SCHEDULE OF MEDICAL EXPENSE BENEFITS
CITY OF BROWNSVILLE ~ PLAN B
Benefits Effective: October 1, 2009

Notification (800) 847-1213 | **Claims (800) 282-5385**

En Español (800) 385-9952

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

The Plan pays a higher benefit for eligible expenses for charges incurred through a Network provider. Consult your Provider Directory, the web site www.tmliebp.org or call TML Intergovernmental Employee Benefits Pool at (800) 282-5385 to locate the provider nearest you.

Benefit	Maximum
Maximum Lifetime Benefit	$1,000,000
Maximum Lifetime Benefit for Chemical Dependency	3 Treatment Series
Maximum Lifetime Benefit for Durable Medical Equipment from Non Network Provider	$5,000
Maximum Lifetime Benefit for Prosthetics from Non Network Provider	$5,000
Maximum Lifetime Benefit for Hearing Test and/or Hearing Appliance (fitting & adjustment not subj. to max)	$1,000
Maximum Lifetime Benefit for treatment of Sleep Disorder (limited to Narcolepsy & Sleep Apnea)	1 per lifetime
Maximum Lifetime Benefit for Wig (Oncology Related)	$150
Maximum Lifetime Benefit for Custom Molded Foot Orthotics	1 pair
Maximum Lifetime Benefit for Prosthetic Bra (Oncology Related)	$150
Maximum Lifetime Benefit for Family Counseling (Limit is combined for all family members)	$500
Maximum Lifetime Benefit for Bereavement Counseling (Limit is combined for all family members)	$250
Maximum Benefit Per Occurrence Ambulance ~ Air	$5,000
Maximum Benefit Per Occurrence Ambulance ~ Ground	$1,500
Maximum Calendar Year Benefit for Preventive Care	$300
Maximum Calendar Year Benefit for Inpatient Rehabilitation (other than Mental/Nervous)	60 days
Maximum Calendar Year Benefit for Inpatient Mental/Nervous Conditions (excluding Serious Mental Illness)	30 days
Maximum Calendar Year Benefit for Outpatient Mental/Nervous (excluding Serious Mental Illness)	30 visits
Maximum Calendar Year Benefit for Physical and Occupational Therapy (Combined Maximum)	$2,000
Maximum Daily Benefit for Skilled Nursing Facility from Non Network Provider	$200
Maximum Calendar Year Benefit for Skilled Nursing Facility	100 days
Maximum Daily Benefit for Home Health Care from Non Network Provider	$55
Maximum Calendar Year Benefit for Home Health Care	100 visits
Maximum Allowable Daily Benefit for Hospice Care from Non Network Provider	$55
Maximum Calendar Year Benefit for Hospice Care	185 days/visits
Maximum Calendar Year Benefit for Chiropractic Care	$1,000
Maximum Allowable Calendar Year Benefit for Vision Exam	$100

Morbid Obesity or obesity (per the Plan's definition) which has an identified underlying illness will be paid for one (1) course of surgical treatment per lifetime, to a maximum benefit of $25,000. Expenses incurred do not accumulate to Out of Pocket maximum and the plan never pays at 100%.

All Lifetime and Plan Year Maximums with a dollar amount represent the Maximum Benefit Payable, unless stated as allowable

For Notification, please call Care Management Services at (800) 847-1213. Notification is required for all inpatient hospital admissions, pregnancy/maternity admissions, emergency admissions, acute care admissions, skilled nursing; long term care rehabilitation, transplant evaluations and services, home health care, hospice, durable medical equipment in excess of $1,000 per piece of equipment, cardiac rehabilitation, physician home health care, positron emission tomography (PET) scans, computerized axial tomography (CAT) scans, magnetic resonance imaging (MRI), diabetic self-management education in excess of $1,000, extended care facility admissions, psychiatric/chemical dependency admissions, residential & day treatment, convalescent nursing home for non-custodial rehabilitation services, dental injury, reconstructive surgical procedures, all treatments for sleep disorders, infusion therapy, prior to administering chemotherapy (including oral), Dialysis for End Stage Renal Disease (ESRD) & some outpatient surgeries. See your medical book for a complete list. A $500 penalty applies for late notification. **FAILURE TO CALL WILL RESULT IN REDUCED BENEFITS.**

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

If Population Health Engagement is refused without medical management agreement, all future disease related diagnosis claims will be adjudicated at the Non Network Benefit percentage and will not at any time pay at 100%.

