

City of San Marcos



Dental Benefits

Claims Address:

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

Customer Care:

English: (800) 282-5385
Spanish: (800) 385-9952

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Schedule of Dental Expense Benefits

City of San Marcos

Benefits Effective: January 1, 2016

This schedule represents a summary of dental benefits. For complete details of benefits and requirements please refer to the Dental Benefits Booklet.

Calendar Year Deductible	Waived for Preventive & Diagnostic
Basic and Major Services	
Individual	\$50
Family (Three family members must meet individual deductible.)	\$150
Maximums	
Preventive, Basic and Major Services (Calendar Year Maximum)	\$1,500

Covered Services	Benefit Level
Preventive & Diagnostic Services	100%
Basic Services	80%
Major Services	50%
Orthodontics	Not Covered

Description of Plan Benefits

Subject to the terms and conditions of the Plan, the Benefit Administrator will not pay benefits in excess of usual, reasonable and customary charges, which are incurred for eligible services, which are rendered by a licensed dentist.

Deductible

Before benefits are paid, you must meet the appropriate deductible shown in the Schedule of Dental Expense Benefits. The scheduled deductibles shall apply individually to each Covered Individual per calendar year. The plan also has a Family deductible amount, which is considered satisfied when three family members meet their entire individual deductible. The deductibles for the Basic Dental Services and for the Major Dental Services are combined and only a single deductible applies to these two (2) benefits in any calendar year.

Benefit Percentage

After the deductible, if any, has been satisfied, the Benefit Administrator will pay the appropriate percentage of eligible dental expenses that is shown in the Schedule of Dental Expense Benefits.

Maximum Benefit

The Benefit Administrator will not pay more than the maximum benefit shown in the Schedule of Dental Expense Benefits for each Covered Individual.

Benefits

The Plan benefits are divided into the following sections:

- Preventive Dental Services
- Basic Dental Services
- Major Dental Services

Alternative Benefits

If there is a less costly alternative to any service or supply which is proposed, furnished or provided and such alternative is within accepted standards of dental practice, then the usual and reasonable charges for such alternative shall be considered to be an eligible expense.

Covered Dental Expenses

The dental plan allows you to see the dentist of your choice. There is not a dental PPO network. The Benefit Administrator may pay benefits directly to the dental care provider if they are assigned by the covered individual and the dental care provider accepts assignment. If the dental care provider does not accept assignment, the benefits will be made payable to the covered individual. Please keep in mind that payment arrangements need to be made before utilizing services as some dentists require payment at the time services are rendered.

Covered dental expenses are those charges considered as the usual, reasonable, and customary dental charge made for dental services that are:

1. Necessary for preventive care and treatment of dental disease or defect.
2. Performed by a dentist or a dental hygienist working under supervision of a dentist.
3. Incurred for preventive, basic and major services while a Covered Individual.

Benefits will be payable after satisfaction of the Plan deductible in accordance with the Schedule of Dental Expense Benefits for the following Covered Expenses.

It is important to note that when there is more than one way to properly treat a particular dental condition, benefits will be payable not to exceed the benefit for the least expensive course of treatment. To help you identify your out of pocket costs, you may request a predetermination for plan benefits from TML MultiState IEBP.

Preventive Services

1. Oral Examinations limited to two (2) exams per calendar year
2. Prophylaxis (cleaning) limited to two (2) treatments per calendar year
3. Fluoride Treatments limited to children under the age of nineteen (19) and two (2) treatments in a calendar year
4. Sealants for children under the age of nineteen (19) not to exceed eight (8) applications per calendar year. One application is defined as sealant applied to a single tooth.
5. Bitewings X-Rays limited to once in a calendar year
6. Full mouth X-Ray limited to one (1) series in a thirty-six (36) consecutive month period, or Panoramic X-Ray limited to one (1) series in a thirty-six (36) consecutive month period
7. Periapical and Intraoral X-rays

Basic Services

1. Emergency oral exams, palliative treatments
2. X-rays (Intraoral/Extraoral and Cephalometric (non preventive))
3. Diagnostic casts
4. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed teeth. (Multiple restorations on the same tooth on the same day, which are billed independently of each other, will be recoded into the most appropriate procedure code as established by the American Dental Association (ADA))
5. Stainless steel crowns – primary/permanent tooth
6. Pin retention
7. Extractions – uncomplicated (single); each additional tooth; surgical removal of erupted or impacted tooth (including tissue flap and bone removal); postoperative visit (sutures and complications) after multiple extractions of impactions*
8. Anesthesia – general, in conjunction with surgical procedures only; analgesia; non- intravenous and intravenous sedation
9. Endodontics treatment – (root canal treatment and pulp capping when not provided on the same day as a permanent restorative service)

10. Periodontics – treatment of periodontal and other disease of the gums and supporting structures of the mouth including but not limited to the following:
 - a. Periodontal maintenance procedure limited to two (2) treatments per calendar year following active periodontal therapy
 - b. Periodontal scaling and root planing – limited to no more than four (4) quadrants in twelve (12) months
 - c. Full mouth debridement
 11. Oral surgery
 12. Occlusal adjustment if in active periodontal treatment
- * *If a participant is covered under both the medical and dental plan of the Employer, expenses incurred due to impacted wisdom teeth including anesthesia and postoperative care will be covered under the medical plan.*

