Pre Sixty-Five Retiree Medical Plan Booklet

PLAN YEAR 2019-2020
FOREWORD

January 2020

TML Health Benefits Pool (TML Health) has prepared this booklet to help you understand the retiree medical benefits provided through your Employer. The Retiree Medical Plan described in this booklet provides coverage for a wide range of medical care, services, and supplies. However, your benefits are affected by certain limitations and conditions that require you to be an informed consumer of health services and to use only those services you need. Benefits are not provided for non-medically evidence-based treatment or ineligible services, even if recommended by your physician. Please review the General Exclusions/Limitations section and the Medical Management section. TML Health urges you to familiarize yourself with the provisions in the Plan description in order to understand your benefits. TML Health is encouraging all members to review the retiree medical benefit booklet and engage in their health. There is a glossary of health care definitions in the back of the book to assist you with your understanding of health care services.

Disclaimer: A new benefit booklet is distributed at the beginning of the Plan Year. Please verify the annual date referenced on the front cover of the Pre Sixty-five Retiree Medical Plan Booklet to make sure you are referring to the medical benefits that coordinate with the incurred service date.
This notice certifies that TML Health has accepted your Employer as a risk-participating member of TML Health. Your Employer has selected a plan of benefits and may have the responsibility for compliance with state and federal laws applicable to retiree benefits. However, for most state and federal laws applicable to a health plan based upon the number of retiree enrolled or eligible to enroll in the health plan, the size of the health plan is determined by the number of individuals enrolled in TML Health as a whole and not based on any one Employer’s number of employees. This is a governmental plan excluded from coverage under ERISA (29 U.S.C.A. 1003(b)).

The Plan covers employees, dependents of employees, elected officials, dependents of elected officials, retirees, and dependents of retirees of Pool Members who are eligible for the coverage, become covered, and continue to be covered according to the terms of the Plan, Pool policies, and of the Employer’s medical benefits. In case of a conflict between a TML Health plan provision, policy rule, regulation, or underwriting guideline and Employer coverage, the TML Health plan provision, policy rule, regulation, or underwriting guideline shall override the Employer coverage in deciding whether an individual is eligible for coverage or whether a benefit should be paid. The Board of Trustees of TML Health reserves the right to amend the Plan if circumstances warrant and has given the Executive Director the discretionary authority to construe the terms of the Plan.

* A Risk Pool created under and governed by the Texas Political Subdivisions Uniform Group Benefits Program (Chapter 172 Texas Local Government Code). Section 172.014 of that chapter 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 [now the Texas Department of Insurance] does not have jurisdiction over a pool created under this Section.”
Helpful Resources

Please visit our website at tmlhealthbenefits.org for current benefit information 24 hours/7days a week.

Address
PO Box 149190, Austin, Texas 78714-9190

Health Care Provider Claim Status and Benefit Verification
(800) 282-6186

Mobile Access
iPhone App Store, Android Google Play, or tmlhealthbenefits.org for all other phones

Customer Care, Medical, and Prescription Information

Customer Care Helpline
(800) 282-5385 | 7:00 AM - 6:00 PM Central

Where to Mail Paper Medical Claims
TML Health, PO Box 149190
Austin, Texas 78714-9190

24/7 Nurse Line
(877) 950 5083

Teladoc
(800) 835-2362 | member.teladoc.com/signin

Summary of Benefits and Coverage (SBC) and benefit denial information can be requested.

1. Login at tmlhealthbenefits.org
2. Click on "Contact Us"
3. Click on "I have a general question"
Notice to Plan Participants regarding TML Health Election under 42 U.S.C. § 300gg-21

Chapter 172 Group health plans are regulated by federal laws named 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. Generally, a group health plan must comply with the requirements of those laws that are listed below. However, the law permits State and local governmental health plans to elect to exempt the plan from these requirements if that plan is self-funded rather than provided through a health insurance policy. TML Health has elected to exempt the Plan from the following requirements:

- Standards relating to benefits for mothers and newborns. A health plan may not restrict benefits for a hospital stay for the birth of a child to less than forty-eight (48) hours for a vaginal delivery and ninety-six (96) hours for a cesarean section;
- Parity in mental health or substance use disorders. 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;
- 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; and
- Coverage of dependent students on medically necessary leave of absence. A health plan must allow a covered dependent child, whose eligibility for coverage is based on student status, to continue coverage for up to one (1) year while on a medically necessary leave of absence from a postsecondary educational institution.

Because of this election:

- The duration of a hospital confinement for a mother and newborn following the birth of a child will be determined based on eligibility.
- Benefits for serious mental illness as defined by Texas law are treated as any other covered medical or surgical condition.
- The Plan pays for evidence-based initial mastectomy/lumpectomy and reconstructive oncology surgery of affected and non-affected breast. Eligible benefits include the initial non-cosmetic removal and replacement of prosthetics due to complications. Reconstructive surgery includes tissue expanders, breast implants, nipple reconstruction, and nipple tattooing.
- TML Health does not determine a dependent child’s eligibility based on student status. Therefore, TML Health does not extend coverage for students on a medically necessary leave of absence.

In addition to the above, on April 14, 2003, the Federal government imposed HIPAA Title II which pertains to administrative simplification of health plans. The administrative simplification process includes: standards for electronic transactions and code sets, national identifiers (Employers, health plans and Health Care Providers), security standards for the protection of health information (Security Rule), standards for notification in case of breach of unsecured health information, and standards for privacy of individually identifiable health information (Privacy Rule). A self-funded, non-federal, governmental health plan cannot exempt itself from any of the requirements of HIPAA Title II.

The intent of TML Health with regard to the Plan is to provide coverage that is compliant with applicable State and Federal laws and regulations, including mid-plan year changes when mandated by law.
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How Benefits are Paid

TML Health (We) relies mainly on information provided when a claim is submitted. If we find that additional information is needed to determine if benefits are payable or for Right of Subrogation under the Plan, a written request for such information will be made to the Covered Individual (you), or if necessary, the Health Care Provider. If the information is submitted and we submit the claim for audit, the In-Network provider will be reimbursed for eighty-five percent (85%) of the eligible charges. The audit will be conducted within one-hundred and eighty (180) days of the receipt of the clean claim, and any additional payment due to the In-Network provider or any refund due to us will be made no later than the thirtieth (30th) day after the completion of the audit. If the information is not provided, the claim will be denied. If the claim is denied because requested information is not provided, the information may be filed as long as the required information is filed within the 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 us; and additional information may also be submitted 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. To avoid a prompt pay penalty, required information must be received by us no later than the prompt pay contract deadline.

Claims

Requests for Reimbursement

No benefits are payable for claims submitted by you or a provider unless the requirements of this paragraph are met. Requests for reimbursement for a covered benefit should be received by us within ninety (90) days of date of service but not 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 us, 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 our sole discretion.

Requests for reimbursement must include:
1. the retiree’s name, address, unique subscriber identification number, and group name;
2. your name and relationship to the retiree;
3. the Health Care Provider’s name, tax ID/national provider identifier (NPI), or unique identification number and address; and
4. a description of the service rendered including charge(s), diagnosis code(s), applicable procedure code(s), and the date(s) of service.
Requests for reimbursement must be legible. If a request is not legible, it may be returned with a request to submit a legible copy. Electronic claim submissions must meet the standards for electronic transactions and codes set forth by the appropriate regulatory body. Claims will be considered for payment in the order received.

**Claims may be mailed to:** TML Health | PO Box 149190 | Austin, Texas 78714-9190

If you have any questions regarding your claim, please call our Customer Care Team at (800) 282-5385 or contact Customer Care via email at [http://tmlhealthbenefits.org](http://tmlhealthbenefits.org). Login and click on "Contact Us", then click on "I have a general question".

Benefits will not be recalculated to allow a better benefit for charges incurred at a later date.

Claim forms are not required for benefits to be payable under the Plan. We may request specific information from you or your Employer in order to complete processing of the claim or to verify eligibility in the Plan. The information requested may include but is not limited to:

1. verification of employment status;
2. information related to accidental injuries;
3. information related to work-related accidents or illness; and/or
4. information regarding any other source of benefits.

You must keep us informed in writing of any change in address, phone number or dependents. We may rely on United States Postal Service and/or the Employer demographic information for your last known address.

As a Covered Individual under the Plan, you must supply us with the information necessary to determine whether the charges incurred are for an Eligible Benefit or to otherwise administer benefits. Decisions with respect to the type of information necessary to determine coverage shall be made at our sole discretion. We reserve the right to withhold or deny payment until the requested information has been furnished.

**Right to Receive and Release Necessary Information**

All personnel involved in the processing of claims are advised of the need to treat all personal and medical information as confidential. However, we have the right to disclose information to or obtain information regarding you from any organization or person if necessary to determine benefits payable under the Plan or if allowed by state or federal statute or regulation.
No Replacement for Workers’ Compensation

The Plan does not replace Workers’ Compensation or provide any benefits if any Workers’ Compensation benefit was paid or could have been paid, whether or not the Employer is a subscriber or non-subscriber in a Workers’ Compensation Program, including those individuals who could have been lawfully covered by workers’ compensation as volunteers. For purposes of this booklet, work on your family farm or ranch is not considered an employment arrangement requiring Workers’ Compensation.

Assignments

The benefits provided under the Plan are payable only to you. We may pay benefits directly to the Health Care Provider if they are assigned by you.

In addition, benefits will not be paid to providers who negotiate benefit settlements with patients (e.g., providers who agree to accept whatever payment the Plan makes or providers who waive deductibles or copayments).

Appeals

You will receive an initial denial notice or Explanation of Benefits (EOB) Form if your claim is being denied, in whole or in part, and the amount you owe the provider will be listed on the form.

The EOB form will:
• Explain the reasons for the denial.
• Explain the steps you may take to submit the claim for appeal (review).

You have a right to request a free copy of the rule, guideline or clinical criteria relied upon for the claim denial.

Procedure for Appeals

If you disagree with the denial of a claim, pre-authorization request, or a rescission (retroactive termination) of coverage, you or your authorized Personal Representative may request that we review our initial determination by submitting a written request as described below. Please note that the process below will differ depending upon if the appeal is related to a clinical or non-clinical denial.

• A clinical denial is a denial or reduction in benefits related to medical judgement such as a denial for no medical necessity, inappropriate level of care, or a service or supply considered by us as experimental or unproven.

• A non-clinical denial is a denial or reduction in benefit due to a non-covered benefit, network status determination, reduction due to discount or allowable charge, eligibility or other non-clinical reason.

• We will not reconsider or respond to duplicate or previously submitted appeals.
First Level of Internal Appeal

This is a mandatory appeal level for both clinical and non-clinical denials. You must first exhaust the following internal appeals procedures before taking any outside legal action.

- You must file the appeal within twelve (12) months of the date of the EOB showing that the claim was denied.
- You or your Personal Representative will be allowed reasonable access to review or copy our related documents, at no charge.
- You must submit written comments, documents, records, and other information related to the claim, at your expense, to explain why you believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- If the claim was denied, in whole or in part, based on a medical judgment, we will consult with a health care professional with training and experience in the relevant medical field.

After the claim, pre-authorization request, or a rescission (retroactive termination) of coverage has been reviewed, you will receive written notification letting you know the outcome of the review.

Second Level of Internal Appeal

This is a voluntary appeal level for clinical denials and a mandatory appeal level for non-clinical denials. Second level appeals require new and pertinent information to be considered for a secondary review.

- If you are not satisfied with the decision following the first internal appeal you have the right to appeal the denial a second time.
- You or your Personal Representative must submit a written request for a second review within sixty (60) calendar days following the date of the determination letter.
- You must submit new and pertinent information such as additional written comments, documents, records, and other information to explain why you believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision.
- If the claim denial was based, in whole or in part, on a medical judgment, we will consult with a health care professional with training and experience in the relevant medical field.
- After the claim, pre-authorization request, or a rescission (retroactive termination) of coverage has been reviewed, you will receive written notification letting you know the outcome of the review.
Voluntary Clinical Appeal Process

This voluntary second level appeal for clinical denials is offered for your convenience and to obtain a quick resolution. We agree that any statutory limitations that are applicable to pursuing the clinical claim, pre-authorization request, or a rescission (retroactive termination) of coverage in court will be put on hold during the period of the voluntary appeal process to give you time to complete this process. The voluntary appeal process is available only after you have followed the mandatory appeal level as required above. We also agree that we will not charge you a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if you elect to pursue a claim in court before following any voluntary appeal process. Your decision about whether to submit a benefit dispute through a voluntary appeal level will have no effect on your rights to any other benefits under the Plan.

Right to External Review for Clinical Related Denials

This process is available at no charge to you after you have exhausted the mandatory internal appeals process identified above and you receive a decision that is unfavorable, or if we fail to respond to your mandatory internal appeal within the timelines stated below.

The external review program offers an independent review process to review the denial of a requested service, or the denial of payment for a service. During this process, we will submit your appeal to an Independent Review Organization (IRO) to review your request. Neither you nor TML Health will have an opportunity to meet with the reviewer or otherwise participate in the reviewer’s decision. The decision of the IRO will be final.

Your written request should include: (1) Your specific request for an external review; (2) Your name, address, and member ID number; (3) Your designated representative’s name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive your request.

Any requests for a clinical related external review must be made within four (4) months of the date you received the original EOB or denial notice. You or an authorized designated representative may request an independent review by sending a written request to the address listed below.

The external review will be performed by an independent Physician who is qualified to decide whether the requested service is: 1) medically appropriate and; 2) a qualified medical care expense under the Plan. The IRO is an independent contractor and has no material affiliation or interest with TML Health.

Within applicable timeframes of the receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon in making a decision on the case; and
- All other information or evidence that you or your Physician has already submitted; and
- All other information or evidence not previously provided
A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law. The decision of the IRO is final. There is no further appeal of the reviewer’s decision.

The reviewer’s decision will be in writing and will include the clinical basis for the determination. If the final independent review decision is that payment or referral will not be made, we will not be obligated to provide benefits for the service or procedure.

You may contact us at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

**Right to External Review for Non-Clinical Related Denials**

You may choose to appeal a decision to the Board of Trustees at no charge to you after you have exhausted the mandatory non-clinical internal appeals process identified above and you receive a decision that is unfavorable, or if we fail to respond to your mandatory internal appeal within the timelines stated below. You must send your non-clinical related appeal in writing within thirty (30) days of receipt of the final determination.

Your written request should include: (1) your specific request for an external review; (2) your name, address, and member ID number; (3) your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive your request.

The TML Health Board of Trustees Executive Committee (Committee) will schedule a meeting and hear the appeal. The appealing party may submit additional information and/or appear before the committee. The appealing party will be notified of the date, time, and place the committee will meet at least five (5) days prior to the meeting date.

A final decision will be made by the Committee and sent to the appealing party. The Committee's final decision will be in writing and include specific references to the Plan provisions on which the decision was based. There is no further appeal of the Board of Trustees Executive Committee’s final decision.

Appeals should be sent within the prescribed time period as stated above to the following address(es).

<table>
<thead>
<tr>
<th>Type of Appeal</th>
<th>Reason for Appeal</th>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Service</td>
<td>• Claim denial</td>
<td>TML Health</td>
</tr>
<tr>
<td></td>
<td>• Retrospective authorization</td>
<td>PO Box 149190</td>
</tr>
<tr>
<td></td>
<td>• Plan eligibility</td>
<td>Austin, TX 78714-9190</td>
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<tr>
<td></td>
<td></td>
<td>Or complete online at</td>
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<td></td>
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<td><a href="http://tmlhealthbenefits.org">http://tmlhealthbenefits.org</a></td>
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<td>Mailing Address</td>
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<tr>
<td>Pre-Service</td>
<td>Pre-authorization of Services</td>
<td>UHC Appeals - TML Health/UMR</td>
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<tr>
<td></td>
<td></td>
<td>PO Box 400046</td>
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<td></td>
<td></td>
<td>San Antonio, TX 78229</td>
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<tr>
<td></td>
<td></td>
<td>Fax: 888-615-6584</td>
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<tr>
<td></td>
<td></td>
<td>Or complete online at <a href="http://www.umr.com">www.umr.com</a></td>
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### Time Periods for Making Decisions on Appeals

After our review, we will notify you of the decision within the following timeframes:

- **Pre-authorization Requests**: Within a reasonable period of time appropriate to the medical circumstances, but no later than thirty (30) calendar days after the Plan receives the request for review.
- **Urgent/Emergency Pre-authorization Requests**: Within seventy-two (72) hours after the Plan receives the request for review.
- **Post-Service Claims**: Within a reasonable period of time, but no later than sixty (60) calendar days after we receive the request for review. Any additional requested information necessary to complete the review must be provided to us within the timeline indicated in the appeal response.

### Legal Actions

No legal action may be brought against us prior to the expiration of sixty (60) days after a written request for reimbursement has been furnished to us in accordance with the requirements of the Plan and all appeal rights available have been exhausted. No such action may 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. Venue for any dispute arising under the terms of the Plan, including but not limited to claims and subrogation disputes or declaratory judgment actions, shall be in Austin, Travis County, Texas.

### Privacy and Security of your Health Information

The Health Insurance Portability and Accountability Act (“HIPAA”), found at 45 C.F.R. §164 et seq., requires that we protect the privacy and security of each individual’s protected health information (“PHI”) through, among other things, implementation of various physical, technical and administrative safeguards. Our Notice of Privacy Practices (“NPP”) explains your rights under HIPAA, as well as how we may use and disclose PHI. Please visit [http://tmlhealthbenefits.org/Forms/TML/Privacy.aspx](http://tmlhealthbenefits.org/Forms/TML/Privacy.aspx) to review TML’s NPP, or you may request a paper copy by calling Customer Care at (800) 282-5385.
Medical Management

Medical Management is designed to assist you in making informed health care decisions. Occasionally, proposed health care or the scheduled length of stay or setting is not an Eligible Benefit. Please read this provision so that you understand the admission, continued stay, and Pre-authorization process and are not faced with an out-of-pocket cost, penalty, or denial for failure to obtain Pre-authorization. Even when Pre-authorization is obtained, reimbursement is subject to the terms and conditions of the Plan including, but not limited to, all Plan exclusions and limitations. Pre-authorization does not constitute verification of eligibility for benefits.

If Medical Management does not receive a Pre-authorization request prior to a scheduled service requiring Pre-authorization, claims for benefits for that service will not be considered eligible unless a retrospective review request is filed. If the medical services are eligible under the Plan, they will be reviewed for eligible payment.

How the Pre-authorization Process Works

The Twenty Three (23) Hour Rule

For the purpose of Pre-authorization, “inpatient” means treatment or confinement in a hospital or other medical facility for more than twenty-three (23) hours. “Outpatient” means treatment or confinement in a hospital or other medical facility for twenty-three (23) hours or less.

What is an admission?

When the hospital or facility submits a claim, the length of time you were in their facility and a designation of inpatient, outpatient, or observation is included. The number of hours, not the classification, determines if the stay is twenty-three (23) hours observation or inpatient. If it appears that you will stay more than twenty-three (23) hours, a Pre-authorization request for the stay must be provided to Medical Management.

If a newborn baby requires more than routine nursery care, Medical Management must be provided a Pre-authorization request so that a separate determination can be issued for the baby. Newborns must be added to the Plan within sixty (60) days of birth in order to be a Covered Individual.

Your Responsibilities

Call the Member Services number on the ID card to request Pre-authorization from Medical Management prior to any health care service that requires Pre-authorization. After hours, Voice Mail records your Pre-authorization request twenty-four (24) hours-a-day and the Medical Management Intake Staff will return your call the next business day.
Pre-authorization Requirements

Pre-authorization enables clinical support and educations, such as:
• Pre-op education for the patient and ensure adherence to nationally recognized guidelines in order to maximize quality and cost efficiency;
• Post-op discharge planning to optimize clinical outcomes; and
• Refer patients to Centers of Excellence.