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

The Covered Individual must notify Care Management of a scheduled admission five (5) working days prior to the date of service, within one (1) day after an emergency admission. If the notification is made after the above-referenced time frames, a late notification penalty will apply. Concurrent stay review requirements apply to all inpatient confinements. No benefits will be paid for any charges related to non-notified days or services.

Intensive Care Management services help you use your benefits wisely during periods of treatment due to serious sickness or injury. This is done through early identification of the need for care management, followed by on-going work with you and your provider to plan health care alternatives to meet your needs. The Intensive Care Manager will try to conserve your benefits by making sure that your care is handled as efficiently as possible.

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

Unproven Medical Procedures - Any medical procedure or drug that does not have scientific evidence that permits conclusions as to its effect on health outcomes. Scientific evidence is only evidence that is obtained from well designed and soundly conducted studies. Such studies must have been published in recognized peer review journals. The study must show a measurable effect on health outcomes that can be duplicated outside of the study's setting. Decisions to cover or exclude a treatment will be based on the conclusions of prevailing medical research. The use of a drug, substance or device that has not been approved by the United States Food and Drug Administration; or has been conditionally approved for limited diagnosis or treatment of conditions other than those for which a Covered Individual is receiving service, supply, or treatment (off label or unlabeled use); or has not been designated as efficacious by NCCN (National Cancer Care Network) or NIH (National Institute of Health) guidelines.

If you have a life threatening condition (e.g. likely to cause death within one year), the plan may provide coverage for a treatment that would otherwise be excluded under this provision. The plan reserves sole discretion to make this determination and a mandatory specialty review will be required prior to making a determination of coverage. Such coverage will only be approved if a treatment is provided under a specific research protocol that meets standards equal to those of the National Institutes of Health and has shown promise in limited use.

Multiple Surgery - the primary medical surgical procedure is considered at 100% of the allowable charges, the second surgical procedure is considered at 50% of allowable charges and the third or following procedure is considered at 50% of allowable charges. The ineligible amount may be the Covered Individual's out of pocket expense.

		Network	Non Network
Deductible Per Calendar Year Covered expenses incurred during any calendar year and applied toward satisfaction of a covered family member's individual calendar year deductible will be accumulated toward the Family Limit.	**Individual:**	$200	$300
Once the family deductible has been satisfied, it will not apply for any other family member's charges. Other family member's charges previously applied to the deductible will not be recalculated.	**Family:**	$600	$900

The calendar year deductible will be waived for the new calendar year for a hospital confinement spanning the end of one calendar year and the beginning of the next calendar year.

Charges incurred in the last three months of a calendar year, [October, November, & December] and used to satisfy the deductible, may be applied toward the next calendar year's deductible. Amounts used to satisfy the Deductible for Network and Non Network are combined.

		Network	Non Network
Out of Pocket Amount Per Calendar Year	**Individual:**	$500	$1,500
Once the deductibles and maximum Out of Pocket amount is satisfied per individual, the plan pays 100% of eligible charges. Once the family out of pocket amount has been satisfied, the Out of Pocket, it will not apply for any other family member's charges. Other family member's charges applied toward the Out of Pocket will not be recalculated.	**Family:**	$1,500	$4,500

If any part of the out of pocket was met during the last three months of a calendar year, [October, November, & December] and used to satisfy the out of pocket amount, those charges may also be used to meet the out of pocket amount in the next calendar year. Amounts used to satisfy the Out of Pocket for Network and Non Network are combined.