Major Services

1. Space Maintainers – initial appliance only for children under age sixteen (16)
2. Removable mouthguards and all appliances used to alleviate thumb sucking, tongue thrashing and bruxism
3. Repair or recementing of crowns, inlays and onlays and bridges
4. Reline and adjustments of partial and complete dentures after six (6) months.
5. Onlays/Inlays
6. Crown Build-ups
7. Crowns – Necessary replacement of crowns or laboratory fabricated restorations, only when the crown or laboratory fabricated restoration is over five (5) years old
The following information must be provided if it is a replacement:
 - a. Date of prior placement; and
 - b. Reason for replacing crown.
8. Bridges-Partial Dentures – Full Dentures – Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace teeth which were extracted while covered under this Plan
Replacement of an existing partial or full removable denture or fixed bridge; the addition of teeth to an existing partial or removable denture; or bridgework to replace teeth which were extracted if satisfactory evidence is presented to the Plan that:
 - a. The replacement or addition of teeth is necessary to replace teeth extracted after the existing denture or bridgework was installed and while covered under the Plan
 - b. The existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to the replacement date
 The following information must be provided:
 - a. Initial placement – provide which teeth are being replaced and the Date of each extraction
 - b. Replacements – provide which teeth are being replaced and the Date of the prior placement and reason for this replacement
9. Gold restorations
10. Dental implants

Orthodontic procedures are not covered.

Dental Care Limitations

Dental benefits are not provided for the following:

1. for which a Covered Individual is not financially responsible or are submitted only because dental coverage exists or for discounts for which the Covered Individual is not responsible, including but not limited to independent and preferred provider discounts;
2. for services or supplies not necessary for the diagnosis or treatment of a dental condition or injury unless otherwise stated in the Plan;
3. for expenses applied toward satisfaction of any deductibles or benefit percentage;
4. in excess of usual and reasonable for services and supplies;
5. Any dental services and supplies for which benefits are, or could be, provided if proper claim were made through Workers' Compensation, Occupational Disease law, or any other present or future laws enacted by the legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality. This limit will not apply to any coverage for dental expenses available through any automobile insurance policy.
6. oral surgery limited to the following maxillofacial surgical procedures:
 - a. excision of non-dental related neoplasms, including benign tumors and cysts and all malignant lesions and growths;
 - b. incision and drainage of facial cellulitis; and
 - c. surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses;
7. for any service or treatment for cosmetic purposes, including but not limited to facings on crowns or pontics posterior to the second (2nd) bicuspid unless the services are required because of accidental bodily injuries and:
 - a. the accident occurs while the Covered Individual is covered under the Plan; and
 - b. the services are rendered while coverage is effective.

Note: This plan will always pay secondary if accident benefits are also payable under a medical plan.
8. for personalization of dentures;
9. for services or supplies provided for personal comfort and not necessary for treatment of a dental condition;
10. for experimental drug therapy or any dental procedure not approved by the Food and Drug Administration (FDA) or the American Dental Association (ADA);
11. for drugs labeled: "Caution - limited by federal law to investigational use" or experimental drugs, even though a charge is made to the Covered Individual;
12. for drugs and medicines lawfully obtainable without a physician's prescription (even if prescribed by a dentist) However, benefits certain medications are available under your Prescription Drug Plan;
13. for repair or replacement of a lost, missing or stolen dental device or appliance;
14. for splinting procedures for the stabilization of teeth;
15. for any service or supply which is not furnished by a dentist, except:
 - a. a service performed by a dental hygienist working under supervision of a dentist; and
 - b. x-rays ordered by a dentist;
16. for sealants at the age of nineteen (19) or above, oral hygiene instruction, a plaque control program or dietary instruction;
17. for replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge unless:
 - a. required because of accidental bodily injury which a Covered Individual sustains while covered under the Plan; or
 - b. the item is unserviceable and placement occurred at least five (5) years prior to replacement;

Note: This plan will always pay secondary if accident benefits are also payable under the City's medical plan.

18. for an appliance or modification where an impression was made or for a crown, bridge or laboratory-fabricated restoration for which the tooth was prepared, before the Covered Individual was covered under this Plan;
19. for charges submitted prior to the seat date of a permanent crown, bridge or laboratory-fabricated restoration;
20. for root canal therapy if the pulp chamber was opened before the Covered Individual was covered under this Plan;
21. for treatment of dysfunction of the temporomandibular joint (TMJ);
22. for occlusal adjustments if the Covered Individual is not in active periodontal treatment;
23. for inpatient and outpatient facilities;
24. for desensitizing medicaments and therapeutic or other drugs;
25. for osseous grafts or tissue regeneration membranes in or approximating extraction sites, when not in conjunction with periodontal services;
26. for office visits on the same day a service is performed;
27. for procedures not completed;
28. for any service being provided by more than one (1) dentist;
29. for services which do not have a favorable prognosis;
30. services requiring specialized construction where alternative benefits are available, including but not limited to coping, precision or semi-precisions attachments and modification of removable prosthesis;
31. for procedures to alter vertical dimension or restore occlusion;
32. for photos, bite analysis or registration; home preventive supplies or devices; athletic mouth guards; sterilization or infection control; irrigation; or consultations;
33. for cone beam craniofacial data capture including two and three dimensional image reconstruction;
34. for claims submitted by the Employee 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 the Group Benefits Administrator, 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, that the dental expense sought to be claimed is due to an injury that is non-compensable, whichever is later. Determination of reasonably possible is at the sole discretion of the Group Benefits Administrator; or
35. for charges incurred as a result of travel outside of the United States or its territories specifically to receive dental treatment, unless otherwise specifically covered under this Plan.

NOTE: If any dental care expenses are eligible under both this dental plan and the medical plan sponsored by the employer, expenses will be paid only under the medical plan. There will be no duplication of payment under the City's medical and dental plan.

Hospital expenses and prescription drug charges will be considered medical expenses. Benefits are not provided for those services under this provision.

Notice of Privacy Practices

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

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

Is all my health information protected?

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

How does the Plan use and share my health information?

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

What are treatment, payment and healthcare operations?

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

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

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

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

How else does the Plan share my health information?