A Pre-authorization request to us is required for the following admissions and/or procedures regardless if our Plan is primary or secondary:

<table>
<thead>
<tr>
<th>Service</th>
<th>Pre-authorization Required &amp; Late Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Admissions</strong></td>
<td>Facility: twenty-four (24) hours after actual admission or by 5 PM the next calendar day for weekend/holiday admissions</td>
</tr>
<tr>
<td><strong>Planned Admissions</strong></td>
<td>Penalty: $400*</td>
</tr>
<tr>
<td>• Orthopedic/Spine Surgeries (spinal surgeries, total knee replacements, and total hip replacements)</td>
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<tr>
<td>• Reconstructive procedures</td>
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<tr>
<td>• Bariatric Surgery: after the approved six (6) consecutive months (within the most recent twelve (12) months) physician-supervised weight management treatment plan with a psychiatric evaluation</td>
<td></td>
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<tr>
<td>• Congenital Heart Disease</td>
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<table>
<thead>
<tr>
<th>Service</th>
<th>Pre-authorization Required &amp; Late Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Inpatient/Emergency/Surgical Admissions</strong></td>
<td>Facility: twenty-four (24) hours after emergency admission or by 5 PM the next calendar day for weekend/holiday admissions</td>
</tr>
<tr>
<td>• Skilled Nursing Facility</td>
<td>Penalty: $400*</td>
</tr>
<tr>
<td>• Mental Health/Substance Use Disorder Inpatient</td>
<td></td>
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<tr>
<td>• Mental Health/Substance Use Disorder Residential Treatment</td>
<td></td>
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<tr>
<td>• Acute Care Hospital/ Facility</td>
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<tr>
<td>• Long Term Acute Care Facility</td>
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<tr>
<td>• Acute Rehabilitation Facility</td>
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<tr>
<td>• Hospice</td>
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<tr>
<td>• Inpatient maternity care that does not result in a delivery</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Pre-authorization Required &amp; Late Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Pregnancy/Maternity (Delivery Admission)</strong></td>
<td>Facility: twenty-four (24) hours after the forty-eight (48) or ninety-six (96) hours after the delivery, or by 5 PM on the following day after a weekend or holiday.</td>
</tr>
<tr>
<td>• Vaginal delivery in excess of forty-eight (48) hours</td>
<td>Penalty: $400</td>
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<tr>
<td>• Cesarean Section delivery in excess of ninety-six (96) hours</td>
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<tr>
<td>• Newborns who remain in the hospital after mother is discharged (where confinement exceeds mother’s original Pre-authorization approval)</td>
<td>Pre-authorization required no later than twenty-four (24) hours of mother’s discharge</td>
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<td></td>
<td>Penalty: $400*</td>
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<tr>
<td>Service</td>
<td>Pre-authorization Required &amp; Late Penalty</td>
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<tr>
<td><strong>Transplant</strong></td>
<td>At least fifteen (15) working days prior to any pre-transplant evaluation</td>
</tr>
<tr>
<td>Pre-Evaluation inpatient and outpatient</td>
<td>Penalty: $400</td>
</tr>
<tr>
<td><strong>Transplant Procedure</strong></td>
<td>Facility: twenty-four (24) hours after actual admission or by 5 PM the next calendar day for weekend/holiday admissions</td>
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<tr>
<td></td>
<td>Penalty: $400*</td>
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<tr>
<td><strong>Scheduled Outpatient/Office Surgical Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>• Blepharoplasty (eyelid surgery)</td>
<td>Three (3) working days prior to procedures, must be authorized before services are rendered to avoid penalty</td>
</tr>
<tr>
<td>• Breast Surgery (excludes Breast Biopsies)</td>
<td>Penalty: $200</td>
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<tr>
<td>• Carpal Tunnel Release (nerve decompression)</td>
<td></td>
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<tr>
<td>• Jaw Surgery (including mandibular joint)</td>
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<tr>
<td>• Joint Surgery (excluding fingers &amp; toes)</td>
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<tr>
<td>• Laparoscopy (except sterilization)</td>
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<tr>
<td>• Nasal Surgery</td>
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<tr>
<td>• Uvulopalatoplasty</td>
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<tr>
<td>• Reconstructive Surgery</td>
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<tr>
<td>• Spinal Surgery</td>
<td></td>
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<tr>
<td>• Cochlear Implantation</td>
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<tr>
<td>• Bariatric Surgery: after the approved <strong>six (6)</strong> consecutive months (within the most recent twelve (12) months) physician supervised weight management treatment plan with a psychiatric evaluation</td>
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<tr>
<td><strong>Outpatient/Office/Medication Therapy</strong></td>
<td></td>
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<tr>
<td>• Pain Management Therapy (IV)</td>
<td>Prior to treatment</td>
</tr>
<tr>
<td>• Oncological Medication Treatment (IV/Injectable/Oral)</td>
<td>Penalty: $200</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td></td>
</tr>
<tr>
<td>• Mental Health/Substance Use Disorder Day Treatment and Intensive Outpatient Treatment</td>
<td>Three (3) working days prior to procedures, must be authorized before services are rendered to avoid penalty</td>
</tr>
<tr>
<td>• Home Health Care</td>
<td></td>
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<tr>
<td>• Physician Home Visit</td>
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<tr>
<td>• Cardiac Rehabilitation</td>
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<tr>
<td>• Pulmonary/Respiratory Rehabilitation</td>
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<tr>
<td>• Positron Emission Tomography (PET) scans</td>
<td></td>
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<tr>
<td>• Computerized Axial Tomography (CAT) scans</td>
<td></td>
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<tr>
<td>• Computerized Tomographic Angiography (CTA) scans</td>
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<tr>
<td>• Magnetic Resonance Imaging (MRI) scans</td>
<td></td>
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<tr>
<td>• Magnetic Resonance Angiography (MRA) scans</td>
<td></td>
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<tr>
<td>• Single Photon Emission Computed Tomography (SPECT)</td>
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<tr>
<td>Service</td>
<td>Pre-authorization Required &amp; Late Penalty</td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>• Hyperbaric Oxygen Therapy</td>
<td>Three (3) working days prior to dispensing/delivery of standard durable medical equipment in excess of $1,500 per base piece of durable medical equipment</td>
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<tr>
<td>• Radiation Therapy</td>
<td></td>
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<tr>
<td>• Medically Necessary Evidence-Based</td>
<td></td>
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<tr>
<td>Genetic/Genomic Testing to direct treatment (after diagnosis has been established)</td>
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<tr>
<td>• Intraoperative Monitoring (inpatient and outpatient)</td>
<td></td>
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<tr>
<td>• Durable Medical Equipment (including repairs) for purchased equipment</td>
<td>Three (3) working days prior to dispensing/delivery of standard durable medical equipment in excess of $1,500 per base piece of durable medical equipment</td>
</tr>
<tr>
<td>• Durable Medical Equipment for rental equipment</td>
<td>Three (3) working days prior to dispensing/delivery of standard durable medical equipment in excess of $500 per monthly rental per base piece of durable medical equipment</td>
</tr>
<tr>
<td>• Prosthetics and non-foot Orthotics (including repairs)</td>
<td>Three (3) working days prior to dispensing/delivery of standard prosthetics/non-foot orthotics and/or implantable-removable ocular prosthetic lens in excess of $1,000</td>
</tr>
<tr>
<td>• Implantable and/or removable ocular prosthetic lens (including repairs)</td>
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</tbody>
</table>

* The attending provider and the facility are responsible for the Pre-authorization requirements. Non-compliant providers will receive the penalty. Providers cannot balance bill a member for the lack of Pre-authorization penalties and denied services.

**Decisions on Appropriate Care**

1. Decision making is based on medical necessity and evidence-based care.
2. There is no financial incentive for decision makers to deny care.

**Responsibilities of Medical Management**

Medical Management does not confirm eligibility or benefits for any treatment or service. Upon receipt of a Pre-authorization request, Medical Management will provide you or the Provider with contact information to enable the person to confirm eligibility and benefits with a Customer Care Representative.
What Happens on Treatment in Excess of Twenty-Three (23) Hours?

You must provide a Pre-authorization request to Medical Management, (800) 282-5385, of a scheduled admission per Pre-authorization Requirements. If the Pre-authorization request is made after the above-referenced time frames, a Late Pre-authorization Penalty or reduction of benefits will apply. Concurrent stay review requirements apply to all inpatient confinements. Failure to provide a Pre-authorization request to Medical Management will result in no paid benefits for facility or related charges.

What Happens if Outpatient Services go over the Twenty-Three (23) Hour Limit?

Outpatient Surgery not on the Outpatient Surgery List

If Pre-authorization is provided to Medical Management within the Pre-authorization Requirements 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 a Pre-authorization request to Medical Management within the Pre-authorization Requirement of the admission, the outpatient Late Pre-authorization Penalty will apply. Failure to provide a Pre-authorization request to Medical Management will result in no paid benefits for related charges.

Outpatient Surgery on the Outpatient Surgery List

If a Pre-authorization request was provided on a scheduled surgery requiring Pre-authorization 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 a Pre-authorization request was not provided will not be a paid benefit. A Late Pre-authorization Penalty will not be applied if prior authorization was provided and the services and length of stay are determined to be appropriate.

Emergent or Immediate Care (Unscheduled) Medical Admission/Services

If a Pre-authorization request is provided to Medical Management for emergent or immediate care, no Late Pre-authorization Penalty will apply.

Maternity Care

Maternity care means services rendered to treat and maintain a pregnancy that is covered under the Plan. Maternity care includes prenatal visits and testing, delivery of the child, post-partum care, and routine care of the newborn child while the mother is Hospital confined.
Continued Stay Review

If your treatment plan changes, the Health Care Provider must provide a Pre-authorization request to Medical Management. Medical Management will obtain an update on the treatment plan and will conduct a concurrent review regarding the additional length of stay.

Medical Management Utilization Management/Catastrophic Care

Utilization 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 Utilization Management for catastrophic cases (chemotherapy, radiation therapy, transplants, NICU babies, brain injuries, multiple trauma, etc.) that require intensive management. The UM/RNs are responsible for accurate and timely processing of requests for all events/services.

The Utilization Management staff consists of licensed, professional nurses. The nurses have years of experience in health care and know the importance of not intruding in the doctor/patient relationship. The nurses add value by promoting health care alternatives such as Case Management or Health Care Coaching for assistance with personal management of health and well-being that are acceptable to you, your doctors, and your employer to help control health care costs and use your benefits wisely.

Population Health Engagement

Population Health Engagement supports members in all stages of health. This program provides information to you regarding healthy lifestyle choices and management of chronic disease states. The program offers personalized professional coaching to support the healthy lifestyle of change and a plan of action. Online tools and educational material(s) are available to you. The population health engagement team consists of an interdisciplinary team of licensed professional nurses, licensed professional counselors, and registered dietitians.

The Personal Health Engagement Program includes

Opt In: Enrollment method by which you call the professional health coaching line and request a professional health care coach or agree to professional health coaching upon receipt of an outreach call or letter.

Self-Assessment Tools and Healthy Living Resources

There are self-assessment tools located on our website including the Well-being Assessment and Wheel of Life. Healthy Living Resources include: Healthy Living Fact Sheets and helpful website links.

Professional Health Information Line

Professional Health Coaches will answer basic health and medication questions.
Description of Plan Benefits

The following benefits are applicable to each Covered Individual for Eligible Benefits subject to the terms and conditions of the Plan. The medical benefits are provided for covered charges while you or your dependent(s) are covered under the Plan. All services provided are subject to Reasonable and Customary charges and average wholesale pricing as determined by us.

In each calendar year, once the deductible amount has been met, the Plan will pay benefits as stated in the SBC. Charges are processed in date order received or upon receipt of all required information.

Benefits payable for hospitalization, certain outpatient surgical procedures, and certain other benefits are subject to Pre-authorization requirements. Please refer to the Medical Management section of this booklet.

Deductible Requirements

(Refer to the SBC.)

In-Network and out-of-network deductibles are separate. The out-of-network deductible accumulates to the in-network; the in-network does not accumulate to the out-of-network deductible.

The in-network deductible is included in the in-network maximum out-of-pocket.

Covered charges that are used toward satisfying the deductible must be incurred during the calendar year.

For an inpatient confinement that continues into a new calendar year, any amounts applied toward the prior calendar year deductible will also count toward the next calendar year deductible for charges for the duration of that inpatient confinement.

The family deductible is a cumulative dollar amount and applies collectively to all covered family individuals. Once the family deductible is satisfied, no further deductible requirements will be applied for any covered family individual within the calendar year.

If you are on a Qualified High Deductible/Health Savings Account (HSA) plan and are covering any dependents, the family deductible must be met before the plan will pay. However, once any individual on the plan meets the Federal individual maximum out-of-pocket, the plan will begin to pay for in-network services for that person.
Copay Requirements

(Refer to the SBC.)

Maximum Out-of-Pocket Requirements

(Refer to the SBC.)

Covered charges that are used toward satisfying the maximum out-of-pocket amount must be incurred during the calendar year. Only covered in-network expenses accumulate to the maximum out-of-pocket.

The family maximum out-of-pocket is a cumulative dollar amount and applies collectively to all covered family individuals. Once the family maximum out-of-pocket is satisfied, the plan will pay 100% for all in-network services for any covered family member during the remainder of the calendar year.

If you are on a Qualified High Deductible/HSA and are covering any dependents, the family out-of-pocket must be met before the plan will pay. However, once any individual on the plan meets the Federal individual maximum out-of-pocket the plan will begin to pay 100% for in-network services for that person.

For an inpatient confinement that continues into a new calendar year, any amounts applied toward the prior calendar year out-of-pocket will also count toward satisfying the next calendar year maximum out-of-pocket for charges for the duration of that confinement.

Reasonable and Customary

The Plan will pay up to billed/negotiated charges but not more than the Reasonable and Customary rate as defined by the Plan document and determined by us.
Eligible Benefits

Charges for Active Employees, COBRA participants, eligible dependents of employees, elected officials, dependents of elected officials, retirees, and dependents of retirees for the following services will be reimbursed by the Plan, subject to the conditions and/or limitations described in this booklet and the SBC.

Hospital

**Inpatient Hospital** *(see Pre-authorization Requirements)*:

1. Semi-Private Room - administratively, room and board charges are allowed up to the rate charged by the hospital for a Semi-Private Room, unless the hospital bill indicates that the facility does not provide Semi-Private Rooms. If a Semi-Private Room is available and a private room is accessed, the Plan will allow up to the cost of a Semi-Private Room rate;
2. intensive care room and board up to the Reasonable and Customary rate; and
3. ancillary services and supplies.

**Inpatient Newborn Care.** Charges by a Physician, hospital, or Health Care Provider for a newborn will be covered as charges to the mother subject to the co-insurance shown on the SBC if the mother is covered by the Plan and the newborn is discharged within two (2) days of delivery for a vaginal delivery and within four (4) days of delivery for a cesarean section delivery. If the mother is not covered and the newborn is enrolled within sixty (60) days, the charges will be considered as charges to the newborn subject to the deductible and maximum out-of-pocket. *(Refer to the SBC.)*

If the newborn is not discharged within two (2) days of delivery for a vaginal delivery or within four (4) days of delivery for a cesarean section delivery, any charges incurred for the newborn will not be covered unless the charges are an Eligible Benefit for the newborn to remain in the hospital. Such charges, if covered on the basis of eligibility for the newborn, will be considered as charges to the newborn subject to the deductible and maximum out-of-pocket. *(Refer to the SBC.)* The newborn must be enrolled within sixty (60) days for any charges to be considered.

The inpatient newborn care benefit includes routine circumcision if completed prior to discharge.

**Skilled Nursing Facility.** Room and board, including necessary medical services and supplies.
Outpatient Hospital

Supplies and services provided by the facility on an outpatient basis.

Pre-Admission Testing Benefit

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

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

Facility Outpatient

Ambulatory Surgical Center (ASC)

Charges for surgical procedures performed by a Physician including charges incurred for covered related services and supplies furnished on the day of surgery. If the office or facility does not meet the definition of an Ambulatory Surgical Center as defined in this booklet, surgical facility charges will not be covered.

Physician

Anesthesia – administered by an Anesthesiologist (MD) and/or Certified Registered Nurse Anesthetist (CRNA).

Co-Surgeon – when the skills of two (2) or more surgeons, usually with different skills, are required in the management of a specific surgical procedure in which the surgeons’ separate contributions to the successful outcome of the procedure are considered to be of equal importance, each surgeon is paid for his or her own procedure.

Physician – all charges for surgery or benefit-eligible medical treatment.

Second Surgical Opinion Benefit – if you obtain and provide us with a written second surgical opinion prior to a covered surgical procedure concerning the need for a surgical procedure, then the deductible will not apply to Eligible Benefits incurred for the opinion and Reasonable and Customary charges will be paid in full. This benefit does not include any diagnostic tests or x-rays ordered by the Physician making the second opinion. Such diagnostic tests and x-rays are subject to the deductible and co-insurance. (Refer to the SBC.)

To qualify for this benefit, a second opinion must be:

1. given within thirty (30) days of the initial recommendation for surgery; and
2. given by a board-certified internist or a board-certified specialist who is not financially associated or affiliated with the surgeon performing the surgery.
Prescription

Coverage for eligible injectable and non-injectable biotech and/or biosimilar prescriptions that are available through the Prescription Drug Plan but are purchased from medical providers will be paid per the Medical Benefit Plan.

A pre-determination of benefits is required for gene therapy, including the injectable Zolgensma, for the treatment of spinal muscular atrophy.

Prescription Drug Plan non-injectable prescriptions purchased outside of the Pharmacy Benefit Manager will not be an eligible benefit under the Medical Benefit Plan other than the biotech/biosimilar prescriptions mentioned above.

Refer to the Prescription Drug Plan Booklet for more information.

Major Medical

**Artificial Limbs or Prosthetic Appliances** – medically necessary new or replacement appliances are limited to the lessor of contractual charge, Reasonable and Customary fee schedule defined by the plan document, or cost of the standard model items as determined by Medical Management.

**Autism Screenings** – eighteen (18) and twenty-four (24) months of age.

**Blood Storage** – when in connection with scheduled surgery or procedure covered under the Plan.

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

**Breast Reduction** – charges will require compliance with Evidence-Based Medicine criteria for approval.

**Cardiac Rehabilitation** – a program of clinically supervised exercise designed to strengthen the heart and improve cardiovascular functioning; requires Medical Management Pre-authorization.

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

**Chiropractor (DC)** – charges for treatment of an illness or injury by manipulation of the spine and appropriate treatments; subject to the benefit maximum. *(Refer to the SBC.)*

**Circumcision.**

**Corneal Transplant** – a Cornea Transplant is covered as a Major Medical Benefit and not subject to requirements under the Transplant Benefit as noted in the Transplant Section of this Benefit Booklet.

Cosmetic procedures/reconstructive surgery only if:
1. for the repair of an accidental injury;
2. for reconstruction incidental to or following surgery resulting from an injury or illness; or
3. for correction of congenital anomalies that result in a functional defect.

Custom Molded Foot Orthotics – medical, documented physiological change that requires a revised orthotic; subject to the benefit maximum. (Refer to the SBC.)

Diabetes Equipment and Supplies – Coverage for equipment and supplies for the treatment of diabetes for which a physician or practitioner has written an order, including:
1. blood glucose monitors, including those designed to be used by or adapted for the legally blind*;
2. test strips specified for use with a corresponding glucose monitor*;
3. lancets and lancet devices*;
4. visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein*;
5. insulin and insulin analog preparations*;
6. injection aids, including devices used to assist with insulin injection and needleless systems*;
7. insulin syringes*;
8. biohazard disposal containers;
9. insulin pumps, both external and implantable, and associated appurtenances, which include:
   a. insulin infusion devices;
   b. batteries;
   c. skin preparation items;
   d. adhesive supplies;
   e. infusion sets;
   f. insulin cartridges;
   g. durable and disposable devices to assist in the injection of insulin; and
   h. other required disposable supplies;
10. repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer’s warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
11. prescription medications which bear the legend “Caution: Federal Law prohibits dispensing without a prescription” and medications available without a prescription for controlling the blood sugar level*;
12. podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
13. glucagon emergency kits*.

* These items are only covered under the Prescription Drug Plan.
**Diabetes Self-Management Education**

1. Education provided after the initial diagnosis of diabetes in the care and management of that condition, including the development of an individualized management plan, nutritional counseling, and proper use of diabetic equipment and diabetic supplies;

2. Additional education authorized on the diagnosis of a Health Care Provider of a significant change in your symptoms or condition of diabetes that requires changes in your self-management regime; and

3. Periodic or episodic continuing education when prescribed by an appropriate Health Care Provider as warranted by the development of new techniques and treatment for diabetes.

**Durable Medical Equipment** – standard rentals and purchases that are limited to the lesser of contractual charge, Reasonable and Customary fee schedule, or cost of standard model items. Charges for the rental of Durable Medical Equipment in excess of the purchase price are not covered. Refer to the Medical Management section above for Pre-authorization requirements. Replacement of non-warranty equipment, prosthetic, non-foot orthotics, implantable and/or removable auditory and/or ocular prosthetics will be an eligible benefit if lost, stolen, or damaged beyond repair in an accident or a natural disaster. Proof of damage or theft will be required. If equipment is worn out, replacement of equipment will be considered if the equipment exhausts the three-year equipment lifetime requirement. Physiological and/or technological medical necessity approval will be required for replacement of equipment prior to the three-year lifetime replacement timeline.

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

**Hearing Evaluation and Appliance Selection** – a Physician-prescribed medically necessary hearing appliance is covered; subject to the benefit maximum. Cochlear Implants are included under the medical plan and are not subject to the Hearing Evaluation and Appliance benefit maximum. *(Refer to the SBC.)*

Necessary diagnostic follow-up care related to a screening test for hearing loss from birth through the date the child is twenty-four (24) months of age is covered.

**Hormone Replacement Therapy** – for hormonal imbalance.

**Infertility Diagnostic** – initial diagnosis only.

**Infusion Therapy.**

**Inpatient Physical, Occupational, and/or Aquatic Therapy** – Services prescribed and performed by a licensed practitioner to restore, keep, learn, or improve skills and functions for daily living.

**Inpatient Speech Therapy** – Services prescribed and performed by a licensed practitioner to restore, keep, learn, or improve skills and functions for daily living.

**Lab & X-ray charges.**

**Lactation Support** – comprehensive prenatal and postnatal lactation support, counseling, and standard equipment/non-disposable supplies rental and/or purchase; standard equipment is provided for duration of breastfeeding.
Lenses – initial removable contact lenses or glasses required following cataract surgery. *(Refer to SBC.)* Standard implantable ocular prosthetics to treat cataract and/or complex corneal diseases.

**Licensed Air and Ground Professional Ambulance** – services to the nearest hospital or emergency care facility equipped to treat a condition requiring immediate care. Non-emergency transportation is covered when deemed medically necessary by TML. *(Refer to the SBC.)*

**Treatment of Temporomandibular Disorders (TMJ)** – including treatment for any jaw joint disorder, TMJ disorder, craniomaxillary or craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull is payable for medically necessary eligible charges limited to:

1. A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation, as necessary;
2. Diagnostic x-rays;
3. Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic procedure is performed on the same date of service;
4. Therapeutic injections;
5. Orthotic appliance for therapy utilizing an appliance that does not permanently alter tooth position, jaw position, or the bite. Benefits for appliance therapy are limited to use of a single appliance, including jaw relations, bite registration, training, office visits, adjustments and repairs; and
6. Surgical treatment of TMJ.