Civil Service Employees please refer to your Civil Services Agreement for additional information on out of pocket maximums.

Pre-Existing Conditions ~ $500 Maximum Benefit (first 12 months/per illness or injury) Charges incurred using a preferred lab facility will not count towards the pre-existing condition limitation.

BENEFIT PERCENTAGE PAYABLE AFTER DEDUCTIBLE/COPAY

	In Network	Non Network
Hospital Benefits (Non network Inpatient charges $100 daily copay~ $300 maximum)		
Inpatient Hospital Facility Charges	90%	70%
Outpatient Benefits	90%	70%
Ambulatory Surgery Centers	90%	70%
Pre-Admission Testing	90%	70%
Emergency Room (Access Fee is waived if admitted)		
Facility charges ~ subject to a $50 Access Fee	90%	70%
Physician	90%	70%
Urgent Care Center	90%	70%
Allergy Injections	100%*	70%
Only one copay applies if billed with an office visit charge.	after a $15 copay	
Physician		
Office Visit Fees	100%*	70%
Includes office visit or office consultation, labs, x-rays & injections	after a $15 copay	
Other Physician Services	90%	70%
Specialty Physicians (ERAP)	90%	90%
Emergency Room Physician, Radiologist, Anesthesiologist, Pathologist, related to services rendered in an in network hospital and/or outpatient surgery/radiology diagnostic clinic will be paid at the in network benefit percentage.		
Newborn Charges	90%	70%
Maternity Charges	90%	70%

	BENEFIT PERCENTAGE PAYABLE AFTER DEDUCTIBLE/COPAY	
	In Network	**Non Network**
Second Surgical Opinion	100%* after a $15 copay	70%
Preferred Lab	100%*	N/A
Includes laboratory expenses from a TML IEBP Preferred Lab Provider and Preferred Lab drawing site (deductible waived for Preferred Lab).		
Physician professional fee is payable as an Other Physician Service if not done at a Preferred Lab drawing site.	90%	70%
Non-Preferred Lab	100% after $15 copay	70%
Outpatient X-ray	90%	70%
Preventive Care Benefits	100%*	70%
Paid at 100% (in-network providers) up to $300 payable max per calendar year. Preventive care above the $300 is **not** an eligible expense. (Mammograms, PSAs, Colon/Rectal exams, Pap tests and immunizations do not apply to the $300 maximum)		
Emergency Ambulance Services (Subject to per occurrence maximum)	80%*	80%*
Transplants	90%	N/A
Home Health Care (Limited to 100 visits per Calendar Year) (Non Network subject to $55 daily maximum benefit ~ in addition to 100 visit maximum)	90%	70%
Skilled Nursing	90%	70%
Skilled Nursing Facility (Limited to 100 days per Calendar Year) (Non Network subject to $200 daily maximum benefit ~ in addition to 100 day maximum)	90%	70%
Hospice Care (Inpatient and Outpatient ~ Limited to 185 days/visits per Calendar Year) (Non Network subject to $55 daily maximum benefit ~ in addition to 185 day/visit maximum).	90%	70%
Speech Therapy	90%	70%
Physical Therapy and Occupational Therapy (Combined limit $2,000 per Calendar Year)	90%	70%
Outpatient Cardiac Rehabilitation	90%	70%
Mental/Nervous (Non network Inpatient charges $100 daily copay~ $300 maximum)		
Inpatient (Limit 30 days per Calendar Year ~ Combined)	90%	70%
Residential Treatment (Limit 30 days per Calendar Year ~ Combined)	90%	70%
Day Treatment (2:1 ~Limit 30 days per Calendar Year ~ Combined)	90%	70%
Intensive Outpatient (Limit 30 visits per Calendar Year ~ Combined)	90%	70%
Outpatient (Limit 30 visits per Calendar Year ~ Combined)	100%* after $15 copay	70%