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

- Directly with you or your personal representative. A personal representative is a person who has legal authority to make healthcare decisions for you. In the case of a child under 18 years of age, the child's personal representative may be a parent, guardian or conservator.
- In the case of an adult who cannot make his own medical decisions, a personal representative may be a person who has a medical power of attorney.
- With the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Plan's compliance with federal regulations on protecting the privacy and security of health information.
- With your family member, other relative, close personal friend or other person identified by you who is involved directly in your care. The Plan will limit the information shared to what is relevant to the person's involvement in your care and, except in the case of an emergency or your incapacity, you will be given an opportunity to agree or to object to the release of your health information.
- For public health activities.
- To report suspected abuse, neglect or domestic violence to public authorities.
- To a public oversight agency.
- When required for judicial or administrative proceedings.
- When required for law enforcement purposes.
- With organ procurement organizations or other organizations to facilitate organ, eye or tissue donation or transplantation.
- With a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties required by law.
- With a funeral director when permitted by law and when necessary for the funeral director to carry out his duties with respect to the deceased person.
- To avert a serious threat to health or safety.
- For specialized government functions, as required by law.
- When otherwise required by law.
- Information that has been de-identified. This means that the Plan has removed all your identifying information and it is reasonable to believe that the organization receiving the information will not be able to identify you from the information it receives.

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

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

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

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

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

The plan must always have your written authorization to:

- Use or share psychotherapy notes, unless the Plan is using or sharing the psychotherapy notes to defend itself in a legal action or other proceeding brought by you.

- Use or share your identifiable health information for marketing, except for: (1) a face-to-face communication from the Plan, or one its business associates, to you; or (2) a promotional gift of nominal value given by the Plan, or one its business associates, to you.
- Sell your identifiable health information to a third party.

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

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

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

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

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

Can I view my health information maintained by the Plan?

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

City of San Marcos
Attn: Director of Human Resources
630 E Hopkins
San Marcos, TX 78666-6397

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

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

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

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

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

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

address would place you in danger. Please be aware that the Plan is required to send the employee any payment for a claim that is not assigned to a healthcare provider, except under certain medical child support orders.

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

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

In writing:

City of San Marcos
Attn: Director of Human Resources
630 E Hopkins
San Marcos, TX 78666-6397

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

When are the privacy practices described in this notice effective?

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

Can the Plan change its privacy practices?

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

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

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

How can I get a paper copy of this notice?

Write to: City of San Marcos
Attn: Director of Human Resources
630 E Hopkins
San Marcos, TX 78666-6397

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

Write to: City of San Marcos
Attn: Director of Human Resources
630 E Hopkins
San Marcos, TX 78666-6397

Eligibility Requirements and Effective Dates for Coverage

Coverage provided under this Plan for Participants and the Dependents shall be in accordance with the Eligibility, Effective Date and Termination provisions as stated in this Plan Document, including any benefit coverage stated in the Schedule of Benefits. All participant coverage under the Plan shall commence at 12:01 A.M. Central Standard Time on the date such coverage is effective.

Participant Eligibility

A Participant eligible for coverage under the Plan shall include only employees who are employed by the City of San Marcos on a regular basis for at least thirty (30) hours per week. Once eligible, the Participant's coverage will be effective on the first day of the month following completion of the thirty (30) day waiting period. The waiting period is waived for eligible employees returning from an unpaid leave of absence.

A Participant eligible for dependent coverage shall be any participant whose dependents meet the definition in the following section of the Plan. Each Participant will become eligible for Dependent Coverage on the latest of the following:

1. The date eligible for participant coverage; or
2. The date a dependent is first acquired; or
3. The date the participant becomes eligible for dependent coverage.

If both spouse are employed by the Employer, and both are eligible for dependent coverage, either spouse, but not both, may elect dependent coverage for their eligible dependents.

Participant Effective Date

Participant coverage under the Plan shall become effective with respect to an eligible person on the first of the month following the 30th day of eligibility, provided written application for such coverage is made prior to the effective date. Eligible employees returning from an unpaid leave of absence will be reinstated on the day the employee returns to work.

In the event that application for coverage is not received prior to the effective date, then the employee will be automatically enrolled for employee only dental coverage.

Dependent Eligibility

A dependent will be considered eligible for coverage on the date the Participant becomes eligible for dependent coverage, subject to all limitations and requirements of this Plan, and in accordance with the following:

Spouse – The term “spouse” means the Participant's lawful spouse, whether or not such spouse is an employee. Common law marriages require a “Declaration and Registration of an Informal Marriage” certificate to be filed with the County Clerk's office before the marriage is considered legal.

Child(ren) – A child or children may be covered from birth to the last day of the month of his/her 26th birthday. Coverage may be extended in some instance as defined in the following section on extension of coverage.

A dependent that enters (or is in) the armed forces of any country as full-time member on active duty for a period that exceeds thirty (30) days is not eligible under this plan as a dependent. Subject to the limitations set forth in this plan, the term “Child” means a person who is not a covered employee under this Plan and is either:

1. Your natural, step-child or legally-adopted (or legally placed for adoption) or foster child placed by the State in the Covered Employee's care;
2. Your child or stepchild, for whom you or your spouse are required by court order to provide coverage regardless of whether the child resides with you or whether the child is eligible to be claimed as an exemption on your federal tax return;
3. Any other children living in your household and under legal guardianship; or
4. Dependent grandchild who is a dependent of the covered employee for federal income tax purposes at the time application for coverage of the child is made. Grandchildren who are not financially dependent upon

the covered employee upon time of enrollment, regardless of age, will not be eligible under the plan. The grandchild must continue to be a dependent of the employee for federal income tax purpose, who is financially dependent on the employee.