**Nursing Services**

1. **Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN)** for professional nursing services.
2. **Inpatient private duty nursing** will be limited to medically necessary services.
3. **Advanced Nurse Practitioner (ANP)** for nursing services including charges as an assistant in surgery. If assisting in surgery, the ANP must meet eligibility guidelines.
4. **Registered Nurse First Assistant (RNFA)** if assisting in surgery. The RNFA must meet eligibility guidelines.

**Nutritional Counseling** – services provided by a licensed dietitian or certified diabetes educator up to Reasonable and Customary; subject to the benefit maximum. *(Refer to the SBC.)*

**Oophorectomy** – evidence-based genetic testing for ovaries with positive results will be required before a prophylactic oophorectomy will be considered as an eligible benefit.
Oral Surgery – limited to the following maxillofacial surgical procedures:

1. The excision of non-dental-related neoplasms, including benign tumors and cysts and situations where proper medical evidence indicates a tumor or cyst is present and all malignant lesions and growths;
2. The incision and drainage of facial cellulitis;
3. Surgical procedures involving salivary glands and ducts and non-dental-related procedures of the accessory sinuses;
4. Reduction of a dislocation of, excision of, and injection of the temporomandibular joint (TMJ);
5. Repair or alleviation of damage to sound natural teeth caused solely by accidental bodily injury, other than a chewing injury, treated within twelve (12) months of the injury; and
6. Eligible anesthesia, medical professional, and facility charges for benefit eligible oral surgical procedures.

A pre-determination of benefits is recommended for any other dental-related service requested to be considered under the medical plan.

Orthomolecular Medicine or Chelation Therapy – for acute metal poisoning.

Outpatient Physical, Occupational, and/or Aquatic Therapy – health care services prescribed by a licensed practitioner that help a person restore or keep, learn, or improve skills and functioning for daily living. Outpatient therapy services must be performed or rendered by a licensed physical or occupational therapist; subject to the benefit maximum. (Refer to the SBC.)

Outpatient Speech Therapy – health care services prescribed by a licensed practitioner that help a person restore or keep, learn, or improve skills and functioning for daily living. Outpatient therapy services must be performed by a licensed speech therapist; subject to the benefit maximum. (Refer to the SBC.)

Podiatric Appliances – therapeutic footwear/shoes for the prevention of complications associated with diabetes; subject to the benefit maximum. (Refer to the SBC.)

Prosthetic Bra, Camisole, and Breast Prosthesis – for an oncology-related mastectomy; subject to the benefit maximum. (Refer to the SBC.)

Respiratory Rehabilitation – a program of clinically supervised exercise and intervention designed to strengthen the lungs and improve pulmonary/respiratory functioning; requires Pre-authorization request to Medical Management.

Surgical Sterilization – eligible benefits.

Telehealth Services

1. Medical information that is communicated in real-time with the use of interactive audio and video communications equipment, and is between the treating physician and/or a distant physician or health care specialist with the patient present during the communication.
2. Telemedicine and Telehealth services, which are services by a physician or other licensed health care professional and you when not at the same site. Eligible services will include audio/visual
evaluation and management intervention using eligible plan-recognized telephone evaluation and management procedure codes.

3. We offer contracted telemedicine services through the convenience of phone calls or online video consultation. Services include diagnostic and/or medication management services for many conditions including allergies, cold and flu symptoms, ear infection, and other minor medical conditions, behavioral health services including: MD initial visit, counseling services, MD follow-up visit, and dermatology MD visits.

**Testosterone Injections** for evidence-based hormonal imbalance.

**Ultrasound and/or Sonograms for pregnancy** – medically necessary services are a covered benefit.

**Wig** – for oncology-related hair loss; subject to the benefit maximum as stated in the SBC.
Preventive/Routine Care Benefit (Calendar Year Biometric Screenings)

The following will be processed for Network reimbursement at 100% of Network allowable. Non-Network provider-eligible billings will be subject to Reasonable and Customary charges and are subject to the Non-Network deductible and co-insurance. To be considered as an eligible preventive/routine care benefit, the provider’s bill must designate or outline a routine diagnosis code. These measures represent important areas for quality improvement by assessing the use of services that are recommendations by the U.S. Preventive Services Task Force (USPSTF) and other national organizations.

Colorectal Exam Benefit

The following will be processed for In-Network reimbursement at 100% of In-Network allowable. Out-of-Network provider-eligible billings will be subject to Reasonable and Customary charges and are subject to the Out-of-Network deductible and co-insurance. To be considered as an eligible preventive/routine care benefit, the provider’s bill must designate or outline a routine diagnosis code.

This benefit will include routine and diagnostic colorectal examinations.

Colorectal examination - coverage for medically-recognized screening examination for the detection of colorectal cancer. This includes colonoscopy (recommended to be performed every ten (10) years); or a fecal occult blood test performed annually and a flexible sigmoidoscopy (examination of the large intestine) recommended to be performed every five (5) years starting at age fifty (50).

Biopsy/polyp removal during preventive colonoscopy plans will be included in the 100% of In-Network allowable cost. This benefit excludes coverage for virtual colonoscopies and colorectal screening using DNA markers (i.e. Cologuard).
Preventive/Routine Care Benefits also include:

Women's Preventive Health Services

The following will be processed for in-network reimbursement at 100% of the in-network allowable (unless otherwise specified). The provider’s bill must designate or outline a routine diagnosis code. Out-of-network provider eligible billings will be subject to Reasonable and Customary charges and out-of-network deductible and co-insurance.

Affordable Care Act Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medical Plan</th>
<th>Prescription Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin, low-dose 81 mg/d as preventive medication after twelve (12) weeks of gestation in women who are at high risk for preeclampsia</td>
<td>N/A</td>
<td>$0 cost share</td>
</tr>
<tr>
<td>Contraceptive management, including patient education and counseling</td>
<td>$0 cost share</td>
<td>N/A</td>
</tr>
<tr>
<td>Diaphragm (cervical), Hormone Vaginal Ring, Hormone Patch, Cervical Cap, Spermicides, Sponges</td>
<td>N/A</td>
<td>$0 cost share</td>
</tr>
<tr>
<td>Diaphragm (cervical) instruction and fitting fee</td>
<td>$0 cost share</td>
<td>N/A</td>
</tr>
<tr>
<td>Emergency contraceptives</td>
<td>N/A</td>
<td>$0 cost share</td>
</tr>
<tr>
<td>Female condoms</td>
<td>N/A</td>
<td>$0 cost share</td>
</tr>
<tr>
<td>Female surgical sterilization</td>
<td>$0 cost share</td>
<td>N/A</td>
</tr>
<tr>
<td>Folic Acid supplements for women who may become pregnant</td>
<td>N/A</td>
<td>$0 cost share</td>
</tr>
<tr>
<td>Implant device</td>
<td>$0 cost share</td>
<td>$0 cost share</td>
</tr>
<tr>
<td>Injectable administration fee</td>
<td>$0 cost share</td>
<td>N/A</td>
</tr>
<tr>
<td>Injectable contraceptives</td>
<td>$0 cost share</td>
<td>$0 cost share</td>
</tr>
<tr>
<td>Insertion and/or removal of contraceptive devices</td>
<td>$0 cost share</td>
<td>N/A</td>
</tr>
<tr>
<td>IUD device</td>
<td>$0 cost share</td>
<td>$0 cost share</td>
</tr>
<tr>
<td>Medications for risk reduction of breast cancer in women who are at increased risk for breast cancer and at low risk for adverse medication effects: Tamoxifen or Raloxifene</td>
<td>N/A</td>
<td>$0 cost share</td>
</tr>
<tr>
<td>Oral contraceptives, generic</td>
<td>N/A</td>
<td>$0 cost share</td>
</tr>
<tr>
<td>Over-The-Counter (OTC) contraceptives (contraceptive films, foams, gels)</td>
<td>N/A</td>
<td>$0 cost share</td>
</tr>
<tr>
<td>Permanent Implantable Contraceptive Coil and hysterosalpingography services related to the fitting</td>
<td>$0 cost share</td>
<td>N/A</td>
</tr>
<tr>
<td>Urine pregnancy test, Urinalysis, Sonogram to detect placement of device</td>
<td>$0 cost share</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## Adult Preventive/Routine Care Benefits

### Abdominal aortic aneurysm one-time screening by ultrasonography in men recommended for ages sixty-seven (67) to seventy-five (75) who have ever smoked

### Anemia screening for asymptomatic pregnant women and children

### Annual examination

Aspirin for the primary prevention of cardiovascular disease and colorectal cancer in adults ages fifty (50) to fifty-nine (59) years who have a 10% or greater ten (10) year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least ten (10) years, and are willing to take low-dose aspirin daily for at least ten (10) years (covered under the prescription plan)

### Bacteriuria urinary tract or other infection lab screening for pregnant women

### Blood pressure screening in adults ages eighteen (18) years or older (included with the office visit)

### Bone Density (Osteoporosis) screening for postmenopausal women younger than sixty-five (65) who are at increased risk of osteoporosis and women sixty-five (65) years and older

### BRCA risk assessment and genetic counseling/testing for women who have family members with breast, ovarian, tubal, or peritoneal cancer with screening tools designed to identify a family history that may be associated with an increased risk of having a potentially harmful gene mutation must receive coverage without cost-sharing for genetic counseling; and, if indicated, testing for harmful BRCA mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2)

### Chlamydia infection lab screening for all sexually active non-pregnant and pregnant women

### Cholesterol lab screening for adults of certain ages or at higher risk

### Comprehensive metabolic lab test

### Counseling intervention for women at increased risk of perinatal depression (included in the office visit)

### Counseling services for alcohol misuse and drug use screening and behavioral counseling interventions to reduce alcohol misuse for adolescents

### Counseling visit to discuss lung cancer screening using low-dose CT scans

### Depression screening

### Diabetes lab screening for abnormal blood glucose as part of cardiovascular risk assessment in adults recommended for ages forty (40) to seventy (70) years who are overweight or obese

### Dietary counseling for members with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease

### Domestic and interpersonal violence screening and counseling for all women

### Electrocardiogram (ECG), routine with at least twelve (12) leads, w/interpretation and report

### Falls prevention – exercise interventions to prevent falls in community-dwelling adults sixty-five (65) years or older who are at increased risk for falls (included in office visit)

### General Health lab panel

### Gestational diabetes lab screening for symptomatic pregnant women after twenty-four (24) weeks of gestation

### Gonorrhea lab screening for sexually active women

### Hearing screening

### Hemoglobin glycosylated lab (HbA1c)

### Hepatitis B virus infection lab screening for pregnant women

### Hepatitis B virus infection lab screening in persons at high risk for infection

### Hepatitis C virus infection lab screening in persons at high risk for infection

### HIV and sexually transmitted infection disease counseling

### HIV lab screening for all pregnant women
<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency/Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV lab screening</td>
<td>Recommended for everyone ages fifteen (15) to sixty-five (65), and other ages at increased risk</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV) DNA lab testing</td>
<td>Recommended every three (3) years for women with normal cytology results, who are age thirty (30) years or older</td>
</tr>
<tr>
<td>Hypothyroidism and hyperthyroidism lab screening for adults</td>
<td>Lab screening test for cervical cancer recommended every three (3) years, for women under the age of sixty-five (65)</td>
</tr>
<tr>
<td>Lactation counseling, breast pumps, and pump supplies for breastfeeding interventions during pregnancy and after birth to support breastfeeding. Hospital grade breast pumps are subject to pre-authorization rules.</td>
<td></td>
</tr>
<tr>
<td>Lung cancer screening</td>
<td>Recommended for adults ages fifty-five (55) to eighty (80) at high risk for lung cancer because they’re heavy smokers or have quit in the past fifteen (15) years. Not covered once a person has not smoked for fifteen (15) years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.</td>
</tr>
<tr>
<td>Mammograms screening</td>
<td>Recommended every one (1) to two (2) years for women beginning at age forty (40)</td>
</tr>
<tr>
<td>Maternal depression screening</td>
<td>Recommended for mothers of infants at one (1), two (2), four (4), and six (6) month visits</td>
</tr>
<tr>
<td>Obesity screening and counseling</td>
<td>Physical examination for the detection of prostate cancer and Prostate Specific Antigen (PSA) lab test recommended for males who are at least fifty (50) years of age and asymptomatic or at least forty (40) years of age and have a family history of prostate cancer or another prostate cancer risk factor</td>
</tr>
<tr>
<td>Preeclampsia screening</td>
<td>Screening in pregnancy by blood pressure measurements (included in office visit)</td>
</tr>
<tr>
<td>Rh(D) blood typing and antibody lab testing for pregnant women</td>
<td></td>
</tr>
<tr>
<td>Rubella lab screening</td>
<td></td>
</tr>
<tr>
<td>Skin cancer counseling</td>
<td>Recommended for young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation recommended for everyone ages six (6) months to twenty-four (24) years with fair skin types to reduce their risk of skin cancer</td>
</tr>
<tr>
<td>Statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages forty (40) to seventy-five (75) years; 2) they have one (1) or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated ten (10) year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of ten (10) year CVD event risk requires universal lipids screening in adults ages forty (40) to seventy-five (75) years (covered under the prescription plan)</td>
<td></td>
</tr>
<tr>
<td>Syphilis screening</td>
<td>Screening for adults at higher risk and all pregnant women</td>
</tr>
<tr>
<td>Tobacco use counseling and interventions</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis screening (TB test)</td>
<td></td>
</tr>
<tr>
<td>Urinalysis</td>
<td></td>
</tr>
<tr>
<td>Well-woman visit to obtain recommended preventive services</td>
<td></td>
</tr>
</tbody>
</table>
Children’s Preventive/Routine Care Benefits

Autism screening, eighteen (18) and twenty-four (24) months of age

Behavioral assessments recommended for children ages: zero (0) to eleven (11) months, one (1) to four (4) years, five (5) to ten (10) years, eleven (11) to fourteen (14) years, fifteen (15) to seventeen (17) years

Bilirubin concentration screening for newborn

Blood pressure screening for children ages zero (0) to eleven (11) months, one (1) to four (4) years, five (5) to ten (10) years, eleven (11) to fourteen (14) years, fifteen (15) to seventeen (17) years (included in office visit)

Blood screening for newborns

Cervical dysplasia screening for sexually active females

Congenital heart defect screening for newborns (included in primary procedure)

Dental screening to assess for dental home and to recommend one if necessary (included in well baby/well child office visit)

Depression screening in adolescents ages twelve (12) to eighteen (18) years

Developmental screening recommended for children under three (3) years of age

Dyslipidemia for children at higher risk of lipid disorders per recommendations of National Institute of Health

Fluoride supplementation to prevent dental caries for infants and children starting at the age of primary tooth eruption; fluoride supplementation starting at six (6) months of age whose primary water source is deficient in fluoride; application of topical fluoride varnish to age five (5) of age

Gonorrhea prophylactic ocular topical medication (newborns)

Hearing screening (newborn); and also recommended for children once between eleven (11) and fourteen (14) years, once between fifteen (15) and seventeen (17) years, and once between eighteen (18) and twenty-one (21) years

Height, weight, and body mass index (BMI) measurements for children ages: zero (0) to eleven (11) months, one (1) to four (4) years, five (5) to ten (10) years, eleven (11) to fourteen (14) years, fifteen (15) to seventeen (17) years (included in well baby/well child office visit)

Hematocrit or hemoglobin screening for all children

Hemoglobinopathies or sickle cell disease screening for newborns

Hypothyroidism screening for newborns

Iron supplements for asymptomatic children ages six (6) to twelve (12) months

Lead screening for children at risk of exposure

Medical history for all children throughout development ages: zero (0) to eleven (11) months, one (1) to four (4) years, five (5) to ten (10) years, eleven (11) to fourteen (14) years, fifteen (15) to seventeen (17) years (included in well baby/well child office visit)

Oral health risk assessment for young children ages: zero (0) to eleven (11) months, one (1) to four (4) years, five (5) to ten (10) years (included in well baby/well child office visit)

Phenylketonuria (PKU) screening for newborns

Screening for Visual Acuity, ages three (3) to five (5)

Sexually transmitted infections screening per recommendations in current edition of AAP Red Book: Report of the Committee on Infectious Diseases

TB testing for children at higher risk of tuberculosis ages: zero (0) to eleven (11) months, one (1) to four (4) years, five (5) to ten (10) years, eleven (11) to fourteen (14) years, fifteen (15) to seventeen (17) years

Tobacco, alcohol, or drug use assessment beginning at age eleven (11)

Visual Acuity screening for age three (3) through age (4), all other vision screenings children included in well baby/well child office visit

Well Baby Care/Well Child Care office visit
Immunizations

The following In-Network eligible immunizations and administrative fees are reimbursable at 100% of the allowable. Non-mandated childhood immunizations received from an Out-of-Network provider will be subject to Reasonable and Customary charges and are subject to the Out-of-Network deductible and co-insurance. Allergy injections and expenses related to routine newborn care are not considered as part of this benefit. To be considered under this benefit, the provider’s bill must designate a routine diagnosis code. This list is a guideline. Travel vaccinations, for example, yellow fever, typhoid, dengue, and Japanese encephalitis are eligible benefits under the Medical Benefit Plan, subject to major medical benefits.

Immunizations/Inoculations

- Diphtheria and Tetanus Toxoids (DT)*
- DtaP Diphtheria, Tetanus Toxoids, and Pertussis*
- Haemophilus Influenza B (HIB)
- Hepatitis A and Hepatitis B*
- Herpes Zoster
- Human Papillomavirus (HPV)
- Influenza (flu shot)
- Measles, Mumps, Rubella (MMR booster)*
- Meningococcal*
- Oral Polio*
- Pediarix (Diphtheria and Tetanus Toxoids and Acellular*)
- Pertussis Absorbed, Hepatitis B (Recombinant) and Inactivated Poliovirus Vaccine Combined)*
- Pneumococcal (Pneumonia)
- Rotavirus
- Shingles Vaccine
- Td (Tetanus) booster*
- Varicella Vaccine (Chicken Pox)*

Any other immunization required by Federal or State law or regulation

* Mandated Childhood Immunization
Weight-Loss Counseling

This plan offers a ten week online behavioral counseling program through our partner Naturally Slim for weight management. To be eligible to participate, you must be eighteen (18) years or older, have a body mass index (BMI) of thirty (30) or higher, or twenty-five (25) to twenty-nine (29) BMI with metabolic syndrome risk factors, and your employer must sponsor/participate in the program. **There is no cost to participate in this program.**

This simple online program uses videos and learning tools to teach you how to lose weight and improve your health. It is available via your desktop, laptop, or mobile device including apps for both iPhone and Android devices.

Hospice Care Benefit

*(Please see Pre-authorization Requirements.)*

We will pay for the Reasonable and Customary charges for hospice care services provided in accordance with a hospice care program to terminally ill Covered Individuals.

Medical Management must receive Pre-authorization prior to hospice care commencement for inpatient services; subject to the benefit maximum. *(Refer to the SBC.)*

Hospice care must be established, approved, and reviewed in writing by the attending physician and 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; and
4. the terminally ill person’s Physician has estimated life expectancy to be six (6) months or less.
Home Health Care Benefit

(Please see Pre-authorization Requirements.)

To be an Eligible Benefit, a home health care plan must be in writing and ordered by the attending Physician. Medical Management must receive a Pre-authorization request 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 and certifies that the patient is confined to his/her home (homebound). Home health care charges are paid subject to the benefit maximum. (Refer to the SBC.)

The maximum payable per visit is $100 for professional services. Custodial care is excluded. Multiple professional visits in a single day may be arranged by Medical Management.

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 RN;
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 you are homebound and Physician homebound intervention is appropriate.

If prescription medication is part of the home health care plan, please refer to the Prescription Drug Plan Booklet for more information.

Nutritional Counseling and therapy services (physical, speech, occupational, or aquatic) performed in the home setting will accumulate to the appropriate benefit maximum. (Refer to the SBC.)

Transplant Benefit

Transplant benefits provided at an Optum Health/Centers of Excellence/Designated Transplant Center differ from those provided at a Non-Designated Transplant Center. At least ten (10) working days prior to any pre-transplant evaluation, the Covered Individual or a family member must provide a Pre-authorization request to Medical Management; failure to do so will result in a Late Pre-authorization Penalty of $400 or a reduction in benefits.

If your treatment plan changes, the Health Care Provider must provide a Pre-authorization request to Medical Management at (800) 282-5385. Medical 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 Management approval and Plan limitations. Under this provision, the term Transplant includes the pre-transplant evaluation, procurement, the transplant itself and one (1) year of post-transplant follow-up care, excluding outpatient prescription drugs covered elsewhere under the Plan.

Transplant benefits are subject to the deductible and co-insurance on the SBC as long as services are provided by an Optum Health Network physician at an Optum Health/Centers of Excellence/Designated Transplant Center and approved by Medical Management.

**Non-Designated Transplant Center**

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

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

**Transplant Center**

The transplant services must be performed at an Optum Health Centers of Excellence Centers. A list of Optum Health Transplant Centers of Excellence may be obtained from Medical Management.