Serious Mental Illness

Expenses incurred by a Covered Individual for treatment of "Serious Mental Illness" are payable as any other illness subject to the lifetime maximum of the plan as stated in the Schedule of Benefits. The term "Serious Mental Illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic & Statistical Manual (DSM) III-R:

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

BENEFIT PERCENTAGE PAYABLE AFTER DEDUCTIBLE/COPAY	**In Network**	**Non Network**
Serious Mental Illness		
Physician Charges	100%* after a $15 copay	70%
Facility Charges (Non network Inpatient charges $100 daily copay~ $300 maximum)		
Inpatient Facility	90%	70%
Outpatient Facility	90%	70%
Chemical Dependency		
Expenses for the treatment of chemical dependency conditions accumulate towards the Plan's $1,000,000 lifetime maximum and are considered the same as any other illness for the Plan's deductible. Expenses for the treatment of chemical dependency have a lifetime maximum of three (3) treatment series.		
Inpatient	90%	70%
Outpatient	100%* after a $15 copay	70%
Alternative Setting	90%	70%
Residential Treatment	90%	70%
Family & Bereavement Counseling (subject to Maximums)	90%	70%
Diabetic Education	90%	70%
Chiropractic Care (Non surgical treatment ~ Limited to $1,000 per Calendar Year) Charges do not apply towards satisfaction of Out of Pocket	90%	70%
Custom Molded Foot Orthotics (One pair per lifetime)	90%	70%
Durable Medical Equipment & Prosthetics (except bras ~ oncology related) (Non Network providers subject to maximum lifetime benefit)	90%	70%
Prosthetic Bra ~ Oncology Related only (Subject to $150 lifetime max)	100%*	100%*
Wig ~ Oncology Related only (Subject to $150 lifetime max)	100%*	100%*
Vision Exam (Limited to $100 per Calendar Year)	100%*	70%
All Other Eligible Medical Expenses	90%	70%

* **Deductible Waived**

Extenuating Circumstances
If a Covered Person is out of the area served by the Preferred Provider Network (i.e., on vacation, a business trip, away at school, etc.). The Plan will pay eligible expenses at the Network Benefit Percentage. An Extenuating Circumstance will also include an immediate care situation as defined by the Plan.

Statewide Network
To locate a statewide provider, call the TML Intergovernmental Employee Benefits Pool number on your medical ID card, consult your Provider Directory, go to the TML IEBP web site www.tmliebp.org or call TML Intergovernmental Employee Benefits Pool at (800) 282-5385 to locate a Network provider nearest you. In order to receive the Network benefits for a statewide provider, you will need to use a TML IEBP preferred provider.

Non Network Providers
For Non Network providers, these expenses are subject to usual, reasonable and customary allowable amount.

Right of Recovery
A Right of Recovery form will need to be completed on all accidents or suspected accident claims. The Covered Person agrees to cooperate fully with TML Intergovernmental Employee Benefits Pool in asserting its right to subrogate. This means the Covered Person must supply TML Intergovernmental Employee Benefits Pool with all information and sign and return all documents reasonably necessary to carry out TML Intergovernmental Employee Benefits Pool's right to recover from the third party any benefit paid under the Plan which are subject to the provision.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
HIPAA provides individuals certain rights and protection relating to their healthcare coverage. Federal law gives the plan sponsor of non-Federal governmental plans the right to exempt the plan in whole or in part from these requirements. The City of Brownsville will opt out of HIPAA and is exempt from the HIPAA Title I requirements.

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. Federal law gives the plan sponsor of non-Federal governmental plans the right to exempt the plan in whole or in part from requirements of Title I except for the creditable coverage certificate requirements. The City of Brownsville's plan has opted out of HIPAA and is exempt from the Title I HIPAA requirements. The City of Brownsville does voluntarily comply with some of the Title I HIPAA requirements. A list may be found on the first page of the Schedule of Medical Expense Benefits.