Dependents' Effective Date

Each participant who makes written request for dependent coverage hereunder, on a form approved by the Employer, shall, subject to the further provisions of this section, become covered for dependent coverage as follows:

Initial Eligibility

A Covered Individual's eligible dependents shall be covered on the date the Covered Individual begins participation in the plan, if a properly completed enrollment form is filed with the City's Human Resources Department within 31 days after the Covered Individual's effective date of coverage. Coverage of a spouse due to marriage will be effective on the first of the month following receipt of the change form in Human Resources as long as the form to add the spouse is received in Human Resources no later than 31 days following the date of marriage. Coverage added due to the qualifying event of birth, adoption or placement for adoption will be effective on the date of the birth, adoption or placement for adoption as long as the change form to add the child is received in Human Resources no later than 31 days after the birth, adoption or placement for adoption.

IMPORTANT: Refer to the section on qualifying events, which defines when changes can be made.

Extension of Coverage

Mentally or Physically Disabled Children

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

The Benefit Administrator may require satisfactory proof of the continued incapacity. The Benefit Administrator may request proof of the incapacity annually. If you fail to submit proof when reasonably required then coverage for the child will terminate.

COBRA Continuation of Coverage under Federal COBRA Laws

Once you and/or any family members become covered, there are specific COBRA events called "qualifying events" that can cause you or your family to lose coverage. The maximum coverage period and the timing of the employer notice requirements are measured from the date coverage is lost due to the qualifying event.

For more information see the section titled "COBRA Continuation of Coverage Rights under COBRA".

During Absence from Work

An employee who meets the definition of an active employee while on employer approved leave will be eligible to continue health care for themselves and their eligible dependents. This includes employees on paid leave, approved FMLA (whether paid or unpaid) and Military Leave (whether paid or unpaid). The City of San Marcos Employee Handbook governs leave policies. Sworn Police and Fire employees are affected by requirements of the Texas Firemen's and Policemen's Civil Service Law (LGC143).

Active Duty Reservists

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

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

In administering this coverage, the Benefits Administrator will follow the time guidelines of COBRA Continuation of Coverage under 42 U.S.C.A. 300bb-1 *et seq.* To qualify for this coverage, the employee must give written notice to the employer within sixty (60) days of the qualifying event. The employer must notify the Benefits Administrator 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 Continuation of Coverage for up to twenty-four (24) months and a right to reemployment once he/she is discharged from active military service.

If the employee will be on active duty for thirty-one (31) days or less, the employer will keep the employee on the plan with no change in coverage. If the employee will be on active duty for more than thirty-one (31) days, the employer will notify the Benefits Administrator of the qualifying event and submit a copy of the employee's written order for call to duty.

The employer must notify the Benefits Administrator by sending a Qualifying Event Notice and mark the qualifying event "Called to Active Duty" and attach a copy of the employee's written order for the call to duty.

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

For the employee nineteen (19) years of age or older to return to the employer's plan and continue their benefits with no waiting period the employee must return to work within the time period required by state and federal law for such return.

The additional 2% of contribution is not charged for an employee called to active duty.

Survivors of Certain Public Safety Employees

Coverage for a dependent cannot extend beyond the date coverage for the active employee ends, unless required by Section 615.071 of Chapter 615 of the Government Code for survivors of certain employees described in Section 615.003 of the Chapter who are killed in the line of duty. Section 615.075(c) requires that the survivor must give the employer notice of election to purchase coverage within 180 days of the decedent's death.

Family and Medical Leave Act of 1993

This plan will be administered in compliance with the Family and Medical Leave Act of 1993, including the right to maintenance and restoration of health benefits of an employee who is absent under the provisions of the act. For more information, contact the City's Human Resources Department or the nearest office of the Wage and Hour Division of the Department of Labor.

Retiree Eligibility

An employee separating from active employment with the City of San Marcos who is entitled to receive retirement benefits from the Texas Municipal Retirement System may elect to purchase continued health care coverage as follows:

Retiree (and Retiree Dependent)

Retirees may enroll themselves and their eligible dependents for coverage in place on the day the employee retires with the City of San Marcos. Retirees may only cover dependents that were on the Plan at the time of the employee's

retirement. Retirees are not permitted to add or change dependent coverage at the time of retirement or thereafter, including at Open Enrollment. In addition, Qualifying Events and Family Status Changes are not applicable to retired employees and their dependents.

Eligible retirees must enroll themselves and eligible dependents no later than the last day of the month in which the employee has coverage as an active employee with the City of San Marcos, or they are ineligible. The retiree must be enrolled for eligible dependents to be enrolled. Retirees are not eligible for participation in the City's plan if eligible for coverage through another employer.

After retirement, a retiree may elect to cancel coverage for themselves and/or dependents at anytime. Coverage will remain effective until the last day of the month in which coverage was cancelled, if premiums have been paid. If coverage for the retiree or eligible dependents is cancelled or the retiree discontinues coverage, there is no re-enrollment right.

Retirees who elect COBRA Continuation of Coverage cannot later elect retiree coverage.

Retiree Effective Date

Retiree coverage under the Plan shall become effective for eligible retirees on the first of the month following the end of active employment, provided written application for such coverage is made on or before the last day of the month in which the employee is covered as an active employee.

Retiree Payment of Contributions

Payment for retiree coverage contribution is due on the first day of the month of coverage with a thirty (30) day grace period. If payment is not received by the Benefits Administrator within the grace period, coverage will end on the last day of the month for which premiums were paid, with no reinstatement right.

Qualifying Events to Make Changes during the Plan Year

The following describes the circumstances under which you may be allowed to add or drop your eligible spouse or dependent children to your dental insurance under this plan, outside of the annual open enrollment period or your initial enrollment period. The spouse or dependent with the qualifying event is **not** the only individual who can make a change or be enrolled as a result of a qualifying event.