This benefit will cover charges resulting from organ transplantation for:

1. $15,000 maximum paid per transplant that includes all food, travel and lodging costs for the recipient and an adult companion (if more than seventy-five (75) miles one way to the designated transplant facility from place of employment).

2. Travel reimbursement:
   a. 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.
   b. The Plan provides for ground or air transportation of you to and from the pre-transplant evaluation, organ transplantation, and any other Eligible Benefit or follow-up appointment.
   c. The Plan provides for ground or air transportation of each eligible companion to and from the pre-transplant evaluation, organ transplantation, and any other eligible provider services or follow-up appointment.
   d. food for the covered transplant recipient and eligible companion
   e. Receipts will be required for reimbursement and submitted on an Expense Activity Report.

3. Organ transportation;

4. Donor medical benefits not covered under the donor’s plan of benefits;

5. Locating and preserving the tissue for the transplant procedure;

6. Fees for maintenance on an organ transplant waiting list.
**Morbid Obesity Benefit**

Bariatric Surgery: Morbid Obesity Services after the approved six (6) consecutive months (within the most recent twelve (12) months) physician supervised weight management treatment plan with a psychiatric evaluation.

Morbid Obesity is defined as a condition for which a Covered Individual, eighteen (18) years of age or older, is 200% over ideal weight or 100 pounds overweight with a Body Mass Index (BMI) of greater than 35. A Pre-authorization Review is required to review the eligibility for the medically evidence-based surgical procedure. This review requires documentation of six (6) consecutive months (within the most recent twelve (12) months) physician-supervised weight management program including psychiatric evaluation.

You, the treating physician, or a family member must provide information for the Medical Management Pre-authorization review. Failure to do so will result in no benefit coverage for morbid obesity services. Medically evidence-based morbid obesity treatment will be an eligible benefit subject to the lifetime maximum morbid obesity benefit limitation. *(Refer to the SBC.)*

Morbid Obesity treatment will not be eligible for individuals with a substance use disorder who do not have Physician-documented six (6) consecutive months (within the most recent twelve (12) months) of recovery. Morbid Obesity treatment procedures are not eligible if the procedure is an Unproven Medical Procedure as defined in this booklet.

**Non-Designated Morbid Obesity Center**

A non-accredited, Out-of-Network UnitedHealthcare Choice Plus, and non-designated Center of Excellence facility will not be eligible for benefit Plan consideration nor any related services. This includes any non-emergent complications or skin removal related to the original surgery.

**Mental Health Conditions**

The Plan provides benefits for the treatment of mental health conditions. Expenses for the treatment of serious mental health conditions are considered the same as any other illness for the Plan’s deductible and co-insurance as stated in the SBC. Expenses not considered as serious mental health conditions will be subject to the Plan’s co-insurance. An order by a court or state agency for treatment is not an indication of eligibility.

**Outpatient Treatment**

The Plan will reimburse up to twenty-six (26) individual visits or group therapy sessions per calendar year for the eligible treatment of a mental health condition. Medication checks and psychological testing do not accumulate to the twenty-six (26) individual visits.
Intensive Outpatient Therapy Program

Intensive outpatient therapy individual visits or group sessions will accumulate to the outpatient visit benefit of twenty-six (26) calendar year visits. The program must treat you for either sixteen (16) hours per week or for a four (4) hour daily session.

Inpatient Treatment

An inpatient confinement requires a Pre-authorization request to Medical Management. Please see the Pre-authorization requirements in the Medical Management section. The Plan will reimburse up to fourteen (14) inpatient days each calendar year for the eligible treatment of a mental health condition.

Alternative Settings Benefit

Residential Treatment requires a Pre-authorization request to Medical Management. Please see the Pre-authorization requirements in the Medical Management section.

The Plan will reimburse up to seven (7) alternative setting days each calendar year for the eligible treatment of mental health conditions while confined in a residential treatment center and are subject to the following restrictions:

1. you must have a mental health condition which would otherwise necessitate hospital confinement;
2. services must be based on an individual treatment plan; and
3. providers of services must be properly licensed.

Day Treatment

The Plan will reimburse up to fourteen (14) day treatment visits per calendar year. The facility must treat you for a minimum of four (4) hours in any twenty-four (24) hour period and a minimum of five (5) days per week. The attending Physician must document that such treatment is in lieu of hospitalization. A Pre-authorization request to Medical Management is required. Please see the Pre-authorization requirements in the Medical Management section.

Serious Mental Health Illness

Expenses incurred by you for treatment of “Serious Mental Health Illness” are payable as any other illness. The term “Serious Mental Illness” means the following mental health conditions as defined by the American Psychiatric Association in the latest version of the Diagnostic and Statistical Manual (DSM):

1. Schizophrenia;
2. Paranoid and other psychotic disorders;
3. Bipolar disorders (mixed, manic, depressive, and hypomanic);
4. Major Depressive disorders (single episode or recurrent);
5. Schizo-affective disorders (bipolar or depressive);
6. Obsessive Compulsive disorders (OCD); and
7. Depression in childhood and adolescence.
**Substance Use Disorder Benefit**

The Plan provides benefits for the treatment of substance use disorders. The substance use disorder benefit is limited to a maximum of three (3) lifetime treatment series that may include: inpatient detoxification, inpatient rehabilitation or treatment, partial hospitalization, intensive outpatient treatment, outpatient treatment, or a series of those levels of treatments without a lapse in treatment in excess of thirty (30) days. An order by a court or state agency for treatment is not an indication of eligibility for benefits under the plan.

**Outpatient Treatment Series**

The Plan will reimburse up to twenty-six (26) individual visits or group therapy sessions for the eligible treatment of a substance use disorder. Medication checks and psychological testing do not accumulate to the twenty-six (26) individual visits.

**Intensive Outpatient Therapy Program**

Intensive outpatient therapy individual visits or group sessions will accumulate to the outpatient visit benefit of twenty-six (26) visits. The program must treat you for either sixteen (16) hours per week or for a four (4) hour daily session.

**Inpatient Treatment Series**

All inpatient confinements require a Pre-authorization request to Medical Management. Please see the Pre-authorization requirements in the Medical Management section. The Plan will reimburse up to fourteen (14) inpatient days for the medically eligible treatment of a substance use disorder.

**Alternative Settings Benefit**

Residential Treatment requires a Pre-authorization request to Medical Management. Please see the Pre-authorization requirements in the Medical Management section.

The Plan will reimburse up to seven (7) alternative setting days for the eligible treatment of substance use disorders while confined in a residential treatment center and are subject to the following restrictions:
1. you must have a substance use disorder which would otherwise necessitate hospital confinement;
2. services must be based on an individual treatment plan; and
3. providers of services must be properly licensed.

**Day Treatment Series**

The Plan will reimburse up to fourteen (14) days for the eligible treatment of a substance use disorder. The facility must treat you for a minimum of four (4) hours in any twenty-four (24) hour period and a minimum of five (5) days per week. The attending Physician must document that such treatment is in lieu of hospitalization. A Pre-authorization request to Medical Management is required. Please see the Pre-authorization requirements in the Medical Management section.
General Exclusions or Limitations

No benefits shall be payable under any part of the Plan with respect to any charges:

1. for which you are not financially responsible or are submitted only because medical coverage exists or for discounts for which you are not responsible, including but not limited to independent and preferred provider discounts;
2. for services not performed for the diagnosis or treatment of an illness or injury unless covered as part of the Preventive/Routine Care Benefit;
3. for treatment of any injury or illness for which you are not under the regular care of a Physician or does not follow the attending Physician’s treatment plan;
4. for expenses applied under the Plan toward satisfaction of any deductibles, copayments, co-insurance, or access charge, except for maximum out-of-pocket Qualified High Deductible/H.S.A. Health Plans;
5. charges in excess of Reasonable and Customary for services and supplies;
6. for treatment of any injury, illness, or disability resulting from or sustained as a result of being engaged in a felonious act or transaction as defined by Texas law regardless of whether arrested, indicted, or convicted. This exclusion will apply when the felonious act or transaction is proven by a preponderance of the evidence;
7. for treatment of any injury, illness, or disability resulting from or sustained as a result of war or act of war, declared or undeclared;
8. for treatment of injuries resulting from your participation in a riot or insurrection;
9. for treatment of any illness, injury, or disability which (a) was incurred while working for wage, hire, or monetary gain, or (b) could have been available if pursued under benefits for Workers’ Compensation whether or not the Employer is a subscriber or non-subscriber in a Workers’ Compensation Program and whether or not the injured person could have been lawfully covered by workers’ compensation as a volunteer. In applying this exclusion, work on the your family farm or ranch is not considered an employment arrangement;
10. 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);
11. incurred in connection with remediing a condition by means of cosmetic surgery unless otherwise specifically covered under the Plan;
12. prophylactic procedures and/or testing due to family history, unless otherwise specifically covered under the Plan;
13. for vocational evaluation, rehabilitation, or retraining;
14. for custodial care or maintenance care;
15. drug testing services that are not Evidence-Based Medicine or standard of practice;
16. for any services furnished by any institution providing primarily convalescent or custodial care;
17. for repair and maintenance or replacement of Durable Medical Equipment unless identified as an eligible benefit;
18. for home health care expenses that are for:
   a. custodial care;
   b. transportation services; or
   c. any period during which you are not under the continuing care of a Physician;
19. for sex therapy, outpatient group family therapy, marriage counseling, or any other social services unless otherwise specified;
20. connected with the treatment of infertility and assisted reproductive technology including but not limited to artificial, in-vitro, embryo transfer and insemination, or any surgical procedure for the induction of pregnancy;
21. for elective abortions for you except in the case of incest, rape or, situations which are life threatening to the mother;
22. for services and/or medications related to gender, sex, and/or intersex reassignment surgery (transsexual services) including any complications;
23. for treatment, non-surgical, and surgical procedures to reverse sterilization;
24. 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 fixed shower benches; purchase, rental, or modification of motorized transportation equipment, manual or electronic lifts, elevators; escalators, and ramps;
25. for air purification, humidifying, cooling, or heating equipment;
26. for exercising equipment, vibratory equipment, swimming or therapy pools, health club memberships, massage therapy, or hippo therapy;
27. incurred in connection with acupuncture or acupressure;
28. for educational testing, educational therapy, hypnosis, biofeedback, recreational therapy, or any behavior modification and learning disability therapy;
29. for spinography or thermography;
30. for any treatment of the temporomandibular joint (TMJ) or jaw-related neuromuscular conditions not listed as an Eligible Benefit;
31. for care or treatment to the teeth, alveolar processes, gingival tissue, or for malocclusion and/or dental implants, unless eligible under accident benefit;
32. for any drug therapy, treatment, or procedures meeting the definition of an Unproven Medical Procedure as defined in this booklet;
33. for routine foot care services except for diabetic foot care;
34. for cosmetic hair loss treatment;
35. for drugs labeled: "Caution - limited by Federal law to investigational use" or experimental drugs;
36. for drugs and medicines lawfully obtainable without a Physician’s prescription (even if prescribed by a Physician) including but not limited to vitamins, cosmetics, dietary supplements, over-the-counter nutritional formulas used as food replacement, over-the-counter home tests, homeopathic remedies, and/or alternative remedies;
37. for prescription drugs, supplies, and equipment dispensed on an outpatient basis which are covered under a Prescription Drug Program (including lifestyle medications, copayments and any required payment differentials between generic and brand name drugs);
38. for services rendered by any of the following relatives:
   a. spouse;
   b. parent(s), step-parent(s), or parent(s)-in-law;
   c. child(ren) or child(ren)-in-law;
   d. brother(s) or brother(s)-in-law;
   e. sister(s) or sister(s)-in-law;
   f. grandparent(s) or grandparent(s)-in-law;
   g. grandchild(ren) or grandchild(ren)-in-law;
   h. aunt(s) or uncle(s) or aunt(s) -or uncle(s)-in-law;
39. for claims submitted by the retiree or provider more 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 us, 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 our sole discretion;
40. for cryotherapy machine to deliver cold therapy for home use;
41. for treatment of conditions specifically excluded by the Plan and for treatment of conditions incurred as a result of, or due to complications of, a non-covered expense whether medically eligible or not. This exclusion does not apply to pregnancy that is connected with the treatment of infertility and assisted reproductive technology including but not limited to artificial, in-vitro, embryo transfer and insemination, or any surgical procedure for the inducement of pregnancy;
42. for non-custom molded foot orthotics;
43. for services, medication, devices, and supplies relating to the lifestyle treatment of erectile dysfunction, impotence, and decreased libido;
44. for medications purchased in a foreign country if purchased for non-immediate services;
45. for Employer-mandated immunizations, medical services, and medical testing;
46. for charges incurred as a result of travel outside of the United States or its territories specifically to receive medical treatment, unless otherwise specifically covered under the Plan;
47. for virtual colonoscopies or colorectal screening using DNA markers (i.e. Cologuard);
48. HyGleaCare Prep Coverage for colonoscopy;
49. for convalescent care;
50. for take home infusion pumps for intralesional administration of narcotic analgesics and anesthetics and intra-articular administration of narcotic analgesics and anesthetics;
51. for treatment of any injury or illness during any extension of the time period of COBRA which is attributable to the Employer’s failure under the law or as required by contract to give timely notice of a qualifying event;
52. for treatment of any injury or illness during any time period following a lump sum or severance settlement of an employment termination unless COBRA has been elected and then only for the time period required by law under COBRA;
53. for expenses that exceed (in scope, duration, or intensity) that level of care which is needed;
54. for services or treatments that are excluded under any part of the Plan;
55. for services, medication, devices, and supplies that are utilized solely for the accreditation of the facility; or
56. Genetic/Genomic Testing is not eligible for sole purpose of diagnosing. Genetic/Genomic Testing is utilized for treatment. Treatment plan must be submitted.
Dates of Eligibility and Coverage

Enrollment Requirements

The names, social security numbers, genders, and birth dates of all persons in a family enrolling in the Plan will be provided to us on an enrollment form or a change form signed and dated by you and your Employer and received by us. You may be required to submit supporting documentation to show your dependents are eligible under the plan.

If we do not receive the dependent information within the designated eligibility timeline specified, but the Employer provides us with payroll documentation that contributions were deducted from your paycheck appropriately, then we will enroll the dependent per the payroll documentation.

Initial Enrollment (New Hire Enrollment)

To receive coverage, new hires and newly eligible employees and their dependents must enroll in the Plan in a timely manner. We must receive enrollment information within thirty-one (31) days of the date of hire or within thirty-one (31) days of the coverage effective date, whichever is later, regardless if the Employer has a waiting period or a waiting and orientation period. (If the employer has 100% participation in our Plan and pays 100% of the employee’s cost of coverage, we will allow a thirty (30) day grace period for this rule.) If you are not enrolled in a timely manner, you and any dependents cannot be added to the Plan until the next Open Enrollment period or when a Qualified Life Event occurs.

Upon timely enrollment, coverage will begin the later of:
1. the date you became an Active Employee working at least twenty (20) hours per week; or
2. the date you complete any waiting period established by your Employer.

Annual Open Enrollment

During the Open Enrollment period, you can make changes to your enrollment, such as adding or dropping dependents. Changes made during Open Enrollment will become effective on the Plan’s effective date. If the Open Enrollment information is not received by us within the Open Enrollment period, you and your dependents may not be enrolled.

Qualified Life Events

A Qualified Life Event is a change in your situation — like getting married, having a baby, or losing other health coverage — that can make you eligible for a Special Enrollment Period, allowing you to enroll in health benefits outside the annual Open Enrollment Period. Refer to IRS 26 CFR § 1.125-4 - Permitted election changes for a complete list.
Adding dependent coverage

When adding a newborn or newly adopted child, you must make enrollment changes within sixty (60) days. The fact that you have other dependent children or a spouse covered does not automatically extend coverage to a newborn.

When adding dependents due to loss of eligibility, under Medicaid or a State Children’s Health Insurance Program (SCHIP), you must make enrollment changes within sixty (60) days of loss of coverage.

For all other Qualified Life Events, you must make enrollment changes within thirty-one (31) days of the Qualified Life Event date (the date of the QLE). Coverage will become effective on the date of the Qualified Life Event.

We will exempt the following employees from the 100% participation requirement:
1. If you are hired to work for a political subdivision and can provide the Employer with documentation of benefits from prior employment due to retirement;
2. You are accessing a parental healthcare plan to the attained age of twenty-six (26);
3. You choose to be covered under the spouse’s healthcare plan in place of our Plan;
4. You or your spouse are accessing Veteran’s Administration (VA) or TRICARE (Employer-provided financial incentive is disallowed);
5. You choose to be on a Medicare plan with NO financial incentive;
6. You access the coverage offered to tribal members;
7. You access another plan due to Full-Time Equivalency status with two Employers (thirty (30) hours a week, one hundred thirty (130) hours a month or one hundred twenty (120) seasonal days a year).

Dropping dependent coverage

The following events may affect dependent coverage. You are required to notify us within thirty-one (31) days of the below events:
1. marriage;
2. sixty (60) days of the birth or adoption or placement for adoption of a child;
3. divorce of the covered retiree; or
4. death of the covered retiree.

You must notify your Employer if you wish to voluntarily drop dependent coverage. Any drop of a dependent regardless of whether the coverage is paid for pursuant to pre-tax or post-tax payroll deduction will only be allowed following a qualifying event as prescribed by the Internal Revenue Service regulations and on these conditions:
1. any change in coverage must be consistent with the qualifying event; and
2. we are notified in writing within thirty-one (31) calendar days of the event.

Once a dependent has been dropped, he or she cannot be added to the Plan until the next Open Enrollment period or a qualifying event occurs. Forms for reporting these changes are available from your Employer.
Retirement

1. To receive coverage, we must receive the enrollment information within thirty-one (31) days of the commencement of your retirement. If you enroll, coverage will begin the date you become a Retiree.

2. Upon retirement, if you enroll in COBRA the Retiree Medical Benefit will not be an option at the termination of COBRA.

3. Retiree Pool coverage is terminated upon Medicare eligibility age sixty-five (65).

Active Duty Reservists

If covered by the Plan as an employee at the time of call to active duty, active duty reservists or guard members and their covered dependents can maintain eligibility on the Plan for up to twenty-four (24) months as prescribed by and subject to the terms and conditions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). The date on which your absence begins is the qualifying event for COBRA to be offered to the reservist or guard member.

If a firefighter 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 firefighter or police officer was called to active military duty until the municipality receives written instructions from the firefighter or police officer to change or discontinue the coverage. Such instruction shall be provided no later than sixty (60) days following the Qualifying Event. If no such instruction is given, then coverage will terminate on the sixty-first (61st) day, which shall then become the Qualifying Event for COBRA purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

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

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

If you will be on active duty for thirty-one (31) days or less, the Employer will keep you on the Plan with no change in coverage. If you will be on active duty for more than thirty-one (31) days, the Employer will notify us of the qualifying event and submit a copy of your written order for call to duty.

If we administer COBRA, the Employer must notify us by sending a Qualifying Event Notice and mark the qualifying event “Called to Active Duty” and attach a copy of your written order for the call to duty.

If the Employer administers their own COBRA, the Employer must notify us of the termination if call to active duty is more than thirty-one (31) days. The Employer is responsible for all required notices.
Section 143.072, Texas Local Government Code may require an Employer to “continue to maintain” coverage on a police officer or firefighter while he/she is on military leave if the Employer has adopted civil service requirements and the leave has been approved by the Firefighters’ and Police Officers’ Civil Service Commission. This section only applies if the Employer meets the requirements of Chapter 143 of that Code, including having a population of 10,000 or more and voted to adopt the applicable provisions of the law.

For you, nineteen (19) years of age or older, to return to the Employer’s Plan and continue your benefits with no waiting period, you 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 you when called to active duty.
Termination Date of Coverage

The Plan excludes payment for any service of any type incurred after coverage ends. For information concerning your right to continuation of medical coverage, please refer to the sections in the booklet on COBRA. Once a Retiree moves to COBRA and COBRA terminates, the Retiree is not eligible for our Retiree benefits.

Rescission of Coverage

Rescission of coverage is the cancellation or discontinuance of coverage retroactive to a previous date. For example, cancellation of your coverage back to the effective date because you did not meet the eligibility requirements of the Plan is a rescission.

The Plan will not rescind your or Employer’s coverage except in the case of fraud, intentional misrepresentation of material fact, or failure to pay for coverage. If the Plan does rescind coverage, we will send a notice to affected individuals thirty (30) days prior to rescinding the coverage.

Coverage will terminate for you and/or your dependent(s) on the earliest of:

1. the end of the month your employment terminates;
2. the end of the month in which you cease to be an Active Employee;
3. the end of the month in which you are no longer eligible for coverage;
4. the date the group benefit Plan terminates coverage with the Employer; or
5. the date your Employer is no longer participating under the Plan;
6. the date your dependent becomes enrolled in Medicaid;
7. the end of the month in which your dependent child attains age twenty-six (26), unless they are physically or mentally incapacitated
8. the end of the month dependent coverage is voluntarily dropped pursuant to a qualifying event as prescribed by the Internal Revenue Service regulations provided we receive written notice within thirty-one (31) days of the event.
9. the end of the month in which the retiree coverage is voluntarily dropped;

Coverage for a dependent cannot extend beyond the date coverage for you ends, unless required by Section 615.071 of Chapter 615 of the Government Code for survivors of certain employees described in Section 615.003 of the Chapter who are killed in the line of duty. Section 615.075(c) requires that the survivor must give the Employer notice of election to purchase coverage within one hundred eighty (180) days of the decedent’s death.
Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

Introduction

You’re getting this notice because you have recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA, which is a temporary extension of coverage under the Plan. This notice explains COBRA, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA.