Title I:

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

Title II:

- Effective April 14, 2003, Administrative Simplification guidelines have been mandated. The administrative simplification process includes standards for electronic transactions and code sets, national identifiers (for individuals, 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);
- A self-funded, non-federal, governmental health plan cannot exempt itself from the Title II requirement.

Coordination of Benefits

When you and/or your dependents are covered under more than one group health plan, the combined benefits payable by this plan and all other plans will not exceed 100% of the eligible expense incurred by the individual.

Continuation of Coverage

For yourself or covered dependents is available if you or your covered dependents have a loss of coverage under the plan as a result of a qualifying event. Your or your covered dependents may have to pay for the benefit coverage. Review your benefit document regarding Continuation of Coverage Rights.

Self-Audit Reimbursement Any covered person who reviews their eligible medical expenses and discovers an overcharge made by the medical facility or practitioner may provide the Group Benefits Administrator with a copy of the original billing, corrected billing and an explanation. The Covered Employee will be reimbursed 30% of the amount of savings generated. The reimbursement may not exceed the Covered Person's individual calendar year deductible and out of pocket amount.

Claims Appeal

If a claim for benefits is wholly or partially denied, an Explanation of Benefits (EOB) will be furnished to the covered individual and the provider of services (if the claim was assigned). This EOB will give the reason(s) the claim was denied. If the covered individual, employee or provider of services does not agree with the claim decision or alleges that a contractual prompt payment requirement was not followed in the administration of a claim, he or she may submit an appeal. The appeal must be in writing and received by the Benefits Administrator within ninety (90) days of the date of the EOB. Relevant information supplied by the covered individual or healthcare provider should be included with the appeal. For claims denied or partially denied for not being notified, the appeal must include the admission history and physical, the discharge summary and the operative and pathology reports (if applicable) before it can be considered.

Any person receiving a copy of Care Management's adverse determination may appeal in writing to Care Management within five (5) business days of the date the adverse determination letter was received. All available medical information must be provided at no cost to the Plan. Care Management's determination will be reviewed by an appropriate physician specialist who has not previously reviewed the case. All parties who were notified of the original determination will be notified of the appeal decision within twenty (20) business days of the receipt of all medical information necessary to render a determination.

An appeal requested without proper documentation may not be considered. These appeal provisions shall be applicable where a provider makes a complaint that a prompt payment contract was not followed.

All written appeals should be sent to:

TML IEBP
Attn: Appeals Department
PO Box 149190
Austin, Texas 78754-9190

If a claim was denied for a reason other than failure to provide Notification, the Service Team Manager or designee, will review the claim and consider any additional information submitted by the Covered Individual. A decision will be recommended within sixty (60) days of the receipt of all information required to reach a determination. The Service Team Manager or designee will provide the information to the employer for the final decision. The Covered Individual will be notified in writing of the results of an appeal.

Filing Deadline

No benefits are payable for claims or information submitted by the employee or a provider more than 12 months after the date incurred.

Important Disclaimer

The information presented in this Schedule of Medical Expense Benefits **IS NOT** a guarantee of payment. The benefits described are subject to all plan limitations, pre-existing information, exclusions and eligibility requirements. These benefits are given in accordance with the details referenced in your medical benefits booklet.

If a patient is on continuation of coverage (COC), coverage could terminate retroactively if the individual's contribution is not made within COC time guidelines.

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

When you contact Member Services you will be given a call reference number. This number **IS NOT** a Notification number. You will need to contact Care Management at (800) 847-1213 for Notification or medical questions.

Claims Address:

PO Box 149190
Austin, Texas 78714-9190

Customer Service:

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

Care Management:

Notification (800) 847-1213

Professional Health Coach Services (888) 818-2822