You have 31 days from the date of the “qualifying” event (or sixty (60) days if the qualifying event is the loss of coverage under Medicaid or SCHIP or becoming eligible for payment assistance under Medicaid or SCHIP) to make an eligible change to your dental coverage. If you make a change during the 31-day period allowed, the change to your coverage will be effective on the later of the first of the month following receipt of the change form **or** the date of the qualifying event, with the following exceptions:

1. Coverage for loss of dependent eligibility will end the last day of the month in which the dependent loses eligibility.
2. The effective date for adding a dependent child due to birth, placement for adoption or adoption will be the date of birth, placement for adoption or adoption, as long as the change form is received in Human Resources within the 31-day period allowed to make a change.
3. Coverage will be reinstated on the day an employee returns to work in an eligible position following leave as allowed under FMLA, USERRA, or unpaid leave of absence.

Evidence of the qualifying event is required. If you do not submit the form within the time period allowed, you will have to wait until the next open enrollment period to make the change, may be subject to a pre-existing condition limitation and may be required to continue payment of premiums under the Flexible Benefits Plan which are not refundable, and for which no benefit may be received under the dental plan.

Please be aware that if you have dependent children covered under your plan and acquire a new dependent child, you **MUST** enroll the new dependent in the plan within 31 days of acquiring that dependent. Coverage for the additional child is not automatic.

Qualifying Events (Change in Status)

1. A change in legal marital status (marriage, divorce, legal separation, annulment, death of spouse).
2. A change in the number of dependents (birth, adoption, placement for adoption, death). Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child’s adoption. The child’s placement for adoption with such person terminates upon the termination of such legal obligation.
3. Change in employment status for you, your spouse or dependent (termination or commencement of employment, strike or lockout, commencement or return from an unpaid leave of absence).
4. Change in dependent status (events that cause a dependent to satisfy or cease to satisfy eligibility requirements for coverage).
5. Initial or change in legal judgment, court decree or court order that requires coverage for a child who is a dependent of the employee.
6. Change in entitlement to Medicare or Medicaid.
7. Significant cost or coverage changes under another employer’s plan (Including a change made by your spouse or dependent during another employer’s open enrollment period that differs from the City of San Marcos’ open enrollment period).
8. Loss of coverage under a State’s children’s health insurance program (SCHIP) under Title XXI of the Social Security Act.
9. Special requirements relating to the Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA).
10. Special enrollment rights allowed under the Health Insurance Portability and Accountability Act of 1996.

Termination of Coverage

Employees are responsible for requesting termination of coverage for dependents that lose eligibility, within 31 days of the qualifying event. Failure to notify the Human Resources Department in a timely manner could result in payment of premiums under the Flexible Benefits Plan that are not refundable and for which no benefits may be received under the dental plan (Section 125 IRS regulations). Due to IRS regulations, we cannot process a change to the Flexible Benefit Plan that is requested more than 31 days after the event, or loss of coverage due to the event, and the next opportunity to end deductions will be at the next open enrollment period.

After termination of coverage, you will be issued a certificate of coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The certificate will show how long you were covered under the Plan and the date your coverage under the Plan ended. The plan will comply with all provisions of COBRA Continuation of Coverage. Coverage under the plan shall end at 12:00 A.M. Central Standard Time, on the last day of the month in which one of the events listed below occurs.

Participant Termination

Participant coverage shall automatically end the last day of the month in which*:

1. Participant terminates employment;
2. Participant ceases to be eligible for coverage;
3. Premiums have been paid; or
4. Termination of the benefit plan, or with respect to any participant benefits of the Plan, the date of termination of such benefit.

** Except as provided in any Extension of Benefits Provision.*

Dependent Termination

The Dependent Coverage of a Participant shall automatically end the last day of the month in which*:

1. The dependent ceases to be an eligible dependent as defined in the Plan;
2. Participant terminates employment;
3. Participant ceases to be eligible for coverage;
4. Participant fails to make any required contribution for dependent coverage by the end of the 30 days grace period;
5. Date the Plan is terminated; or with respect to any dependent's benefit of the Plan, the date of termination of such benefit; or
6. The dependent enters the armed forces of any country as full-time member if active duty is to exceed thirty (30) days.

** Except as provided in any Extension of Benefits Provision*

Retiree Termination

If a retiree elects to continue coverage for themselves and on a subsequent date elects to discontinue such coverage, the retiree and/or dependent is no longer eligible for coverage under this plan.

Retiree Participant coverage shall automatically end the last day of the month in which*:

1. Retiree elects to discontinue such coverage;
2. Retiree participant is eligible for group health benefits coverage through another employer;
3. Participant ceases to be eligible for coverage;
4. Premiums have been paid; or
5. Termination of the benefit plan or with respect to any participant benefits of the Plan, the date of termination of such benefit.

** Except as provided in any Extension of Benefits*

Retiree Dependent Termination

If the person elects to continue coverage for any dependent and on a subsequent date elects to discontinue such coverage, the dependent is no longer eligible for coverage under this plan.

The Dependent Coverage of a Retiree shall automatically end the last day of the month in which*:

1. The dependent ceases to be an eligible dependent as defined in the Plan;
2. Participant terminates participation in the plan;
3. Participant ceases to be eligible for coverage;
4. Participant fails to make any required contribution for dependent coverage by the end of the 30-day grace period; or
5. Date the Plan is terminated; or with respect to any dependent's benefit of the Plan, the date of termination of such benefit.

* *Except as provided in any Extension of Benefits*

COBRA Continuation of Coverage (COC) Rights under COBRA

Introduction

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

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

What is COBRA Continuation of Coverage?

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

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

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

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

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

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

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

Any decision of whether an Employee was terminated because of gross misconduct will be made by the Employer. The employer may not change its decision 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 Continuation of Coverage election notice was mailed to the employee, 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 II of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer and the bankruptcy results in the loss of coverage for any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see that your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA Continuation of Coverage does not limit your eligibility for coverage for a tax credit through the marketplace. Additionally, you may qualify for a special enrollment opportunity for 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 your enrollment within thirty (30) days.