The right to COBRA was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA can become available to you and other members of your family when your group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan booklet or contact TML Health, PO Box 149190, Austin, Texas 78714-9190 or by telephone (800) 282-5385.

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

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

What is COBRA?

COBRA is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA may be required to pay for coverage depending on the policy of your Employer.

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

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

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

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage for any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

**When is COBRA available?**

The Plan will offer COBRA to qualified beneficiaries only after we have been notified that a qualifying event has occurred. The Employer must notify us of the following qualifying events:

1. The end of employment or reduction of hours of employment;
2. Death of the employee;
3. Commencement of a proceeding in bankruptcy with respect to the employer; or

**You must give notice of some Qualifying Events**

For all other qualifying events (divorce or legal separation of you and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify us within sixty (60) days after the qualifying event occurs. You must provide notice to: TML Health, PO Box 149190, Austin, Texas 78714-9190 or by telephone (800) 282-5385.
How is COBRA provided?

Once we receive notice that a qualifying event has occurred, COBRA will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA. You may elect COBRA on behalf of your spouse, and parents may elect COBRA on behalf of their children.

COBRA is a temporary continuation of coverage. When the qualifying event is the death of the employee, your becoming entitled to Medicare benefits (Part A, Part B and/or Part C), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA 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 your hours of employment, and you became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA for qualified beneficiaries other than you lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight (8) months before the date on which your employment terminates, COBRA for your 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 your hours of employment, COBRA generally lasts for only up to a total of eighteen (18) months. There are three (3) ways in which this eighteen (18) month period of COBRA can be extended.

Active Duty Reservists extension of COBRA

If covered by the Plan as an employee at the time of call to active duty, active duty reservists or guard members and their covered dependents can maintain eligibility on the Plan for up to twenty-four (24) months as prescribed by and subject to the terms and conditions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). The date on which your absence begins is the qualifying event for COBRA to be offered to the reservist or guard member.

If a firefighter or police officer is called to active duty for any period, the Employer must continue to maintain any health, dental, or life coverage received on the date the firefighter or police officer was called to active military duty until the Employer receives written instructions from the firefighter or police officer to change or discontinue the coverage. Such instruction shall be provided no later than sixty (60) days following the Qualifying Event.

If no such instruction is given, then coverage will terminate on the sixty-first (61st) day, which shall then become the Qualifying Event for COBRA purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

In administering this coverage, we will follow the time guidelines of COBRA under 42 U.S.C.A.300bb-1 et seq. To qualify for this coverage, you must give written notice to the Employer within sixty (60) days of the qualifying event. The Employer member must notify us that you have been called to active duty and submit a copy of the Employer member’s active reservist policy to us.
Disability extension of COBRA

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify us within sixty (60) days of that determination, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA for a total maximum of twenty-nine (29) months. The disability must start at some time before the sixtieth (60th) day of COBRA and must last at least until the end of the eighteen (18) or twenty-four (24) month period of COBRA. You may contact us about a disability determination at PO Box 149190, Austin, Texas 78714-9190 or by telephone (800) 282-5385.

Second Qualifying Event extension of COBRA

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

Are there other coverage options besides COBRA?

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

Adding dependents

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

Coverage will terminate on the earliest of:
1. the end of the month you voluntarily drop coverage;
2. the last day for which any required COBRA contribution is made;
3. the date the required period of COBRA expires;
4. the date you become covered under another group plan, (If you were covered by another health plan before electing COBRA, including Medicare (under Part A, Part B, or Part C), coverage under that plan does not affect your eligibility for COBRA.);
5. the date you become entitled to Medicare; or
6. the date the former Employer no longer provides group coverage to any other employees.

Once a Retiree moves to COBRA and COBRA terminates, the Retiree is not eligible for our Retiree benefits. Please refer to the COBRA section of this booklet for more information.

COBRA is the legal obligation of your Employer and not us. Once your Employer terminates coverage, any notices of qualifying events should be sent to your Employer who has the responsibility to notify your COBRA administrator.

If you have questions

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

- www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_fact_sheet.html; or
- www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html#COBRA

Keep your plan informed of address changes

In order to protect your family’s rights, you should keep us informed of any changes in addresses of family members. You should also keep a copy, for your records, of any notices you send to your Employer and us.
Non-Duplication of Benefits

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

Coordination of Benefits (COB)

This plan includes a COB provision that determines how benefits will be paid when you or your dependent is covered by more than one group health plan. When you have other group medical coverage (through your spouse’s employer, for example), your benefits paid under this plan may be combined with others to pay covered charges. The COB provision eliminates duplicate payments for the same medical expenses. COB does not apply to individual policies.

Under the COB provision, the plan that is required to pay first is called the primary plan. The secondary plan typically makes up the difference between the primary plan's benefit and the covered charge. When one plan does not have a COB provision, that plan is always considered primary and always pays first. COB payments do not always total 100% of charges.

We will pay the difference between the allowable amount and the benefit paid by the primary plan, not to exceed the amount we would have paid in the absence of any other coverage.

Definitions for the Purpose of COB

Closed Panel Plan

A plan that provides benefits primarily in the form of services through a panel of providers that have contracts with, or are employed by the Plan, and excludes coverage for services provided by other providers, except in the case of an emergency or referral by a panel member.

Custodial Parent

The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.
The Plan
The medical benefits provided by your Employer through us.

Other Plan means any of the following arrangements that provide medical benefits or services:
1. insurance or any arrangement of benefits for groups;
2. individual plans that offer medical and hospitalization coverage that qualifies as minimum essential coverage under 26 USC 5000A(f)(1). This would exclude limited reimbursement policies such as supplemental policies under 26 USC 5000A(f)(3);
3. prepayment coverage or any coverage toward the cost of which any Employer makes contributions;
4. a labor-management plan, union welfare plan, Employer organization plan, or retiree organization plan;
5. any governmental program or coverage required by statute;
6. dependent ineligible Employer-sponsored health care benefit information; or
7. non-motor vehicle coverage for expenses due to accidental bodily injury or disease to the extent to which payment as a settlement, judgment, or otherwise is made by any person or their insurers without regard to whether or not liability is admitted.
8. Plan does not include disability income protection coverage; workers’ compensation coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident-only coverage, (including school accident-type coverage); benefits provided in long-term care insurance contracts for non-medical services or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that by law provides benefits that are in excess of those of any private insurance plan; or other non-governmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Primary Plan
A plan that pays Eligible Benefits without regard to the existence of any other Plans.

Secondary Plan
A plan that coordinates payments so that the total payments from all plans shall not exceed 100% of the Plan’s allowable benefit.
### Special Rules

If both plans have a coordination provision, the primary plan will be determined according to the following rules:

<table>
<thead>
<tr>
<th>Rule</th>
<th>We Pay Primary when...</th>
<th>We Pay Secondary when...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rule 1 - Non-Dependent/Dependent:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The benefits of the plan that covers you as an Active Employee is primary to benefits accessed as a dependent.</td>
<td></td>
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</tr>
<tr>
<td><strong>Rule 2a - Dependent Child/Parents, (natural or adoptive), are married or are living together, whether or not they have ever been married:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The benefits of the plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the plan of the parent whose birthday falls later in that Calendar Year</td>
<td>1. Natural or adoptive parent is an employee of our Plan and birthday falls earlier in the year; and</td>
<td>1. Natural or adoptive parent is an employee of our Plan and birthday falls later in the year; and</td>
</tr>
<tr>
<td>2. If both parents have the same birthday, the plan which has covered one parent for the longer period of time will be primary</td>
<td>2. If parents share the same birthday, our Plan has covered the parent for the longest period of time</td>
<td>2. If parents share the same birthday, our Plan has covered the parent for the shortest period of time</td>
</tr>
</tbody>
</table>

| 2b - **Dependent Child/Parents, (natural or adoptive), are divorced or separated or not living together, whether or not they have ever been married:** | | |
| 1. Dependent child covered under both parents’ group health plans. If a court decree states both parents have responsibility for the health care expenses or health care coverage: The benefits of the plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the plan of the parent whose birthday falls later in that Calendar Year; | 1. Natural or adoptive parent is an employee of our Plan and birthday falls earlier in the year; and | 1. Natural or adoptive parent is an employee of our Plan and birthday falls later in the year; and |
| 2. If both parents have the same birthday, the plan which has covered one parent for the longer period of time will be primary | 2. If parents share the same birthday, our Plan has covered the parent for the longest period of time | 2. If parents share the same birthday, our Plan has covered the parent for the shortest period of time |

<p>| 2b - <strong>Dependent Child/Parents, (natural or adoptive), are divorced or separated or not living together, whether or not they have ever been married:</strong> | | |
| If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or | 1. Natural or adoptive parent is an employee of our Plan and birthday falls earlier in the year; and | 1. Natural or adoptive parent is an employee of our Plan and birthday falls later in the year; and |
| 2. If parents share the same birthday, our Plan has covered the parent for | 2. If parents share the same birthday, our Plan has covered the parent for | 2. If parents share the same birthday, our Plan has covered the parent for |</p>
<table>
<thead>
<tr>
<th>Rule</th>
<th>We Pay Primary when...</th>
<th>We Pay Secondary when...</th>
</tr>
</thead>
<tbody>
<tr>
<td>health care coverage of the dependent child, rule 2a will determine the order of benefits</td>
<td>the longest period of time</td>
<td>for the shortest period of time</td>
</tr>
<tr>
<td><strong>2b -</strong> Dependent Child/Parents, (natural or adoptive), are divorced or separated or not living together, whether or not they have ever been married:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Dependent child covered under both parents group health plans and if the court decree expires due to dependent child’s age, the order of benefits for the child are as follows:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. The plan that has covered you for the longest period of time is primary</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2b -</strong> Dependent Child/Parents, (natural or adoptive), are divorced or separated or not living together, whether or not they have ever been married:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Employee of our Plan is the custodial parent; or</td>
<td>1. Employee of non-TML Health plan is either the custodial step parent, non-custodial parent or non-custodial step parent; or</td>
<td></td>
</tr>
<tr>
<td>2. Employee of our Plan is the custodial step parent, (where custodial parent does not cover the dependent child); or</td>
<td>2. Employee of non-TML Health plan is either the non-custodial parent or non-custodial step parent; or</td>
<td></td>
</tr>
<tr>
<td>3. Employee of our Plan is the non-custodial parent, (where custodial parent or step-parent do not cover the dependent child)</td>
<td>3. Employee of non-TML Health plan is the non-custodial step parent</td>
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<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>2b -</strong> If there is no court decree allocating responsibility for the dependent child’s health care expenses or health care coverage, and the dependent child attains the age of nineteen (19) years, the order of benefits for the child are as follows:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The plan that has covered the dependent child for the longest period of time is primary</td>
<td>Our Plan has covered the dependent child for the longest period of time</td>
<td>Our Plan has covered the dependent child for the shortest period of time</td>
</tr>
<tr>
<td><strong>2b -</strong> Individual covered as a dependent child under a natural, adoptive, or step-parent plan and also covered as a dependent under a spouse’s plan. The order of benefits will be determined by the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The plan that has covered the dependent child for the longest period of time is primary</td>
<td>Our Plan has been in effect the longest period of time</td>
<td>Our Plan has been in effect for the shortest period of time</td>
</tr>
<tr>
<td>Rule</td>
<td>We Pay Primary when...</td>
<td>We Pay Secondary when...</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Rule 3 - Active/Inactive Employee:</td>
<td></td>
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</tr>
<tr>
<td>The benefits of the plan that covers you as an Active Employee who is neither laid off nor retired are determined before those of a plan which covers that same person as laid off or retired employee. The same would hold true if you were a dependent of an Active Employee and that same person is a dependent of a Retiree or laid off 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.</td>
<td>Our Plan is the Active Employee Plan</td>
<td>Our Plan is the Retiree Plan (for the same person who is an Active Employee under another plan)</td>
</tr>
<tr>
<td>Rule 4 - COBRA:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. If a person has coverage provided under COBRA pursuant to federal or state law and is also covered under another plan, the following shall be the order of benefit determination:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. First, the benefits of a plan that covers you as an employee, a Member, or a subscriber (or as a dependent of an employee, member, or subscriber).</td>
<td>Our Plan is the Active Employee Plan</td>
<td>Our Plan is the COBRA Plan (for the same person who is an Active Employee under another plan)</td>
</tr>
<tr>
<td>b. Second, the benefits under the COBRA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. This rule does not apply if rule 1 determines the order of benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. If the other plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this paragraph does not apply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rule 5:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If none of the above rules determine the order of benefits, then the plan that has covered you for the longest period of time is primary</td>
<td>Our Plan has covered you for the longest period of time</td>
<td>Our Plan has covered you for the shortest period of time</td>
</tr>
</tbody>
</table>

When a primary plan is a Qualified High Deductible/H.S.A. Health Plan, Coordination of Benefits as the secondary carrier will occur after the IRS Guidance deductible has been satisfied.
Facility of Payment

A payment made under another plan may include an amount that should have been paid under the Plan. If it does, the Plan will pay its full liability for services, and any overpayments received from another plan must be reimbursed directly back to the other plan.

Recovery of COB Overpayments

If the amount of the payments made by the Plan for COB administration is more than it should have paid under this COB provision, it will recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for you. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Other Party Liability

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

Contractual Right of Reimbursement

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

In addition, you specifically delegate to us the right to make a claim or assert a cause of action on your behalf against any source of recoveries, and assign to us the right to any proceeds from the claim or cause of action.

“Source of recovery” shall include, but not be limited to:
1. any third party;
2. any liability or other insurance covering the third party;
3. uninsured motorist, underinsured motorist, no-fault, personal injury protection, or medical payments coverage that is in the name of, paid for, or payable by a non-immediate family member; or
4. any other responsible party. We may seek direct reimbursement for benefit coverage from any source of recovery.
By enrolling in the Plan, you agree to abide by the provisions in one (1) through ten (10) following this paragraph. We may suspend payment of claims for the injury or illness based on the amount of the claim, indication of other insurance, indication there may be another source to pay for the medical services required as a result of the injury or illness, or evidence that the claim may not be covered because it is work-related.

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

1. provide any and all information requested by us to include a completed Accident/Injury questionnaire; and
2. agree in writing not to settle damages whether by legal action, settlement, or otherwise and only after consulting with us to determine the full and potential medical charges; and
3. agree that should you settle for damages as a result of an injury/illness with a third party or insurer, prior to securing such written permission, we and the Employer’s health benefits Plan are relieved of any liability for medical benefits resulting from the injury/illness; and
4. agree that we may provide any medical bills or payment information related to the injury/illness to your attorney, any insurer, or any other person who will be reimbursing us for medical benefits; and
5. agree in writing to reimburse us immediately upon collection of damages whether by legal action, settlement, or otherwise including, but not limited to, uninsured motorist, underinsured motorist, no-fault, personal injury protection, or medical payments coverage that is in the name of, paid for, or payable by a non-immediate family member; and
6. agree in writing to provide us with a right of subrogation on proceeds recovered for this injury to the extent of benefits provided by the Plan; and
7. agree in writing that venue for all subrogation disputes shall be in Travis County, Texas; and
8. agree in writing to provide us with a copy of any settlement agreement relating to this injury/illness if requested; and
9. agree to cooperate fully with us in asserting our right to subrogate. This means you must supply us with all information and sign and return all documents reasonably necessary to carry out our right to recover from the third party any benefits paid under the Plan which are subject to this provision; and
10. agree to all provisions of the benefit Plan.

If you accept reimbursement or assign benefits for an injury or illness for which money or benefits were received or paid by another source, and payment has also been made by us, you must reimburse us the amount paid to you or any provider for services or treatment for the injury or illness. If you do not reimburse us, the amount not reimbursed may be withheld from future benefits.
Automobile/Homeowners Liability and/or Medical Payments Insurance Benefits

Benefits payable under the Plan may be adjusted by us for any insurance benefits available for medical benefits, including no-fault, medical payments, personal injury protection, or uninsured motorist coverage if the coverage for such medical benefits is in the name of, paid for, or payable by a non-immediate family member whether or not any party has admitted liability.

Right of Subrogation

We have the right to seek reimbursement on any overpayment from one or more of the following:

1. you;
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, you specifically delegate to us the right to make a claim or assert a cause of action on your behalf against any source of recovery, and assigns to us the right to any proceeds from the claim or cause of action.

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

Our lack of timely receipt of appropriate subrogation documentation will result in your claim adjudication process being put on hold until appropriate information is received.

Overpayment Provisions

Right of Offset

If we make any payment on behalf of you exceeding the amount needed to satisfy its obligation under the terms of the Plan, then we reserve the right to offset the overpayment against future benefits otherwise payable to you or a provider.

Facility of Payment

When another plan makes a payment which should have been made under the Plan, we reserve the right to decide:

1. whether or not to reimburse the organization making the payment; and
2. the amount to be paid in order to satisfy the intent of this provision.

Any such payment made by us will fulfill our responsibility in the amount paid.
**Fraudulent or Erroneous Billing**

We reserve the right to conduct our own investigation of any person or organization suspected of filing fraudulent claims and to turn over its findings to an authorized governmental agency or department for further investigation and/or prosecution.

**Coordination with Medicare**

*Medicare* is a federal health insurance program for people age sixty-five (65) or older and certain disabled individuals provided by Title XVIII of the Social Security Act, as amended.

**Full Medicare Coverage** is coverage under both Part "A" (Hospital Insurance), Part "B" (Medical Insurance) and/or Part "C" (HMO/Advantage Insurance). If you are entitled to premium-free Part "A", you will be deemed to have full Medicare coverage, even if they have not enrolled in Part "B", Part "C" and/or Part "D".

Who will pay first or primary usually depends on work status of the employee regardless of how many persons the Employer may employ.

<table>
<thead>
<tr>
<th>Status</th>
<th>Age</th>
<th>Primary Plan</th>
<th>Status</th>
<th>Age</th>
<th>Primary Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retired</td>
<td>65+</td>
<td>Medicare</td>
<td>Active</td>
<td>65+</td>
<td>Employer</td>
</tr>
<tr>
<td>Spouse of Retiree</td>
<td>65+</td>
<td>Medicare</td>
<td>Spouse of Active EE</td>
<td>65+</td>
<td>Employer</td>
</tr>
<tr>
<td>Spouse of Retiree</td>
<td>&lt;65</td>
<td>Employer</td>
<td>Spouse of Active EE</td>
<td>&lt;65</td>
<td>Employer</td>
</tr>
</tbody>
</table>

There are special rules for people with permanent kidney failure and persons under sixty-five (65) who have Medicare because of a disability.

If the Plan is primary, the normal benefits payable under the Plan will be paid without regard to Medicare. If Medicare is primary, the combined total payable by full Medicare coverage and the Plan will not exceed the normal benefit payable by the Plan.

If Medicare coverage is due to End Stage Renal Disease, the order of payment shall be determined by applicable federal regulations.

We will determine which plan is primary. The determination is based on your status on the date expenses are incurred.

Even if a person does not enroll for full Medicare coverage or make due claim for Medicare benefits, we will calculate the benefits which would have been paid by full Medicare coverage and adjust the Plan benefits payable accordingly to the Medicare allowed amount.

In cases where a provider has opted out of Medicare where neither the provider nor the beneficiary receives any reimbursement from Medicare, we will calculate the benefits which would have been paid by Medicare coverage (see table above), according to the Medicare allowed amount.

We submit electronic eligibility information to Medicare as required by law and secondary payor regulations.
Definitions

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

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

**Active Employee**
Is an employee who works and is paid by the Employer for at least twenty (20) hours per week as defined by your employer. An employee may retain eligibility for coverage under this Plan if the employee is temporarily absent on leave as defined by the employer’s leave policy, provided that contributions continue to be paid on a timely basis, including but not limited to accessing vacation, sick, personal, paid time off, paid/unpaid Family Medical Leave Act of 1993 (FMLA), sick leave pool, unpaid approved leave, catastrophic leave, emergency leave, or short term disability leave.

In order for any form of leave that is not accrued on a weekly, monthly, annual, or other periodic basis to be considered as vacation, sick, personal, or paid time off leave under the previous paragraph, Member’s leave policy must be (1) in writing, (2) on file with us prior to the start of the Employer’s plan year, and (3) available uniformly to all employees. This non-accruing leave shall include but not be limited to sick pool leave, catastrophic leave, disability leave, non-FMLA medical leave, workers' compensation injury leave, and emergency leave. In order for compensatory time to be considered as actively at work hours, the Member’s compensatory policy must be (1) in writing, on file with us prior to the start of the Employer’s plan year, (2) available uniformly to all employees, (3) clearly documented on each payroll document, and (4) in compliance with U.S. Department of Labor requirements. Employees that do not meet the definition of an Active Employee in the benefit book are not eligible for medical benefits.

An FMLA certification shall extend the period of coverage for Active Employee(s) when the FMLA documentation is provided in writing to us within thirty (30) days of the certification and one hundred and twenty (120) days of the beginning date of the FMLA leave.

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

**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 an Ambulatory Surgery Center.

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

American College of Surgeons Bariatric Surgery Center Network Accreditation Program (ACS BSCN)
Accredits facilities in the United States.

Aquatic Therapy
Services prescribed and performed by a licensed practitioner to restore keep, learn, or improve skills and functions for daily living.

Benefit
The amount payable by the Plan for Eligible Benefits.

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.

Board of Trustees
The Board of Trustees is our governing body as established by Section 172 of the Local Government Code.

