – A procedure performed incidental to an injury, sickness, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of reconstructive surgery does not classify such surgery as cosmetic when a functional impairment exists, and the surgery restores or improves function.

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

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

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

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

ROUTINE – Being in accordance with an established procedure.

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

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

- 1. is primarily engaged in providing for inpatient skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation service for the rehabilitation of injured or sick persons;
- 2. has policies which are developed with the advice of (and with provision for review of such policies from time to time) a group of professional personnel, including one or more Physicians and one or more Registered Nurses, to govern the skilled nursing care and related medical care or other services provided;
- 3. has a Physician, a Registered Nurse (RN) and a medical staff responsible for the execution of such policies;
- 4. has a requirement that the healthcare of every patient must be under the supervision of a physician and provides for having a Physician available to furnish necessary medical care in case of emergency;
- 5. maintains clinical records on all patients;

- 6. if required, provides twenty-four (24) hour nursing care under the supervision of a Registered Nurse (R.N.);
- 7. provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
- 8. has in place a utilization review plan which provides for the review of admissions to the institution, the duration of stays and the professional services furnished with respect to eligibility;
- 9. is licensed by the appropriate state or local agency; and
- 10. is Medicare or Medicaid eligible.

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

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

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

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

SUBSTANCE ABUSE – See Chemical Dependency.

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

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

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

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

- Any drug not approved by the U.S. Food and Drug Administration (FDA) for marketing; any drug that is classified as IND (Investigational new drug) by the FDA;
- Determined not to be effective for treatment of the medical condition and/or not to have a beneficial
 effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted
 randomized controlled trials;
- Not consistent with the standards of good medical practice in the United States as evidenced by endorsement by national guidelines;
- Exceeds (in scope, duration, or intensity) that level of care which is needed Given primarily for the personal comfort or convenience of the patient, family member(s) or the provider;
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered Experimental or Investigational.); or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1 or 2 clinical trial, or is the experimental arm of a Phase 3 or 4 clinical trial as set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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

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

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

IMPORTANT ADDRESSES

Employer/Plan Sponsor

www.cityofcarrollton.com

City of Carrollton 1945 E. Jackson Road Carrollton, Texas 75011 (972) 466-3090

Group Benefits Administrator

www.tmliebp.org TML Intergovernmental Employee Benefits Pool (TML IEBP) Group#: ACARROL1

PO Box 149190 Austin, TX 78714-9190 (800) 282-5385

Care Management

www.tmliebp.org Group#: ACARROL1 TML IEBP – Care Management PO Box 149190 (800) 847-1213 Austin, TX 78714-9190

(800) 847-1213

Professional Health Coach Services (888) 818-2822

EAP www.deeroaks.com

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

NOTICE OF PRIVACY PRACTICES

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

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

Is all my health information protected?

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

How does the Plan use and share my health information?

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

What are treatment, payment and healthcare operations?

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

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

Healthcare operations include quality assessment and improvement, reviewing competence or qualifications of healthcare professionals, underwriting and other activities necessary to create or renew health plans. It also includes population health engagement, case management, conducting or arranging for medical review, legal services, auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information from your claims to contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

How else does the Plan share my health information?

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

Directly with you or your personal representative. A personal representative is a person who has legal
authority to make healthcare decisions for you. In the case of a child under 18 years of age, the child's
personal representative may be a parent, guardian or conservator. In the case of an adult who cannot
make his own medical decisions, a personal representative may be a person who has a medical power of
attorney.

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

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

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

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

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

Your request to revoke your authorization must be in writing and will not apply to any information shared before the Plan receives your request.

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

You may make a written request to the Plan's Privacy Officer for a list of any disclosures of your health information made by the Plan during the last six years. The list will not include any disclosures made for treatment, payment or healthcare operations; any disclosures made directly to you; any disclosures made based upon your written authorization; any disclosures reported on a previous list; or any disclosures made before April 14, 2004.

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

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

Can I view my health information maintained by the Plan?

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

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

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

You may request that the Plan correct any of your health information that it creates and maintains. All requests for correction must be made to the Plan's Privacy Officer, must be in writing and must include a reason for the correction. Please be aware that the Plan can correct only the information that it creates. If your request is to correct information that the Plan did not create, the Plan will need a statement from the individual or organization that created the information explaining an error was made. For example, if you request a claim be corrected because the diagnosis is incorrect, the Plan will correct the claim if the Plan (or its business associate) made an error in the data entry of the diagnosis. However, if your healthcare provider submitted the wrong diagnosis to the Plan, the Plan cannot correct the claim without a statement from your healthcare provider that the diagnosis is incorrect.

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

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

If mailing communications to the covered employee's address would place you in danger, the Plan will accommodate your request to receive communications of health information by alternative means or at alternative locations. Your request must be reasonable, must be in writing, must specify an alternative address or other method of contact, and must include a statement that sending communications to the covered employee's address would place you in danger.

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

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

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

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

When are the privacy practices described in this notice effective?

This privacy notice is effective January 1, 2013, and replaces any privacy notice issued by the Plan before that date.

Can the Plan change its privacy practices?

The Plan is required by law to follow the terms of its privacy notice currently in effect. The Plan reserves the right to change its privacy practices and to apply the changes to any health information the Plan received or maintained before the effective date of the change. The Plan will distribute any revised notice to covered employees, either by hand or by mail, before the effective date of the revised notice.

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

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

How can I get a paper copy of this notice?

To request that the Plan mail you a paper copy of this notice, call the Plan's Privacy Officer at (936) 633-0228.

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

Write to:

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

SIGNATURE PAGE

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

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

Dated this _____ day of _____ December, 2012

Title: Workforce Services Director

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