When is COBRA Continuation of Coverage available?

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

You must give notice of some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Benefits Administrator within sixty (60) days after the qualifying event occurs. Notice must be provided to: TML MultiState IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385.

How is COBRA Continuation of Coverage provided?

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

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

Active Duty Reservists

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

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

In administering this coverage, the Benefits Administrator, will follow the time guidelines of COBRA Continuation of Coverage under 42 U.S.C.A.300bb-1 *et seq.* To qualify for this coverage, the employee must give written notice to the employer within sixty (60) days of the qualifying event. The employer member must notify the Benefits Administrator that an employee has been called to active duty and submit a copy of the employer member's active reservist policy to the Benefits Administrator.

Disability extension of COBRA Continuation of Coverage

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

Second Qualifying Event extension of COBRA Continuation of Coverage

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

Adding Dependents

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

If you have questions

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

- http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_fact_sheet.html; or
- <http://www.cms.gov/CCIIO/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 the Benefits Administrator informed of any changes in addresses of family members. You should also keep a copy, for your records, of any notices you send to the Benefits Administrator.

Benefits Administrator Contact Information

TML MultiState IEBP
1821 Rutherford Lane, Suite 300
Austin, Texas 78754

Phone:	(512) 719-6500
Customer Care:	(800) 282-5385
Medical Care Management:	(800) 847-1213
Spanish Line:	(800) 385-9952

How Benefits are Paid (Claims)

The Benefit Administrator may request specific information to complete processing of the claim or to verify eligibility in the Plan. As a covered individual and claimant under the Plan, you are responsible to supply the Benefit Administrator with information necessary to determine if charges incurred are for a covered expense. The Benefit Administrator reserves the right to withhold payment or deny a claim until the requested information has been furnished. Covered Individuals need to update their personal information, including address, in a timely manner through the City's Human Resources Department.

If required information is not provided, the claim will be denied. The claim may be re-filed as long as it is within the later of 12 months of the date of service or within ninety (90) days after a non-compensable claim decision is made by Workers' Compensation. Claims or information submitted later than 12 months from the date of service (or within ninety (90) days after a non-compensable claim decision is made by Workers' Compensation) will not be paid. To avoid a prompt pay penalty, required information must be received by TML MultiState not later than the prompt pay contract deadline.

Deductible and co-insurance (out-of-pocket amount) accumulate on a calendar year basis.

Benefits will not be paid to providers who negotiate benefit settlements with patients, i.e., agree to accept whatever payment the Plan makes or providers who waive deductibles or copays.

Requests for Reimbursement

All requests for reimbursement, or proof that services for a covered benefit have been incurred, must include:

1. the employee's name, address, social security number and group name;
2. the patient's name and relationship to the employee;
3. the health care provider's name, tax ID (National Provider Identification/NPI number or social security number) and address; and
4. a description of the service rendered including charges, diagnosis code and applicable procedure codes and the date of service.

The request for reimbursement must be legible. If a claim is not legible, it may be returned with a request to submit a legible copy. Claims submitted electronically must meet the Standard for Electronic Transactions and Code Sets set forth by appropriate regulatory bodies.

A Clean Claim must be submitted by a network provider no later than the filing deadline. If the provider fails to submit a clean claim within the filing deadline, the provider forfeits the right to payment unless the failure is a result of a catastrophic event that substantially interferes with the normal business operations of the network provider.

Claims or information submitted after twelve (12) months of the date of service or not within 90 days after a non-compensable claim decision by Workers' Compensation (the later of) will not be paid.

Assignments

The benefits provided under the Plan are payable to the covered individual. However, the Benefit Administrator will pay benefits directly to the health care provider if they are assigned by the Covered Individual.

Claims may be mailed to:

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

If you have any questions regarding your claim, please call IEBP's Customer Care Team at (800) 282-5385 or contact Customer Care via e-mail at www.iebp.org. Login and click on "Online Customer Care" under the "My Tools" menu, then click on "Send a Secure Email".

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, the Benefit Administrator has the right to disclose or obtain information regarding a Covered Individual from any organization or person if necessary to determine benefits payable under the Plan.

As a Covered Individual under the Plan, you must supply the Benefit Administrator with the information necessary to determine benefits payable. The Benefit Administrator reserves the right to withhold payments until the requested information has been furnished.

No Replacement for Workers Compensation

The Plan does not cover charges **arising out of the course and scope of any occupation** for wage or profit, or for which the Covered Individual is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law.

Self Audit Reimbursement

Once TML MultiState IEBP has audited and made payment on a bill, a covered individual who discovers an overcharge made by the medical facility or practitioner may provide the Benefit Administrator with a copy of the original billing, corrected billing and an explanation. The covered individual will be reimbursed 30% of the amount of savings generated. The reimbursement may not exceed \$500 per calendar year.

Subrogation

This Plan may withhold payment of benefits when a party other than the Covered Individual or the Plan may be liable for expenses until such liability is legally determined.

In the event of any payment for services under the Plan, the Employer shall, to the extent of such payment, be subrogated to all the rights of recovery of the Covered Individual arising out of any claim or cause of action which may accrue because of the alleged negligent conduct of a third party. Any such Covered Individual hereby agrees to reimburse the Plan, for any benefits so paid hereunder, out of any monies recovered from such third party as the result of judgment, settlement or otherwise; and such Covered Individual hereby agrees to take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Plan Administrator may require to facilitate the enforcement of their rights.

Conformity with Law

If any provision of this Plan is contradictory to any law to which it is subject, such provision is hereby amended to conform thereto.