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.
Child
The term “child” means:
1. a natural child of the covered employee who is under twenty-six (26) years of age;
2. a legally adopted child of the covered employee (including a child placed with the covered employee for adoption) who is under twenty-six (26) years of age;
3. a stepchild of the covered employee who is under twenty-six (26) years of age;
4. a foster child placed by the state in the covered employee’s care who is under twenty-six (26) years of age;
5. a child under twenty-six (26) years of age for whom the covered employee or spouse is legal guardian or conservator;
6. a child under twenty-six (26) years of age for whom a divorce decree or court order requires the covered employee or spouse to provide healthcare coverage for the child;
7. a child age twenty-six (26) or older, provided the child is totally disabled or incapacitated, see Incapacitated Child; or
8. a grandchild whose naturally born or legally adopted parent is an eligible child/dependent of the covered employee. The term “grandchild” means a person who is a naturally born or legally adopted child of a naturally born or legally adopted child/dependent of the covered employee. A grandchild who is covered by the Plan must be considered as a dependent of the covered employee for support pursuant to federal income tax law. The grandchild will be eligible until the child/dependent of the covered employee attains age twenty-six (26).

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 subscriber identification number, provider’s name, address and tax ID number, national provider identification number, date(s) of service, diagnosis narrative or ICD code, procedure narrative or CPT-4 codes, services and supplies provided, physician name and license number, provider charges and an itemized bill if the bill is in excess of $15,000 outpatient and $20,000 inpatient. Such itemized bill will be required to adjudicate the claim. Claim must be submitted by provider no later than the filing deadline. A “Clean Claim” does not include a claim where coordination of benefits is actively pursued, medical claims review is necessary, subrogation is pursued or where a work related condition may exist.

If the provider fails to submit the claim within compliance of the filing deadline and the clean claim definition, the provider forfeits the right to payment unless the failure to submit the claim in compliance is a result of a catastrophic event that substantially interferes with the normal business operations of the Network provider.
Clinical Trials
Clinical trials are controlled scientific studies designed to assess the effectiveness of procedures, drugs and devices. Typically, clinical trials are performed after a treatment shows promise during limited testing.

1. Phase I Trials – Medical researchers test the drug with a small group of people to discover its metabolic and pharmacologic actions in humans, as well as its safety, dosage and side effects. They also test the impact of increasing doses and early evidence of effectiveness. This trial may include healthy participants or patients.

2. Phase II Trials – This stage is a controlled clinical study that evaluates the effectiveness of the drug for a particular indication or indications in patients with the condition under study. During this stage, researchers test the new drug with a slightly larger group of people (100 to 300) to collect more information about its common short-term side effects, efficacy and risks.

3. Phase III Trials – The third stage expands controlled and uncontrolled trials after preliminary evidence suggests the effectiveness of the drug has been determined. Its purpose is to gather more information to evaluate the overall risk – benefit of the drug and provide a satisfactory basis for physician labeling. Researchers give the drug to an even bigger group (between 1000 to 3000 people) monitor its use, compare it to other treatments and further ensure its safety.

4. Phase IV Trials – Post marketing studies to identify additional uses for an U.S. Food and Drug Administration (FDA) approved medication. The studies also identify the drug’s risks, benefits and optimal use.

5. Well Conducted Clinical Trials – Trials in which two or more treatments are compared to each other, and the patient or provider is not allowed to choose which treatment is received.

Co-insurance
The percentage of costs of covered health care services you pay (20%, for example) after you have paid your deductible.

Concurrent Review
A service provided by Medical Management to review the medical necessity of continued treatment.

Confinement
Recognized as treatment in an inpatient setting accessing inpatient care.

Contribution
The amount payable by the Employer, the amount payable by the Retiree, or the amount payable by the Employer/Retiree jointly for participation in the benefits of the Plan.

Coordination of Benefits
A provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Copay
A specified dollar amount that is your responsibility to pay to a Health Care Provider. Copays are usually connected with specific benefits and may be in addition to or in lieu of the Plan deductible.
Cosmetic Procedures
Procedures performed solely to improve appearance.

Covered Benefits
See Eligible Benefits.

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

Covered Individual
An employee, dependent, Retiree, Retiree dependent, elected official and elected official’s dependent who is eligible and has 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 mental health/substance use disorder 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 mental health/substance use disorder treatment facility that meets all of the following requirements:
1. provides treatment for individuals suffering from acute mental health disorders and/or substance use disorders 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 mental health Facilities and is licensed by the 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 the Plan.

If you are on a Qualified High Deductible/HSA plan and are covering any dependents, the family deductible must be met before the plan will pay. However, once any individual on the plan meets the Federal individual maximum out-of-pocket, the plan will begin to pay for in-network services for that person.
Dentist
Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is a member or eligible member of the state Dental Association or eligible for membership in such association.

Dependent
The spouse or child of a covered employee who is eligible for benefits under the Plan. A spouse or child who does not meet the definition of spouse or child in this benefit booklet is not eligible for medical benefits.

We may request written proof of the eligibility of any dependent. For example, we may request a copy of a child’s birth certificate or a copy of a divorce decree. These requests are to verify eligibility and to determine if the Plan is primary or secondary.

Designated Transplant Center (Centers of Excellence)
An Optum Health Network hospital or facility of a particular organ transplant procedure. The hospital or facility selected must meet all of the following requirements:
1. has performed the transplant procedure regularly/periodically for three (3) or more years; and
2. has a twelve (12) month survival rate of at least eighty percent (80%) for the transplant procedure, with the exception of bone marrow/stem cell transplants.

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

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. Standard model items refer to the base model without added options and/or accessories.

Eligible Benefits
The Reasonable and Customary fees charged for medical service and supplies covered by the 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 Immediate Care.
Emergent/Immediate Care
Benefit eligible services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:
1. Placing the patient’s life in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Employer
An eligible entity under Section 172 of the Local Government Code that is a member of TML Health.

Enroll
To make written application for coverage on the prescribed forms or through an online enrollment system. Enrollment is not completed until accepted by the Employer and received by us within required timelines.

Essential Health Benefits (EHB)
The Patient Protection Affordable Care Act defines essential benefits to include items and services within the following ten (10) benefit categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including mental health treatment, prescription drugs (plan must offer one drug for each USPSTF category and class or the number of drugs in the EHB benchmark Plan), rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services (including pediatric oral and vision screening during a well child visit), and chronic disease management.

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. Such charges are listed in “General Exclusions or Limitations.”

Extenuating Circumstances
If a Covered Person requires care from a specialist care provider, but there is not a Network specialist care provider within a seventy-five (75) mile radius from the employee’s place of business, the provider would be paid at Network benefits subject to U&R allowable amounts.
Family and Medical Leave Act
FMLA provides eligible Retirees up to twelve (12) workweeks (continual and/or intermittent) of unpaid leave a year if they have worked 1,250 hours during the twelve (12) months prior to the start of leave, and requires group health benefits to be maintained during the leave as if Retirees continued to work instead of taking leave. Retirees are also entitled to return to their same or equivalent job at the end of their FMLA leave. The FMLA also provides certain military family leave entitlements. Eligible Retirees may take FMLA leave for specified reasons related to certain military deployments of their family members. Additionally, they may take up to twenty-six (26) weeks of FMLA leave in a single twelve (12) month period to care for a covered service member with a serious injury or illness.

Filing Deadline
The latest date a claim may be received by us in order to be considered eligible for payment. All requested additional information relating to the claim must also be received within the same time frame unless the information is required for contractual prompt pay compliance. The 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 deadlines as determined by us, or within ninety (90) days after a non-compensable claim decision is made by the Employer’s Workers’ Compensation carrier or by the Workers’ Compensation Division of the Texas Department of Insurance, whichever is later.

Genetic Testing
Involves the examination of human DNA for an anomaly associated with a disease or disorder. DNA is taken from a sample of your blood, body fluid, or tissue.
**Habilitation Services**

Habilitation services means skilled, medically necessary, health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitation services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is medically necessary to maintain your current condition or to prevent or slow further decline.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or condition in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be “skilled” simply because there is not an available caregiver.

**Limitations and Exclusions**

- Coverage is excluded for services that are solely educational or vocational in nature or otherwise paid under state or federal law for purely educational services. A service that does not help you to meet or maintain functional goals in a treatment plan within a prescribed time frame is not a habilitative service.
- Coverage is excluded when the patient does not meet criteria for coverage as indicated in the indications for Coverage section above and enrollee specific benefit document.
- Coverage is excluded if the service is considered by us to be Unproven, Investigational or Experimental.
- Coverage is excluded for Custodial care, respite care, day care, therapeutic recreation vocational training, and residential treatment.
- In the absence of a disabling condition, services to improve general physical condition are excluded from coverage.
- Coverage is excluded once the treatment plan goals are met.
- Coverage is excluded for physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. An example includes, but not limited to, the same day combined use of hot packs, ultrasound and iontophoresis in the treatment of strain.
- Coverage is excluded for programs that do not require the supervision of Physician and/or a licensed therapy provider.
- Coverage is excluded for work hardening.
- Coverage is excluded for confinement, treatment, services or supplies that are required: a) only by a court of law, or b) only for insurance, travel, employment, and school or camp purposes.
- Coverage is excluded for services beyond any visit limits specified in the enrollee specific benefit document.
- Coverage is excluded for gym and fitness club memberships and fees, health club fees, exercise equipment or supplies.
- Biofeedback services are excluded.
He, Him, His
Whenever the masculine pronoun is used in the Plan, it shall include the feminine gender as well, unless the context clearly indicates otherwise.

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

Health Insurance Marketplace

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 health care coverage.

Homebound
Physician certification that you are confined to your home is required for home health services. Any absence from the home to receive health care 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 your 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 RN.

Home Health Care Plan
A program for care and treatment:
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) RN 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 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 your 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.

Humanitarian Use Device (HUD)
The coverage determination on an HUD will be made according to the hierarchy of evidence applied towards the evaluation of any technology, in the same way the evaluation would be applied to a service or technology that is FDA approved without a Humanitarian Device Exemption.

If the device is determined to be proven for the use it should be covered; if the device is determined to be unproven for use then it should not be covered.

Illness
Sickness or disease which requires treatment by a licensed Health Care Provider.

Immediate Care
Those benefit-eligible services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:
1. placing your life in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.
Incapacitated Child
A dependent child age twenty-six (26) or older who is mentally or physically incapable of supporting himself/herself and is primarily dependent upon you for financial support. We may require satisfactory proof of the continued incapacity documented as a disability by the Social Security Administration (SSA). We 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 us to have the child examined, then coverage for the child will terminate.

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

Infusion Therapy
Medications administered intravenously (IV).

Injury
See Accidental Injury.

In-Network
Treatment or services rendered by providers that are included as contracted providers in the UnitedHealthcare Choice Plus PPO or Nexus ACO Network as indicated on your SBC.

Inpatient
Treatment or confinement to a medical facility where you have been admitted to the hospital for bed occupancy with the expectation you will remain overnight for the purposes of receiving inpatient hospital services.

Inpatient Physical, Occupational, and/or Aquatic Therapy
Services prescribed and performed by a licensed practitioner to restore, keep, learn, or improve skills and functions for daily living.

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/respiratory, and other special care units.

Intensive Outpatient Therapy
Outpatient mental health substance use disorder treatment of high frequency over a short period of time.

Long Term Acute Care (LTAC) Facility
A long-term acute care hospital that provides extended, intensive medical care to patients who are clinically complex and suffering from multiple acute or chronic conditions. Such patients typically require a longer than usual hospital stay because of the severity of illness or the chronic nature of the disease process.
**Maintenance Care**
All services, equipment, and supplies which are provided solely to maintain your condition and from which no functional improvement can be expected.

**Maternity Care**
The care of women and their children during pregnancy, childbirth, and postnatal.

**Maximum Out-of-Pocket Amount**
The most you will pay for covered services in a calendar year. After you spend this amount on deductibles, copayments, and co-insurance, the plan will pay 100% of the cost of covered benefits.

**Medical Management Services**
A system that includes Pre-authorization, concurrent review, discharge planning, retrospective review of health care services and case management for complex medical conditions. Medical Management Services does not include elective requests for clarification of coverage.

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

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

**Medicare Secondary Reporting Requirements**
Eligibility information will be securely and electronically submitted to Medicare regarding all Covered Individuals.

**Mental Health**
Those conditions or illnesses that are classified by the most recent edition of either a DSM (Diagnostic & Statistical Manual of mental health disorders) diagnostic code or an ICD (International Classification of Disease) code for mental health disorders.
Mental Health/Substance Use Disorder Intensive Outpatient Treatment
Conditions that require more frequent outpatient services in a short period of time; subject to the benefit maximum. *(Refer to the SBC.)*

Mental Health Treatment Facility
A facility constituted and operated under law which includes all of the following:
1. is accredited as a hospital under the Hospital Accreditation Program of the JCAHO;
2. maintains permanent and full-time facilities for care of five (5) or more patients;
3. provides a program for diagnosis, evaluation, and effective treatment of mental health conditions;
4. complies with all licensing and other legal requirements;
5. has a Physician, 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 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.

Non-Accredited Morbid Obesity Treatment Center
A non-accredited, Out-of-Network UnitedHealthcare Choice Plus and non-designated Center of Excellence facility will not be eligible for benefit plan consideration.

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

Nurse Midwife/Certified Professional Midwife (CPM)
A licensed 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.

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

Open Enrollment
The thirty (30) or thirty-one (31) day period prior to the new plan year in which dependents who are not currently covered by the Plan can be added. Coverage for the dependents will become effective on the first day of the new plan year.

Out-of-Network
Treatment or services rendered by providers that are not included as contracted providers in the UnitedHealthcare Choice Plus PPO or Nexus ACO Network as indicated on your SBC. A facility-based physician or other health care practitioner may not be included in Plan’s network, and such facility-based physician may balance bill for amounts not paid by this Plan.
Outpatient
Treatment or confinement in a medical facility where you have not been admitted as inpatient. If you notify Medical 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 you to determine the need for further outpatient treatment or for inpatient admission.

Outpatient Physical, Occupational, and/or Aquatic Therapy
Services prescribed and performed by a licensed practitioner to restore, keep, learn, or improve skills and functions for daily living.

Pharmacy Benefit Manager
The Plan’s prescription 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.

Plan Administrator
TML Health has been designated to serve as the Plan Administrator.

Plan Sponsor
The Employer, except for the purposes of (1) federal privacy laws or regulations, or (2) assessments imposed as a result of the Affordable Care Act, in which case we shall be designated as Plan Sponsor due to Multi-Employer Pool.

Pool
TML Health Benefits Pool (TML Health).

Pre-authorization
The process for requesting approval in advance for medical treatment or services.

Pre-determination
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 the Plan, pregnancy includes one or more of the following:
1. period from conception through childbirth;
2. miscarriage;
3. any complications arising wholly from pregnancy, childbirth or miscarriage;
4. any pregnancy complications arising from any trauma; and/or
5. extra-uterine pregnancies are considered to be genitourinary conditions.

**Prompt Pay**
Provider contractual or statutory requirement that assesses penalties for failure for contractual/ regulatory timely claim payment.

**Reasonable and Customary**
A Reasonable and Customary charge is deemed to be not less than 110% of the amount prescribed by the Centers for Medicare and Medicaid Services (CMS), Resource-Based Relative Value Scale (RBRVS), and other specialty fee schedules. If the fees charged by the out-of-network provider are higher than the plan-determined reasonable and customary amount, the individual receiving the service maybe responsible for paying the difference.

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

**Rehabilitative Hospital**
An institution constituted and operated under law which:
1. is primarily engaged in providing rehabilitation services for sick or injured persons and meets the definition of a Hospital; and
2. is not, other than incidentally, a place for custodial care, for care of the aged or senile, for treatment of mental health or substance use disorder 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 (COA), the JCAHO or the American Association of Psychiatric Services for Children (AAPSC).

**Retiree**
An employee who has ceased active, benefit eligible employment with the Employer and meets the Employer’s guidelines to qualify as a Retiree and draws all other applicable Retiree benefits.
Right of Subrogation
The right of the Pool to recover amounts paid for benefits on your behalf when a third party may be liable or legally responsible for expenses incurred by you for an illness, sickness, or bodily injury.

Routine
Being in accordance with an established procedure.

Semi-Private Room
Administratively, room and board charges are allowed up to the rate charged by the hospital for a Semi-Private Room, unless the hospital bill indicates that the facility does not provide Semi-Private Rooms. If a Semi-Private Room is available and a private room is accessed, the Plan will allow up to the cost of a Semi-Private Room rate.

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) by a group of professional personnel, including one (1) or more Physicians and one (1) or more RNs, to govern the skilled nursing care and related medical care or other services provided;
3. has a Physician, an RN and a medical staff responsible for the execution of such policies;
4. has a requirement that the health care 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 an RN;
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 an RN, LVN, or LPN for health services.
Spouse
Individual legally married to you under the laws of any state. We may request written proof of the spousal relationship, such as a copy of the marriage certificate. Proof of a properly filed declaration of informal marriage is required for an informal marriage to be recognized by the Plan.

Substance Use Disorder
Habituation, abuse, and/or addiction to alcohol or other chemical substance not including nicotine. This includes physiological and/or psychological dependence.

Substance Use Disorder Treatment Facility
A facility which provides a program for the treatment of substance use disorder pursuant to a written treatment plan approved and monitored by a physician and which facility meets the requirements under #1, #2, and #3 below or the requirements under #4 below:
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 JCAHO; and
3. licensed as a substance use disorder treatment program by the TCADA; or
4. licensed, certified, or approved as a substance use disorder treatment program or center by any other state agency having legal authority to so license, certify, or approve and is also an approved health care facility.

Telemedicine
Telemedicine services are medical services provided via telephone, the internet, or other communication networks or devices that do not involve direct, in-person patient contact.

Transplant
The removal and replacement of human tissue and/or organ.

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

United States Preventive Services Task Force (USPSTF)
Quality Improvement preventive services task force that works with other national organizations. PHS Act section 2713 and the interim final regulations require non-grandfathered group health plans in individual or group benefits administration prohibit the cost-sharing requirements with respect to, the following:
1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the USPSTF with respect to the Covered Individual;
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the Covered Individual;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

4. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

Unproven Medical Procedures/Treatment
Experimental/Investigational/Unproven Services: medical, surgical, diagnostic, mental health, substance use disorder, 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 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.

Waiting Period
A required period of time an Active Employee must complete before an employee or his/her eligible dependents can be effective for coverage under the Plan. Waiting periods must not be in excess of ninety (90) days. A thirty (30) day bona fide employment-based orientation period may be added to the ninety (90) day waiting period limitation. Check with your employer to determine your waiting period.

Work Hardening
Work hardening is an interdisciplinary program consisting of physical therapy, occupational therapy and counseling professionals for injured workers or other adults whose injuries or disease processes interfere with their ability to work. It provides structured treatment designed to progressively improve physical function as a transition between acute care and return to work.
Required Notices

Insurance Marketplace Notice

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to
employer-offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

**How Can I Get More Information?**

For more information about your coverage offered by your employer, please check your summary plan description or contact _______________________.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](http://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.
PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
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</thead>
<tbody>
<tr>
<td>5. Employer address</td>
<td>6. Employer phone number</td>
</tr>
<tr>
<td>7. City</td>
<td>8. State</td>
</tr>
<tr>
<td>10. Who can we contact about employee health coverage at this job?</td>
<td></td>
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<tr>
<td>11. Phone number (if different from above)</td>
<td>12. Email address</td>
</tr>
</tbody>
</table>

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [ ] All employees. Eligible employees are:

- [ ] Some employees. Eligible employees are:

- With respect to dependents:
  - [ ] We do offer coverage. Eligible dependents are:

  - [ ] We do not offer coverage.

  - [ ] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](http://HealthCare.gov) will guide you through the process. Here’s the employer information you’ll enter when you visit [HealthCare.gov](http://HealthCare.gov) to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

**13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**
- Yes (Continue)
  - 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy) (Continue)
- No (STOP and return this form to employee)

**14. Does the employer offer a health plan that meets the minimum value standard***?
- Yes (Go to question 15)
- No (STOP and return form to employee)

**15. For the lowest-cost plan that meets the minimum value standard*** offered only to the employee (don’t include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn’t receive any other discounts based on wellness programs.
  a. How much would the employee have to pay in premiums for this plan? $___________
  b. How often?
- Weekly
- Every 2 weeks
- Twice a month
- Monthly
- Quarterly
- Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

**16. What change will the employer make for the new plan year?___________
- Employer won’t offer health coverage
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
  a. How much would the employee have to pay in premiums for this plan? $___________
  b. How often?
- Weekly
- Every 2 weeks
- Twice a month
- Monthly
- Quarterly
- Yearly

- An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)
Certificate of Group Health Plan Coverage

1. Date of this certificate: «Date»
2. Name of group health plan: «Group_Name»
3. Name of participant: «EE_FullName»
4. UID: «UID»
5. Name of individuals to whom this certificate applies: «COCC Applies To»
6. Name, address and telephone number of plan administrator or issuer responsible for providing this certificate:
   TML Health | PO Box 149190, Austin, Texas 78714-9190 | (512) 719-6500
7. For further information, call: (800) 282-5385
8. If the individual(s) identified in line 5 has (have) at least eighteen (18) months of creditable coverage (disregarding periods of coverage before a sixty-three (63) day break), check here and skip lines 9 and 10: ☐
9. Date waiting period or affiliation period (if any) began: «Waiting_Period»
10. Date coverage began: «Date_Coverage_Began»
11. Date coverage ended: «Date_Coverage_Ended»; or check if coverage is continuing as of the date of this certificate: ☐

Note: TML Health will furnish separate certificates if information is not identical for the covered employee and each dependent.
**Statement of HIPAA Portability Rights**

**Important - Keep this Certificate.** This certificate is evidence of your coverage under the TML Health plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a pre-existing condition exclusion period under another plan, to help you get special enrollment in another plan or to get certain types of individual health coverage if you have health problems.

**Be Aware** - HIPAA’s portability rights apply to most, but not all group health plans. HIPAA requires TML Health to include with this certificate the following educational information on HIPAA’s portability rights. However, HIPAA’s portability rights do not apply to TML Health plans; and the rights described below do not apply to individuals enrolled in, or wanting to enroll in, a TML Health plan.

**Pre-existing Condition Exclusions**

Some group health plans restrict coverage for medical conditions present before an individual’s enrollment. These restrictions are known as “pre-existing condition exclusions.” A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six months before your “enrollment date.” Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than twelve (12) months after your enrollment date eighteen (18) months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within thirty (30) days after birth, adoption or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children’s Health Insurance Program (SCHIP) and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for sixty-three (63) days or more without coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a sixty-three (63) day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if you enroll in another plan.
Right to get Special Enrollment in another plan

Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within thirty (30) days. Additional special enrollment rights are triggered by marriage, birth, adoption and placement for adoption.

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse’s plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor

Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage

Under HIPAA, if you are an “eligible individual,” you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least eighteen (18) months without a break in coverage of sixty-three (63) days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a sixty-three (63) day break.

State flexibility

This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information

If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at (866) 444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at (800) 633-4227 (ask for “Protecting Your Health Insurance Coverage”). These publications and other useful information are also available on the Internet at: dol.gov/ebsa, the DOL’s interactive web pages – Health ELaws, or cms.hhs.gov/hipaa1.
Medicare Prescription Non-Creditable Coverage Notice

«EEDep_First_Name» «EEDep_Last_Name»
«Adr1» «Adr2»
«City» «St» «Zip_Code»

Re: Important Notice about your Prescription Drug Coverage and Medicare

Dear «Salutation» «EEDep_Last_Name»,

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage through TML Health and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three (3) important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. TML Health has determined that the prescription drug coverage offered by «Group_Name» is, on average for all plan participants, NOT expected to pay as much as the standard Medicare prescription drug coverage pays (due to the high deductible). Therefore, your prescription drug coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you have prescription drug coverage through TML Health. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

You can keep your current coverage through TML Health. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a Medicare drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage, in your area. Read this notice carefully — it explains your options.
When can you join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you decide to drop your current coverage through TML Health, since it is employer-sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage through TML Health.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?

Since the coverage through TML Health is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn’t join, if you go sixty-three (63) continuous days or longer without prescription drug coverage that is creditable, your monthly premium may go up by a least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage through TML Health will be affected. If you join a Medicare drug plan, your TML Health prescription benefits will end. If you do decide to join a Medicare drug plan and drop your TML Health coverage, be aware that you and your dependents will not be able to get the TML Health coverage back.

For More Information

For more information about this notice or your current prescription drug coverage, call TML Health at (800) 282-5385.

Note: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if your coverage through TML Health changes. You may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage, read your "Medicare & You" handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

2. Call your State Health Insurance Assistance Program for personalized help (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number)
3. Call 1-800-MEDICARE - (800) 633-4227 | TTY users should call (877) 486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call (800) 772-1213, TTY (800) 325-0778.
Special Enrollment Rights Notice

Para asistencia en español, llame al departamento de Servicio al Cliente 1-800-282-5385 quien la proveerá servicios de traducción

For Hearing Impaired assistance call 711 | Para personas con discapacidad auditiva, marque 711

If you do not enroll yourself or an eligible dependent (including your spouse) in TML Health’s medical plan because you or your dependent has other medical coverage, you may enroll in the TML Health medical plan at a later date if you or your dependent loses coverage under the other medical plan. To enroll in TML Health’s medical plan, the loss of other coverage must be due to loss of eligibility for coverage or because the employer who sponsors the other plan stops contributing toward the cost of your or your dependent’s coverage.

Also, you must request enrollment in TML Health’s medical plan within thirty-one (31) days of the date your or your dependent’s other coverage ends. In general, only the person who loses other coverage may enroll in TML Health’s medical plan as a result of this special enrollment opportunity. However, an employee who declined enrollment in TML Health’s medical plan when offered must enroll himself or herself at the same time he or she enrolls a dependent.

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in TML Health’s medical plan if you request enrollment within thirty-one (31) days of the date of the marriage, or within sixty (60) days of the birth, adoption or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or a dependent experiences a loss of eligibility for Medicaid or a state Children’s Health Insurance Program (CHIP), you and your plan-eligible dependents may be allowed to enroll in a TML Health plan if you request enrollment within sixty (60) days after the coverage with Medicaid or state CHIP ends.

- If you or a dependent becomes eligible for payment assistance with the cost of coverage under a TML Health medical plan through Medicaid or state CHIP, TML Health will allow you and your plan-eligible dependents to enroll in a TML Health medical plan. You must request coverage within sixty (60) days of the date you or your dependent becomes eligible for payment assistance.

To request special enrollment or for more information about special enrollment opportunities, call TML Health’s Customer Care staff at (800) 282-5385.
Women’s Health and Cancer Rights Act (WHCRA) Notice

TML Health’s medical plan provides comprehensive benefits, including benefits for mastectomy and breast reconstruction. If you have a disease of the breast and mastectomy is the recognized necessary medical treatment for that disease, TML Health covers eligible expenses for the mastectomy/lumpectomy and for any complications of the mastectomy, including lymphedema.

Eligible benefits include the initial non-cosmetic removal and replacement of prosthetics due to complications. Reconstructive surgery includes tissue expanders, breast implants, nipple reconstruction, and nipple tattooing.

Benefits for breast reconstruction are available even if your mastectomy was performed before you were covered under the TML Health medical plan. However, the mastectomy must have been performed because of a disease of the breast.

Eligible expenses for mastectomy and breast reconstruction are payable subject to the same deductibles and co-insurance that apply to other medical and surgical expenses covered by TML Health’s medical plan. If you would like more information on benefits for mastectomy or breast reconstruction, call TML Health’s Customer Care at (800) 282-5385.
Medicaid and Children’s Health Insurance Program (CHIP) Notice

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within sixty (60) days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your state for more information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA – Medicaid</td>
<td>Website: <a href="http://www.myalhipp.com">http://www.myalhipp.com</a></td>
</tr>
</tbody>
</table>
| ALASKA – Medicaid | The AK Health Insurance Premium Payment Program  
Website: http://myakhipp.com | Phone: 1-866-251-4861  
Email: CustomerService@MyAKHIPP.com  
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx |
| ARKANSAS – Medicaid | Website: http://myarhipp.com | Phone: 1-855-MyARHIPP (855-692-7447) |
| COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+) | Health First Colorado Website: https://www.healthfirstcolorado.com/  
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711  
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus  
<p>| FLORIDA – Medicaid | Website: <a href="http://flmedicaidtplprecovery.com/hipp">http://flmedicaidtplprecovery.com/hipp</a> | Phone: 1-877-357-3268 |
| GEORGIA – Medicaid | Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> | Click on Health Insurance Premium Payment (HIPP); Phone: 404-656-4507 |</p>
<table>
<thead>
<tr>
<th>State</th>
<th>Contact</th>
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<tbody>
<tr>
<td>INDIANA – Medicaid</td>
<td>Healthy Indiana Plan for low-income adults 19-64</td>
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<tr>
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<td>Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a></td>
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<td></td>
<td>All other Medicaid:</td>
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<td></td>
<td>Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
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<td>IOWA – Medicaid</td>
<td>Website: <a href="http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a></td>
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<tr>
<td></td>
<td>Phone: 1-888-346-9562</td>
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<td>KANSAS – Medicaid</td>
<td>Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a></td>
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<td>KENTUCKY – Medicaid</td>
<td>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
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<tr>
<td>LOUISIANA – Medicaid</td>
<td>Website: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a></td>
</tr>
<tr>
<td>MAINE – Medicaid</td>
<td>Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-800-442-6003</td>
</tr>
<tr>
<td>MASSACHUSETTS –</td>
<td>Website: <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a></td>
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<tr>
<td>Medicaid and CHIP</td>
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<td>MINNESOTA – Medicaid</td>
<td>Website: <a href="http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp">http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp</a></td>
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<tr>
<td>MISSOURI – Medicaid</td>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
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<tr>
<td>MONTANA – Medicaid</td>
<td>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a></td>
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<tr>
<td>NEBRASKA – Medicaid</td>
<td>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a></td>
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<tr>
<td>NEVADA – Medicaid</td>
<td>Medicaid Website: <a href="https://dhcfp.nv.gov/">https://dhcfp.nv.gov/</a></td>
</tr>
<tr>
<td>NEW HAMPSHIRE –</td>
<td>Website: <a href="https://www.dhhs.nh.gov/ombp/nhhpp/">https://www.dhhs.nh.gov/ombp/nhhpp/</a></td>
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<td>Medicaid</td>
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<td>NEW JERSEY – Medicaid</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
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<td></td>
<td>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
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<td>NEW YORK – Medicaid</td>
<td>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a></td>
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<tr>
<td>NORTH CAROLINA –</td>
<td>Website: <a href="https://dma.ncdhhs.gov/">https://dma.ncdhhs.gov/</a></td>
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<tr>
<td>Medicaid</td>
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<tr>
<td>NORTH DAKOTA –</td>
<td>Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
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<td>Medicaid</td>
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<td>OKLAHOMA – Medicaid</td>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
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<td>and CHIP</td>
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<td>State</td>
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| OREGON – Medicaid     | Website: [http://healthcare.oregon.gov/Pages/index.aspx](http://healthcare.oregon.gov/Pages/index.aspx)  
| PENNSYLVANIA – Medicaid | Website: [http://dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm](http://dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)  
|                       | Phone: 1-800-692-7462                                                   |
| RHODE ISLAND – Medicaid | Website: [http://www.eohhs.ri.gov/](http://www.eohhs.ri.gov/) | Phone: 855-697-4347 |
| SOUTH CAROLINA – Medicaid | Website: [https://www.scdhhs.gov](https://www.scdhhs.gov) | Phone: 1-888-549-0820 |
| SOUTH DAKOTA – Medicaid | Website: [http://dss.sd.gov](http://dss.sd.gov) | Phone: 1-888-828-0059 |
| TEXAS – Medicaid       | Website: [http://gethipptexas.com/](http://gethipptexas.com/) | Phone: 1-800-440-0493 |
| UTAH – Medicaid and CHIP | Medicaid Website: [https://medicaid.utah.gov/](https://medicaid.utah.gov/)  
| VERMONT – Medicaid     | Website: [http://www.greenmountainincare.org/](http://www.greenmountainincare.org/) | Phone: 1-800-250-8427 |
| VIRGINIA – Medicaid and CHIP | Medicaid Website: [http://www.coverva.org/programs_premium_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)  
|                       | CHIP Website: [http://www.coverva.org/programs_premium_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)  
|                       | Phone: 1-800-432-5924                                                  |
| WEST VIRGINIA – Medicaid | Website: [http://mywvhipp.com/](http://mywvhipp.com/)  
|                       | Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)                      |
| WISCONSIN – Medicaid   | Website: [https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf](https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf) | Phone: 1-800-362-3002 |
| WYOMING – Medicaid     | Website: [https://wyequalitycare.acs-inc.com/](https://wyequalitycare.acs-inc.com/) | Phone: 307-777-7531 |

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, you can contact either:

**U.S. Department of Labor**  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
1-866-444-EBSA (3272)

**U.S. Department of Health and Human Services**  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565
HIPAA Notice of Privacy Practices for Protected Health Information (PHI)

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.

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

Is all my health information protected?

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

What steps does TML Health take to protect my information?

Because TML Health believes that protecting your health information is of the highest priority, TML Health takes the following steps to ensure that your health information remains confidential:

- **Business Associate Agreements** - TML Health follows the requirements of federal law and makes sure that any TML Health business associate who receives your personal health information signs a written agreement to protect your health information.

- **Encryption of Health Data** - TML Health encrypts your health information that is sent electronically (for example, over the Internet) so that no one, who is not supposed to, can view your health information. To make sure that only the people who need your health information to administer your health plan benefits are able to see it, TML Health reviews the list of people who are allowed to view your personal health information on a regular basis.

- **Independent Review** - TML Health periodically employs an independent security company to review and test TML Health’s security controls to make sure they meet the requirements of federal law. The independent security company provides certified security professionals to conduct the review.

- **Use of Health Information** - TML Health’s Privacy Officer reviews the use of personal health information by TML Health to ensure that it complies with both federal law and with TML Health’s own privacy policies.
How does TML Health use and share my health information?

TML Health’s most common use of health information is for its own treatment, payment and healthcare operations. TML Health 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.)

TML Health also may share your health information with a TML Health business associate if the business associate needs the information to perform treatment, payment or healthcare operations on TML Health’s behalf. For example, if your health plan includes a retail and mail order pharmacy network, TML Health must share information with the pharmacy network about your eligibility for benefits. Healthcare providers, other health plans, healthcare clearinghouses and TML Health business associates are all required to maintain the privacy of any health information they receive from TML Health. TML Health 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 TML Health activities such as billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review and notification of healthcare services. For example, TML Health may tell a doctor if you are covered under a TML Health plan and what part of the doctor’s bill TML Health will pay.
- **Healthcare operations** include quality assessment and improvement, reviewing competence or qualifications of healthcare professionals, underwriting and other activities necessary to create or renew health plans. It also includes disease management, 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, TML Health may use information from your claims to contact you about treatment alternatives or other health-related benefits and services that may be of interest to you. Please note that while TML Health may use and share your health information for underwriting, TML Health is prohibited from using or sharing any of your genetic information for underwriting.

How else does TML Health share my health information?

TML Health 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 eighteen (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 TML Health’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. TML Health 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 TML Health 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 TML Health from using or sharing my health information for any of these purposes?

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

Are there any other times when TML Health may use or share my health information?

TML Health may not use or share your health information for any purpose not included in this notice, unless TML Health 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 TML Health receives your request.
TML Health must always have your written authorization to:

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

**Will TML Health share my health information with my employer?**

TML Health shares summary health information with the employer who sponsors your group health plan. Employers need this information to get bids from other health plans or to make decisions to modify, amend or terminate the TML Health group health plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by the entire group of people covered under a health plan. Summary health information does not include any information that identifies you, such as your name, social security number or date of birth.

Also, TML Health shares with the employer who sponsors your group health plan information on whether you are enrolled in TML Health’s group health plan or if you recently added, changed or dropped coverage.

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

You may make a written request to TML Health’s Privacy Officer for a list of any disclosures of your health information made by TML Health during the last six (6) 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; or any disclosures reported on a previous list.

Generally, TML Health will send the list within sixty (60) days of the date TML Health receives your written request. However, TML Health is allowed an additional thirty (30) days if TML Health 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 twelve (12) month period, TML Health may charge you a reasonable, cost-based fee for each additional list.

**Can I view my health information maintained by TML Health?**

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

TML Health  
ATTN: Privacy Officer  
PO Box 149190, Austin, Texas 78714-9190

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

You may request that TML Health correct any of your health information that it creates and maintains. All requests for correction must be made to TML Health’s Privacy Officer, must be in writing, and must include a reason for the correction.

Please be aware that TML Health can correct only the information that it creates. If your request is to correct information that TML Health did not create, TML Health 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, TML Health will correct the claim if TML Health made an error in the data entry of the diagnosis. However, if your healthcare provider submitted the wrong diagnosis to TML Health, TML Health cannot correct the claim without a statement from your healthcare provider that the diagnosis is incorrect.

TML Health has sixty (60) days after it receives your request to respond. If TML Health is not able to respond, it is allowed one (1) thirty (30) day extension. If TML Health denies your request, either in part or in whole, TML Health will send you a written explanation of its denial. You may then submit a written statement disagreeing with TML Health’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, TML Health will accommodate your request to receive communications of health information by alternative means or at alternative locations. Your request must be reasonable, must be in writing, must specify an alternative address or other method of contact, and must include a statement that sending communications to the covered employee’s address would place you in danger.

Please be aware that TML Health is required to send the employee any payment for a claim that is not assigned to a healthcare provider, except under certain medical child support orders.

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

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

Write to:  
TML Health  
ATTN: Privacy Officer  
PO Box 149190, Austin, Texas 78714-9190

Or call:  
(800) 282-5385

Also, you may file a complaint with the U.S. Department of Health and Human Services. TML Health will not retaliate against you for filing a complaint.
When are the privacy practices described in this notice effective?
This privacy notice has an effective date of September 1, 2013.

Can TML Health change its privacy practices?
TML Health is required by law to follow the terms of its privacy notice currently in effect. TML Health reserves the right to change its privacy practices and to apply the changes to any health information TML Health received or maintained before the effective date of the change. TML Health will maintain its current privacy notice on its website at tmlhealthbenefits.org. If a revision is made during your plan year, TML Health will post the revised notice to its website on the date the new notice goes into effect. You will receive a paper copy of the revised privacy notice before the start of your next plan year.

What happens to my health information when I leave the plan?
TML Health is required to maintain your records for at least six (6) years after you leave TML Health’s group health plan. However, TML Health 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 TML Health mail you a paper copy of this notice, call (800) 282-5385.

Who can I contact for more information on my privacy rights?
Write to:  TML Health
          ATTN: Privacy Officer
          PO Box 149190, Austin, Texas 78714-9190

Or call:  (800) 282-5385
Non-Discrimination Notices

English

TML Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. TML Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

TML Health:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  ▪ Qualified sign language interpreters
  ▪ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:
  ▪ Qualified interpreters
  ▪ Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that TML Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

   Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, (800) 282-5385, TTY 711, Fax (512) 719-6539, CRCoordinator@tmlhb.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

لم يتم ترجمة الحقوق المدنية الفردية المعمول بها ولا يميز على أساس العرق أو
اللون أو الأصل الوطني أو السن أو الإعاقة أو نوع الجنس. لا يستبعد TML Health Benefits
الأشخاص أو عاملهم على نحو مختلف بسبب النوع أو اللون أو الأصل الوطني أو السن أو الإعاقة أو نوع الجنس.

TML Health Benefits

- يوفر مساعدات وخدمات مجانية للأشخاص من ذوي الإعاقة للتواصل بصورة فعالة، مثل:
  - مترجم لغة إشارة مؤهلين
  - معلومات كتابية بتنسيقات أخرى (مطبوعة بأحرف كبيرة، مواد صوتية، تنسيقات الكترونية متبسطة،
وغير ذلك من التنسيقات)
- يوفر خدمات لغوية مجانية للأشخاص الذين لغتهم الأساسية ليست الإنجليزية، مثل:
  - مترجمين مؤهلين
  - معلومات مكتوبة بلغات أخرى

Civil Rights Coordinator

إذا كنت بحاجة لهذه الخدمات، اتصل بـ

TMY 711، TTY 800-282-5385، PO Box 149190، Austin، TX 78754-9190، Civil Rights Coordinator

يمكن أن تقدم بشكوى شخصيًا أو CRCoordinator@tmlhb.org، TML Health Benefits
إذا كنت بحاجة للمساعدة في التقدم بشكوى، فإن Civil Rights Coordinator
بالبريد أو بالفاكس أو البريد الإلكتروني.

يمكن أيضًا أن تقدم بشكوى إلكترونيًا لوزارة
Office for Department of Health and Human Services (مكتب الحقوق المدنية)، من خلال مكتب Office for Civil Rights
U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building

Washington, D.C. 20201


or https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Civil Rights Complaint Portal

بالبريد أو الهاتف على:

(703) 483-6200، (800) 448-4545، (800) 537-7697، (800) 669-4977، (800) 863-8638

مقابل الخروج والمطالبة بالمزيد من المعلومات أو الحصص المقدمة على الرابط

Chinese

TML Health 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。TML Health 不因種族、膚色、民族血統、年齡、殘障或性別而排斥任何人或以不同的方式對待他們。

TML Health:

- 向殘障人士免費提供各種援助和服務，以幫助他們與我們進行有效溝通，如：
  - 合格的手語翻譯員
  - 以其他格式提供的書面資訊（大號字體、音訊、無障礙電子格式、其他格式）

- 向母語非英語的人員免費提供各種語言服務，如：
  - 合格的翻譯員
  - 以其他語言書寫的資訊

如果您需要此類服務，請聯絡 Civil Rights Coordinator

如果您認為 TML Health 未能提供此類服務或者因種族、膚色、民族血統、年齡、殘障或性別而透過其他方式歧視您，您可以向 Civil Rights Coordinator 提交投訴，郵寄地址為，TML Health PO Box 149190, Austin, TX 78754-9190，電話號碼為 1-800-282-5385、TTY（聽障專線）號碼為 TTY 711，傳真為 Fax 512-719-6539，電子信箱為 CRCoordinator@tmlhb.org。您可以親自提交投訴，或者以郵寄、傳真或電郵的方式提交投訴。如果您在提交投訴方面需要幫助，Civil Rights Coordinator 可以幫助您。
您還可以向 U.S. Department of Health and Human Services（美國衛生及公共服務部）的 Office for Civil Rights（民權辦公室）提交民權投訴，透過 Office for Civil Rights Complaint Portal 以電子方式投訴：https://ocrportal.hhs.gov/ocr/portal/lobby.jsf，或者透過郵寄或電話的方式投訴：

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019，800-537-7697 (TDD)（聾人用電信設備）

登入 http://www.hhs.gov/ocr/office/file/index.html 可獲得投訴表格。
**French**

TML Health respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap. TML Health n'exclut et ne traite aucune personne différemment en raison de sa race, sa couleur de peau, son origine nationale, son âge, son sexe ou son handicap.