Legal Actions

No legal action may be brought against the Employer and/or the Benefit Administrator prior to the expiration of sixty (60) days after written proof of services incurred has been furnished in accordance with the requirements of the Plan and all appeal rights pursuant to the Plan have been exhausted. No such action shall be brought after the expiration of two years from the date services were incurred. This paragraph shall be applicable where a provider makes a complaint that a prompt payment contract was not followed.

The Employer and/or the Benefit Administrator reserves the right to take any legal action available against a Covered Individual to recover expenses incurred by the Employer and/or the Benefit Administrator to defend frivolous lawsuits or actions brought before all appeal rights have been exhausted. Venue for any dispute arising under the terms of this plan, including but not limited to claims and subrogation disputes or declaratory judgment actions, shall be in Austin, Travis County, Texas.

Appeal of Denied Claims

If a claim for benefits is wholly or partially denied, an Explanation of Benefits (EOB) will be furnished to the Covered Individual and if benefits were assigned, to the Provider. This EOB will give the reason(s) the claim was denied. Should you disagree with the denial or allege that a contractual prompt payment requirement was not followed in the administration of a claim, you have a right to appeal. The appeal must be in writing and received within one hundred eighty (180) days from receipt of the related EOB.

On a claim denied for no notification, the request for review must include the admission medical history, physical inventory of conditions, the discharge summary and the operative and pathology report (if applicable) before being considered for response. An appeal without proper documentation may not be considered. Additional information may be required following review of the appeal. The Covered Individual is responsible for any charges for medical records necessary to render a determination of the appeal.

The Benefit Administrator will review the documentation submitted, request additional information if necessary and render a determination within sixty (60) days of receipt of the appeal. An extension of sixty (60) days will be allowed for making this decision if special circumstances are present.

The participant will be notified in writing of any extension within the first sixty (60) days following the appeal. The appealing party will be notified in writing of the final decision.

If the treatment is determined to have been an eligible benefit and the length of stay appropriate, benefits will be considered according to the plan. If the length of stay was not appropriate for the diagnosis and treatment, those unnecessary room and board and/or observation room charges will not be covered. If the treatment is determined not to be an eligible benefit, no benefits are payable.

If the Covered Individual does not agree with the appeal determination, they may appeal the decision to the Benefit Administrator a second time. The Benefit Administrator will render a recommendation to the appropriate City representative for review. The second appeal must be in writing and must be received within sixty (60) days of receipt of the initial appeal determination.

All requests for appeal should be submitted addressed as follows:

TML MultiState IEBP
Appeals
P.O. Box 149190
Austin, TX 78714-9190

Definitions

These terms define words that may be used in the Plan Document or to the extent that they relate to the administration of the Plan benefits. These definitions shall not be construed to provide coverage under any benefit unless specifically provided.

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

Actively at Work – a regular employee who works for the City of San Marcos for at least thirty (30) hours a week in the usual course of the employers business and who is not a temporary employee. An employee who is on paid leave, unpaid leave under the Family and Medical Leave Act of 1993 (FMLA) or on any other Government required leave including Military leave, will be considered an active employee for the purposes of this plan.

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

Benefit – the amount applied to the deductible, out-of-pocket or payable by the Plan for a covered service or supply.

Benefit Administrator – TML MultiState IEBP.

Benefit Percentage – that portion of eligible expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan.

Benefit Year – a period of time commencing with the effective date of this Plan or the Plan Anniversary, and terminating on the date of the next succeeding Plan Anniversary.

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

Clean Claim – a Clean Claim is a claim for covered services – that is received from a network provider that reflects the standard claim format, and accurately contains the following information: patient name, patient’s date of birth, unique identification number, provider’s name, address and tax ID number, national provider identification number, date(s) of service, diagnosis narrative or ADA code, procedure narrative or CPT-4 codes, services and supplies provided, physician name and license number and provider charges. If a claim exceeds \$15,000 outpatient and \$20,000 inpatient, an itemized bill will be required to adjudicate the claim. Claim must be submitted by provider no later than the filing deadline. A “Clean Claim” does not include a claim where integration/coordination of benefits is actively pursued, medical claims review is necessary, subrogation is pursued or where a work related condition may exist.

If the provider fails to submit the claim within compliance of the filing deadline and the clean claim definition the provider forfeits the right to payment unless the failure to submit the claim in compliance is a result of a catastrophic event that substantially interferes with the normal business operations of the network provider.

Contribution – the amount payable by the Employer, the amount payable by the Employee, or the amount payable by the Employer/Employee jointly for participation in the benefits of the Plan. Also referred to as contributory.

Cosmetic Procedure – a procedure performed solely for the improvement of a Covered Individual’s appearance rather than for the improvement of restoration of bodily functions.

Covered Dependent – an eligible and enrolled dependent of a Covered Individual as defined in the Definitions section and in the Eligibility section of this Plan.

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

Covered Expenses – benefit eligible services, or supplies that are not specifically excluded from coverage elsewhere in this Plan.

Covered Individual – a Covered Employee, Covered Dependent or Covered Spouse who is eligible and has enrolled in the Plan.

Covered Spouse – the term “covered spouse” means the Participant’s lawful spouse under applicable Texas state law, whether or not such spouse is an employee. Common law marriages require a “Declaration and Registration of an Informal Marriage” certificate to be filed with the County Clerk’s office before the marriage is considered legal.

Deductible – the amount withheld from eligible expenses before benefits become payable by this plan. The deductible is an out-of-pocket expense for the covered individual.

Dentist – a person who is a Doctor of Dental Surgery, (DDS) or Doctor of Dental Medicine (DMD) and who is a member of his/her state Dental Association or eligible for membership in such association.

Dependent – the legal spouse or eligible unmarried child of a Covered Individual/Retiree who is enrolled in the Plan. See the definition of dependent eligibility on pages 12-13.