TML Health:

- Fournit gratuitement des aides et services aux personnes handicapées afin de permettre une communication efficace avec nous, par exemple :
  - Interprètes qualifiés en langue des signes
  - Informations écrites dans d'autres formats (gros caractères, audio, formats électroniques accessibles, autres formats)

- Fournit gratuitement des services linguistiques aux personnes dont la langue principale n'est pas l'anglais, par exemple :
  - Interprètes qualifiés
  - Informations écrites dans d'autres langues

Si vous avez besoin de ces services, contactez Civil Rights Coordinator

Si vous pensez que TML Health n'a pas fourni ces services ou a fait preuve d'une autre forme de discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou le handicap, vous pouvez déposer une réclamation auprès de : Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCordinator@tmlhb.org. Vous pouvez déposer une réclamation en personne ou par courrier, télécopie ou e-mail. Si vous avez besoin d'aide pour déposer une réclamation, Civil Rights Coordinator se tient à votre disposition pour vous y aider.
Vous pouvez également déposer une réclamation concernant vos droits civiques auprès de l'U.S. Department of Health and Human Services (Département de la Santé et des Services Sociaux des États-Unis), Office for Civil Rights (Bureau des Droits Civiques), par voie électronique via l'Office for Civil Rights Complaint Portal, disponible à l'adresse https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, par courrier ou par téléphone à:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Des formulaires de réclamation sont disponibles à l'adresse http://www.hhs.gov/ocr/office/file/index.html
German


TML Health:

- Bietet kostenlose Hilfe und Dienstleistungen für Menschen mit Behinderung zur effektiven Kommunikation, wie z. B.:
  - Qualifizierte Gebärdensprachen-Dolmetscher
  - Schriftliche Informationen in anderen Formaten (große Ausdrucke, Audio, zugängliche elektronische Formate, sonstige Formate)
- Bietet kostenlose Sprachdienste für Menschen, deren Hauptsprache nicht Englisch ist, wie z. B.:
  - Qualifizierte Dolmetscher
  - Schriftliche Informationen in anderen Sprachen

Sollten Sie diese Dienstleistungen benötigen, so wenden Sie sich an Civil Rights Coordinator

Sollten Sie der Ansicht sein, dass TML Health es versäumte, diese Dienstleistungen anzubieten, oder auf sonstige Weise aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht diskriminierte, so können Sie eine Beschwerde einreichen bei: Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org. Sie können eine Beschwerde persönlich oder per Post, Fax oder E-Mail einreichen. Sollten Sie Hilfe beim Einreichen einer Beschwerde benötigen, so steht Ihnen Civil Rights Coordinator gerne zur Verfügung.

Sie können ebenfalls eine Menschenrechtsbeschwerde einreichen bei: Department of Health and Human Services (U.S.-Gesundheitsministerium), Office for Civil Rights (Amt für Bürgerrechte), elektronisch über das Office for Civil Rights Complaint Portal, zugänglich über https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, oder per Post oder telefonisch an:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

TML Health સમવાયી નાગરિક વિભાગ કાયદા સાથે સંઘટન છે અને વદવત, રંગ, રાજકીય જાતીય, ધ્રુપદિય અને વિશ્વસતા અથવા ક્ષેત્ર વિભાગો આપતાં ઉલ્લેખમાં આવતો નથી.

TML Health વદવત, રંગ, રાજકીય જાતીય, ધ્રુપદિય અને વિશ્વસતા અથવા ક્ષેત્રના મેળવેલા કારણો વાળો આદાત નથી. તમારી અધયાયની માંહિમ સહાય અને સેવાઓ તમારે પાયેલ કરાવામાં આવે છે:

- આવશ્યક પરિસ્થિતિ સાથે વદવત નથી ફાળવવાની સુખી ભાષા

- સ્વચ્છતા બાંધકામાં જમાવે માંહિમ (મોટી નગરિક, ઓંટી, વિશેષતાની ઉપસ્તાનની શોધાંક,

- અન્ય પ્રાથમિક બાયાણ નો હોય તે બાદ બદલાયેલી પ્રવાસની સહાય સેવાઓ

- પાયલમાં આખે છે:

- આવશ્યક પરિસ્થિતિ નો ફાળવના વાતાબ્યાર કેવારે માંહિમ હોય તો, તમે કરો Civil Rights

Coordinator
The U.S. Department of Health and Human Services (U.S. Department of Health and Human Services), Office for Civil Rights (Office for Civil Rights Complaint Portal, \(https://ocrportal.hhs.gov/ocr/portal/lobby.jsf\) for complaints and office for Civil Rights (Office of the Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org) for information and assistance.

To report a problem, please contact the Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org.

For more information, visit \(https://ocrportal.hhs.gov/ocr/portal/lobby.jsf\) or contact the Office for Civil Rights (Office of the Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org).
Hindi

TML Health लोग होने योग्य संघीय नागरिक अधिकार कानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आय, विवकलांगता, या लग के आधार पर भेदभाव नहीं करता है।

TML Health जाति,
रंग, राष्ट्रीय मूल, आय, विवकलांगता, या लग के आधार पर लोग को बाहर या उनके साथ अलग तरह का बर्तन नहीं करता है।

TML Health:
• विवकलांग लोग की हमारे साथ भावशाली ढंग से संबंध करने के लिए करता है।

करता है निःशुल्क सहायता और सेवाएं दान जैसे:

○ योग्यता अथवा सांकेतिक भाव दभाविया
○ अन्य फॉर्म (बड़े टेट, ऑडियो, स्लूम इलेक्ट्रॉनिक फॉर्मेट, अन्य फॉर्म) लिखित जानकारी

• जिन लोग का आय्यमक भावा अंतर्राष्ट्रीय नहीं है उन लोग को निःशुल्क भावा सेवाएं दान करता है, जैसे:

○ योग्यता दभाविया
○ अन्य भावा मिलिनिर्धारित जानकारी

यदि आपको इन सेवा के आवश्यकता है तो Civil Rights Coordinator से संपर्क करें

यदि आपको निःशुल्क सेवा है TML Health ये सेवाएं दान करने मिलवाता रहा है या जाति, रंग, राष्ट्रीय मूल, आय, विवकलांगता, या लग के आधार पर कसी तरह से कोई भेदभाव का है तो आप निःशुल्क जानकारी के पास
िशकायत दजर कर सकते हैं: Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCordinator@tmlhb.org. आप स्वयं जाकर या डाक, फैक्स, या ईमेल द्वारा भी इशकायत दजर कर सकते हैं। शेष आपको इशकायत दजर कराने में सहायता की आवश्यकता है तो Civil Rights Coordinator आपके सहायता के लिए उपलब्ध है।

आप https://ocrportal.hhs.gov/ocr/portal/lobby.jsf पर उपलब्ध, Office for Civil Rights Complaint Portal के माध्यम से इंटरनेट तरीके से, या डाक या फोन द्वारा भी U.S. Department of Health and Human Services (U.S. Department of Health and Human Services) के पास भी एक नागरिक विश्वास भावनात्मक विश्वास दजर करा सकते हैं।

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1-800-368-1019, 800-537-7697 (TDD)

िशकायत फॉर्म http://www.hhs.gov/ocr/office/file/index.html पर उपलब्ध है।
Japanese

TML Health は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害、または性別に基づく差別をいたしません。TML Health は人種、肌の色、出身国、年齢、障害、または性別を理由として人を排除したり、異なる扱いをいたしません。

TML Health：

- 効果的にコミュニケーションを図るため、障害のある人に以下の支援やサポートを無料で提供いたします。
  - 資格ある手話通訳者
  - その他形式の文字情報（大きな活字、音声信号、手軽な電子形式、その他）

- 英語を母語としない人へ以下の言語サービスを無料で提供いたします。
  - 資格ある通訳者
  - 英語以外の言語で書かれた情報

これらのサービスを必要とされる場合は、Civil Rights Coordinatorまでご連絡ください。

TML Health がこれらのサービスの提供を怠ったり、人種、肌の色、出身国、年齢、障害、または性別に基づいた何らかの方法で差別したと思われる場合、こちらまで苦情を申し立てることができます：Civil Rights Coordinator、TML Health、PO Box 149190、Austin, TX 78754-9190、1-800-282-5385、TTY 711、Fax 512-719-6539、CRCoordinat@tmlhb.org。苦情の申し立ては、直接、または郵便、ファックス、メールで行うことができます。苦情を申し立てにあたり援助が必要な場合は、Civil Rights Coordinator がお手伝いいたします。
また、公民権に関する苦情は、U.S. Department of Health and Human Services（保健社会福祉省）のOffice for Civil Rights（公民権局）へ、Office for Civil Rights Complaint Portal [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)から電子申請するか、以下へ郵便または電話で申し立てることもできます:

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Korean

TML Health 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다. TML Health 은(는) 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 누군가를 배제하거나 다른 방식으로 대우하지 않습니다.

TML Health:

- 장애인들이 저희와 효과적으로 의사소통할 수 있도록 다음과 같은 무료 지원과 서비스를 제공합니다.
  - 자격있는 수화 통역자
  - 다른 형식의 서면 정보 (큰 활자, 음성, 사용 가능한 전자 형식, 기타 형식)
- 주로 사용하는 언어가 영어가 아닌 이들에게는 다음과 같은 무료 언어 서비스를 제공합니다.
  - 자격있는 통역자
  - 다른 언어로 작성된 서면 정보

이러한 서비스가 필요하시면 Civil Rights Coordinator 에 연락하십시오.

TML Health 이(가) 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 이러한 서비스를 제공하지 않거나 다른 방식으로 차별했다고 생각하시는 경우 Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCordinator@tmlhb.org (으)로 연락하여 불만을 제기하실 수 있습니다. 직접 방문하거나 우편, 팩스 또는 이메일로 불만을 제기하실 수 있습니다. 불만 제기와 관련하여 도움이 필요하시면, Civil Rights Coordinator (으)로부터 지원을 받으실 수 있습니다.
또한 공민권 민원을 미국 Department of Health and Human Services(보건복지부), Office for Civil Rights(시민권 사무국)에 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf에 있는 시민권 사무국 민원 포털을 통해 전자 방식으로 제출하거나 우편이나 전화로 제출할 수 있습니다. 주소 및 연락처는 다음과 같습니다.

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TML Health ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມືອງຂອງຣັຖບານກາງທີ່ບັງຄັບໃຊ້ແລະບໍ່ຈຳແນກບຸກຄົນໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ,ສີຜິວ,ຊາດກຳເນີດ,ຢາຍ,ຄວາມພິການ,ຫຼືເພດ, TML Health ຍັງຈຳແນກບຸກຄົນໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ,ສີຜິວ,ຊາດກຳເນີດ,ຢາຍ,ຄວາມພິການ,ຫຼືເພດ.

TML Health:

1. ໃຫ້ການຊ່ວຍເຫຼືອແລະການບໍລິການໂດຍບໍ່ເສັຽຄ່າແກ່ບຸກຄົນທີ່ພິການເພື່ອໃຫ້ສາມາດສື່ສານກັບພວກເຮົາໄດ້ຢ່າງມີປະສິດທິພາບ,ເຊັ່ນ:
   - ວາງພາສາໃບ້ທີ່ມີຄຸນສົມບັດເໝາະສົມ
   - ລາຍລັກອັກສອນໃນຮູບແບບອື່ນໆ (ເຊັ່ນ: ທ່ານຕ້ອງການບໍລິການເຫຼົ່ານີ້ຈຳແນກໃນທາງອື່ນໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ,ສີຜິວ,ຊາດກຳເນີດ,ຢາຍ,ຄວາມພິການ,ຫຼືເພດ,ທ່ານສາມາດຍື່ນເລື້ອງຮ້ອງທຸກກັບ:

2. ໃຫ້ບໍລິການດ້ານພາສາໂດຍບໍ່ເສັຽຄ່າແກ່ບຸກຄົນທີ່ພາສາຫຼັກຂອງເຂົາເຈົ້າບໍ່ແມ່ນພາສາອັງກິດ,ເຊັ່ນ:
   - ສາມາດໂດຍຄົ້ນຄວ້າທຸກຮູບແບບບໍລິການເຫຼົ່ານີ້
   - ວາງພາສາໃບ້ທີ່ມີຄຸນສົມບັດເໝາະສົມ
   - ລາຍລັກອັກສອນໃນພາສາອື່ນຖ້າວ່າທ່ານຕ້ອງການບໍລິການເຫຼົ່ານີ້ຈຳແນກໃນທາງອື່ນໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ,ສີຜິວ,ຊາດກຳເນີດ,ຢາຍ,ຄວາມພິການ,ຫຼືເພດ,ທ່ານສາມາດຍື່ນເລື້ອງຮ້ອງທຸກກັບ:

CRCoordinator@tmlhb.org,

Pre 65 Retiree Medical Plan Booklet CY2020 121
In case of a conflict, the Civil Rights Coordinator, or, in writing to
the Office for Civil Rights Coordinator, outside of which you can
also report by mail to the Office for Civil Rights Complaint Portal,
visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by phone
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200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
بهبود نوعی شرایط زنان ارجاع می‌شود.

برای افرادی که ناتوانی دارند، برای برقرار کردن ارتباط موثر، کمک های بی بطور رایگان فراهم می‌کند، مانند:

- مترجمین وجد شرایط زبان اشاره
- اطلاعات نوشته‌ای به فرم‌های دیگر (چاپ با حروف دشت، صوتی)
- تشریفات‌ها به جز فارسی کافی است.

برای افرادی که زبان اولیه شان انگلیسی نیست خدمات زبانی رایگان ارائه می‌کند، مانند:

- مترجمین شفاهی وجد شرایط
- اطلاعات نوشته‌ای به زبان‌های دیگر

تاسیس [Coordinator Civil Rights Coordinator] می‌تواند [Coordinator Civil Rights Coordinator] می‌تواند با راهبرد سازنده کمک کند.

آگر معتقد که قانونی حقیقی را به آرایه نداده است/اگر معتقد که CML Health Benefits به معنی شکایت شده در [Coordinator Civil Rights Coordinator] می‌تواند با راهبرد سازنده کمک کند.

برای افرادی که شکایتی ندارند و سهمیه بندی شناختن ندارند در مورد شکایت در [Coordinator Civil Rights Coordinator] می‌تواند با راهبرد سازنده کمک کند.

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Russian

TML Health соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола. TML Health не исключает людей и не относится к ним по-разному из-за расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

TML Health:
- Для эффективного взаимодействия предоставляет безвозмездную помощь и оказывает услуги людям с ограниченными возможностями, а именно:
  - услуги квалифицированных сурдопереводчиков;
  - письменную информацию в других форматах (крупный шрифт, аудио формат, доступные электронные форматы, прочие форматы).
- Предоставляет бесплатные услуги перевода людям, для которых английский не является основным языком, а именно:
  - услуги квалифицированных переводчиков;
  - письменную информацию на других языках.

Если вы нуждаетесь в таких услугах, обратитесь к Civil Rights Coordinator

Если вы считаете, что в TML Health вам не предоставили указанных услуг или иным образом дискриминировали вас по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола, вы можете подать жалобу: Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCordinator@tmlhb.org. Вы можете подать жалобу лично или отправить по почте, факсу или электронной почте. Если вам нужна помощь в подаче жалобы, вам поможет Civil Rights Coordinator.

Вы также можете подать жалобу о нарушении гражданских прав в U.S. Department of Health and Human Services (Министерство здравоохранения и социальных служб США), Office for Civil Rights (Управление по гражданским правам), в электронном виде через Office for Civil Rights Complaint Portal, доступный по ссылке: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, по почте или по телефону:

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200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201 (США)
1-800-368-1019, 800-537-7697 (TDD)

Spanish

TML Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. TML Health no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

TML Health:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Intérpretes de lenguaje de señas capacitados.
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).

- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
  - Intérpretes capacitados.
  - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con Civil Rights Coordinator.

Si considera que TML Health no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, Civil Rights Coordinator está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Tagalog

Sumusunod ang TML Health sa mga naaangkop na Pampederal na batas sa karapatang sibil at hindi nandiskrimina batay sa lahi, kulay, bansang pinanggulan, edad, kapansanan o kasarian. Ang TML Health ay hindi nagtatangi ng mga tao o hindi nagpapakita ng ibang pakikitungo dahil sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Ang TML Health ay:

- Nagbibigay ng mga libreng tulong at serbisyo sa mga taong may kapansanan upang mahusay silang makipag-ugnayan sa amin, gaya ng:
  - Mga kwalipikadong interpreter ng sign language
  - Nakasulat na impormasyon sa iba pang mga format (malaking print, audio, mga naa-access na electronic na format, iba pang mga format)

- Nagbibigay ng mga libreng serbisyo sa wika sa mga taong hindi Ingles ang pangunahing wika, gaya ng:
  - Mga kwalipikadong interpreter
  - Impormasyong nakasulat sa iba pang mga wika

Kung kailangan mo ang mga serbisyong ito, makipag-ugnayan kay Civil Rights Coordinator

Kung naniniwala kang hindi naibigay ng TML Health ang mga serbisyong ito o nandiskrimina ito sa ibang paraan batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian, maaari kang maghain ng karaingan sa:

- Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCordinator@tmlhb.org. Maaari kang maghain ng karaingan nang personal o sa pamamagitan ng koreo, fax o email. Kung kailangan mo ng tulong sa paghahain ng karaingan, narito si Civil Rights Coordinator upang tulungan ka.

Maaari ka ring maghain ng reklamo sa mga karapatang sibil sa U.S. Department of Health and Human Services (Kagawaran ng Mga Serbisyong Pangkalusugan at Pantao ng U.S.), Office for Civil Rights (Tanggapan para sa Mga Karapatang Sibil), sa electronic na paraan sa Office for Civil Rights Complaint Portal, na makikita sa https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o sa pamamagitan ng koreo o telepono sa:

- U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  1-800-368-1019, 800-537-7697 (TDD)

TML Health Benefits

• معذور افراد کے بارے میں ساتھ ملوث ابلاغ کے لیے مفت مین مدد اور خدمات فراہم کرتا ہے، مثلاً:
  o اب اشاروں کی زبان کے ترجمان
  o دیگر صورتوں میں تحremium معلومات (پہچانہ پرتنش، صوتی، قابل رسانی برقی ترائیب، دیگر ترائیب)
  o دیگر زبانوں میں تحریر کردہ معلومات

• اگر اپنے خدمات کی ضرورت ہو تو نوریبطہ کرین Coordinator

TML Health Benefits اگر خدمات کی فراہمی میں دستیابی نہیں ربا ہو تو نسل، رنگ، قومیت، عمر، معذوری یا جنس یا کسی دوسرا صورت میں امتیاز کرتا ہے

Civil Rights Coordinator، PO Box: Austin، TX 78754-9190، 1-800-282-5384، TTY 711، 512-719-6539، 149190)

• اپنی شکایت زیربستہ ہا فایڈ با ای میل کے ذریعے کرواسکی بین، اگر اپنی کرواسکی مین مدد درکار ہو تو

Ab Apna Samajhie Samaqta Bi Bi ha TML Health Benefits

U.S. Department of Health and Human Services

200 Independence Avenue، SW

Room 509F، HHHI Building

Washington، D.C. 20201

1-800-368-1019، 800-537-7697 (TDD)

http://www.hhs.gov/ocr/office/file/index.htm

Aap Sheri Haqeeq ki Shakayat

(شیری حقوق کے دفتر)

Office of Civil Rights

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Rights Complaint Portal

Kroaskee Sake Bi:

U.S. Department of Health and Human Services

Pre 65 Retiree Medical Plan Booklet CY2020 127
Vietnamese

TML Health tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính. TML Health không loại trừ mọi người hoặc đối xử với họ khác biệt vì chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

TML Health:

- Cung cấp dịch vụ hỗ trợ miễn phí cho những người khuyết tật để giao tiếp với chúng tôi có hiệu quả, như:
  - Thông dịch viên ngôn ngữ ký hiệu đủ năng lực
  - Thông tin bằng văn bản ở các định dạng khác (chữ in lớn, âm thanh, định dạng điện tử có thể tiếp cận, các định dạng khác)

- Cung cấp miễn phí các dịch vụ ngôn ngữ cho những người có ngôn ngữ chính không phải là tiếng Anh, như:
  - Thông dịch viên đủ năng lực
  - Thông tin được trình bày bằng ngôn ngữ khác

Nếu bạn cần những dịch vụ này, hãy liên hệ Civil Rights Coordinator

Nếu bạn tin rằng Name of covered entity không cung cấp những dịch vụ này hoặc phân biệt đối xử theo cách khác dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính, bạn có thể nộp đơn khiếu nại với: Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, Fax 512-719-6539. Bạn có thể trực tiếp nộp đơn khiếu nại hoặc gửi qua đường bưu điện, chuyển fax, hoặc email. Nếu bạn cần trợ giúp nộp đơn khiếu nại, Civil Rights Coordinator sẵn sàng giúp bạn.

Bạn cũng có thể nộp đơn khiếu nại về dân quyền lên U.S. Department of Health and Human Services (Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ), Office for Civil Rights (Văn Phòng Dân Quyền) bằng hình thức điện tử qua Office for Civil Rights Complaint Portal, có trên trang https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, hoặc qua đường bưu điện hoặc bằng điện thoại tại:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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