Disability – any of the following conditions could be classified as a disability:

1. Illness;
2. Bodily malfunction;
3. Accidental injury;
4. Pregnancy;
5. Mental and nervous conditions; or
6. Chemical dependency.

A disabled person must be eligible for Medicare and have received Social Security due to disability. All expenses incurred as a result of the same or a related cause are considered one disability.

Disabled Child – an over age dependent child who is mentally or physically incapable of supporting themselves and is primarily dependent upon the Covered Individual for financial support.

All requirements of the definition must be met before an item can be considered to be Durable Medical Equipment.

Eligible Benefits – services or supplies which are covered benefits under this plan, as determined by this Plan Document and the Benefit Administrator.

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

Eligible Persons – all active, regular full-time Employees, Qualified Retirees, and qualifying Dependents will be considered Eligible Persons.

Employee – a person who works for the Employer.

Employer – the City of San Marcos or the San Marcos Area Chamber of Commerce.

Enroll – to make written application for coverage on the prescribed forms. Enrollment is not completed until such forms are received by the Employer and approved by the Benefit Administrator.

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

Full-time Employment – a basis whereby a Participant is employed by the Employer for a **minimum of thirty (30) hours per week**. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Participant to travel, and for which he/she receives regular earnings from the Employer.

Health Insurance Marketplace – Health insurance market plan through the Affordable Care Act’s Health Insurance Marketplace, www.HealthCare.gov.

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

Title I:

- › Refers to healthcare coverage reform and includes provisions for special enrollments and non-discrimination based on Health Status Factors;
- › HIPAA Title I does not apply to this dental plan.

Title II:

- › Effective April 14, 2003, Administrative Simplification guidelines were mandated. The administrative simplification process includes standards for electronic transactions and code sets, national identifiers (for employers, health plan and providers), Security and Electronic Signature Standards (final rule was published February 20, 2003) and Standards for Privacy of Individually Identifiable Health Information (Privacy Rule);
- › HIPAA Title II does apply to this dental plan.

Participant – See *Employee*.

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), Doctor of Medical Dentistry (DMD), or Doctor of Chiropractic (DC) who is eligible for membership in his/her 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 after coverage ends.

Plan Administrator – the City of San Marcos.

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.

Retiree – an employee who separates from active employment with the City of San Marcos and who is entitled to receive retirement benefits from the Texas Municipal Retirement System.

1. has policies which are developed with the advice of (and with provision for review of such policies from time to time) a group of professional personnel, including one or more physicians and one or more registered nurses, to govern the skilled nursing care and related medical care or other services provided;
2. has a physician, a registered nurse (R.N.), and a medical staff responsible for the execution of such policies;
3. 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;

4. maintains clinical records on all patients;
5. if required, provides twenty-four (24) hour nursing care under the supervision of a registered nurse (R.N.);
6. provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
7. 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;
8. is licensed by the appropriate state or local agency; and
9. 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.

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

Special Enrollee – the term “Special Enrollee” means an Employee or Dependent who is entitled to and who requests Special Enrollment within 31 days of losing other health coverage; or for a newly acquired Dependent, within 31 days of the marriage, birth, adoption, or placement for adoption.

Totally Disabled – a physical state of a Covered Individual resulting from an illness or injury which wholly prevents:

1. In the case of a Participant, from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and
2. In the case of a Dependent from performing the normal activities of a person of a like age and sex in good health.

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

Treatment Plan – a dentist's report to the Benefits Administrator which:

1. is on a form acceptable to the Benefits Administrator; and
2. lists the dental services he proposes to render to a Covered Person; and
3. shows his charge for each service; and
4. is accompanied by pretreatment x-rays or other diagnostic data which the Group Benefits Administrator may require.

Unproven Dental Procedures/Treatment – dental, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use;
- Determined not to be effective for treatment of the dental 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 or cohort studies in the prevailing published peer-reviewed dental literature;
- 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.);
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial, or the experimental arm of a Phase IV Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight;
- The subject of cohort studies in the prevailing published peer-reviewed dental literature;
- Well-conducted randomized controlled trials. Two (2) or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received; or
- Well-conducted cohort studies. Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Usual, Reasonable and Customary – a charge based on the geographical area in which services were provided. The geographical area is a county or greater area as necessary to establish a representative cross-section of health care providers regularly furnishing the services.

1. A charge is usual when it is the most consistent charge by a physician or provider of service to patients for a given service.
2. A charge is reasonable when it meets the usual and customary criteria as determined by the Plan; or it may be reasonable, if upon review, it merits special consideration based on the nature and extent of treatment of the particular case.
3. A charge is customary when it is within the range of usual charges for a given service billed by most physicians or providers of service.
4. A usual, reasonable and customary charge for a surgical procedure includes the total amount allowable as an eligible expense under the Plan for the surgery, hospital visits and postoperative visits following the surgical procedure by the doctor performing the surgery and/or any associates, partners, or affiliated physicians.

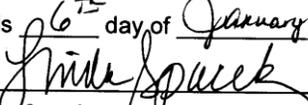
Waiting Period – the term that must pass under this Plan (or for purposes of determining Creditable Coverage, any other health plan) before an Employee or Dependent is eligible to enroll in the Plan (or other health plan as the case may be). Notwithstanding the foregoing, the time between the date a Late Enrollee or Special Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage shall not be treated as a Waiting Period.

Well-baby Care – medical treatment, services, or supplies rendered to a child or newborn solely for the purposes of health maintenance and not for the treatment of an illness or injury.

Signature Page

The effective date of the City of San Marcos Group Dental Plan Document is August 1, 2001 with amendments through January 1, 2016.

It is hereby agreed by the City of San Marcos that the provisions of this document are correct to the best of our knowledge and will be the basis for the administration of the City of San Marcos Group Dental Plan.

Dated this 16th day of January, 2016
By 
Title H.R. Director

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