Denison

CORE PLAN

Plan Benefits Effective: 10-01-2006 to PRESENT

Notification: (800) 847-1213

Claims: (800) 282-5385

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 incurred through a Network provider. To locate Network providers, consult your Provider Directory, the TML IEBP website (www.tmliebp.org) or call TML IEBP at (800) 282-5385

Maximum Lifetime Benefit	$2,000,000
Maximum Lifetime Benefit for Chemical Dependency	One Treatment Plan
Maximum Lifetime Benefit For Hospice Care	$30,000
Maximum Lifetime Benefit For Wigs for Oncology Covered Individuals	$150
Maximum Lifetime Benefit For Prosthetic Bra for Oncology Covered Individuals	$150
Maximum Lifetime Benefit for Hearing Appliance	$1,000
Maximum Lifetime Benefit for Custom Molded Foot Orthotics	One pair per Lifetime
Maximum Lifetime Benefit for Sleep Disorders	$5,000
Maximum Lifetime Benefit for Morbid Obesity Treatment	$30,000
Calendar Year Maximum for Preventive Care Benefits	$300
Calendar Year Maximum for Mammogram	1 exam
Calendar Year Maximum for Pap Screening	1 exam
Calendar Year Maximum for PSA (Prostate Specific Antigen Test)	1 exam
Calendar Year Maximum for Inpatient Private Duty Nursing	$1,000 at 50%
Calendar Year Maximum for Mental/Nervous	

Inpatient and Residential	7 days
Day Treatment	14 days
Outpatient	26 visits
Calendar Year Maximum for Chemical Dependency	
Inpatient and Residential	7 days
Day Treatment	14 days
Outpatient	26 visits
Calendar Year Maximum for Chiropractic Care	$1,000
Calendar Year Maximum for Speech Therapy	$2,000
Calendar Year Maximum for Physical and/or Occupational Therapy (combined)	$2,000
Calendar Year Maximum for Nutritional Counseling	$1,000

Pre-Existing Conditions

Maximum Benefit
Initial 12 Months of benefit eligibility
Same as any other illness thereafter or if treatment free for 12 consecutive months.

$2,000

Notification requires standard care management notices: emergency admission; scheduled admissions; newborn/ pregnancy/maternity admissions; transplant services; morbid obesity evaluation services; outpatient surgical procedures; outpatient infusion therapy; miscellaneous: Hospice, Home Healthcare; physician home visit; cardiac rehabilitation; Positron Emission Tomography (PET) scans; convalescent nursing home services; inpatient rehabilitation services; dental injury; end stage renal dialysis (ESRD); reconstructive surgical

procedures; and durable medical equipment in excess of $1,000. (See Medical Benefits booklet for a complete list). For notification, please call Care Management Services at (800) 847-1213.

Disease Management services help control the affects of chronic diseases. This is done through a pro-active program of disease identification. Once a need is identified, the program offers ongoing education, support and coordination of professional and self-care needs for the disease. If Disease Management is refused, all future payments will be paid at the Non Network benefit percentage or 50% for indemnity plans and will not, at any time, pay at 100% for medical services under the out of pocket provision of this Plan.

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. The care manager will try to conserve your benefits by making sure that your care is handled as efficiently as possible. The care management staff consists of licensed, professional nurses. They are aware of the importance of the doctor/patient relationship. Care Management also monitors the care of the Covered Individual, offers emotional support to the family and coordinates communications among healthcare providers, patients and others. These objectives will be met through Plan benefits (and non-Plan benefits as arranged by Care Management) to Covered Individuals who are eligible.

Care Management is an option. However, should Care Management be refused by the Covered Individual or physician, benefits will pay at the Non Network benefit percentage or 50% for indemnity plans and will not, at any time, pay at 100% for any medical services under the out of pocket provision of this Plan. If Care Management is refused, all future payments for any medical services will be paid at the reduced benefit. The individual Deductible and out of pocket amount must be met each calendar year.

The Care Management Team will coordinate care and document notification communication.

What Happens on Inpatient Treatment?
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.

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.

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. 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.

Full-Time Student - coverage may be extended for a child from the age of nineteen (19) up to the end of the twenty-fourth (24th) birthday month who is attending:

An accredited high school;
Junior college, College or university on a full-time basis (the equivalent of at least twelve (12) semester hours for undergraduate student; and the equivalent of at least nine (9) semester hours for graduate student or considered full time by the educational institution for student body population); or
Attending a licensed trade school at least twenty (20) hours per week in a course requiring a minimum of six (6) months to complete. Proof of enrollment must be provided when requested.

Proof of enrollment will be requested twice per plan year.

The Group Benefits Administrator will request written proof of the eligibility of any dependent other than a spouse or natural child. In special circumstances, the Group Benefits Administrator, in its discretion, may request written proof that a spouse or natural child is an eligible dependent. These requests are to verify eligibility and to determine if this Plan is primary or secondary. Proof of a properly filed declaration of informal marriage will be necessary for an informal marriage to be recognized by the Plan.

Qualified Medical Child Support Order (QMCSO) Managing Conservator of a Minor Child
In subchapter J Medical Child Support Article 3.96-1 Section 154.18 & 154.187 Texas Family Code Provision, TML IEBP will extend benefits to children of covered employees who are divorced, separated or born out of wedlock. TML IEBP will impose the late entrant limitation if time of enrollment is subject to the late entrant provision. If the child is covered under a Qualified Medical Support, the child will obtain Continuation of Coverage rights if coverage is lost due to a qualifying event.

TML IEBP will require the Covered Individual to complete the application form to have benefits paid by the managing conservator of a minor child. Once the form is complete, TML IEBP will review the request and make a decision if the request meets the definition of a Qualified Medical Child Support Order for TML IEBP. Within 30 days of receipt, TML IEBP will provide a written notice of the decision regarding manager conservator of an eligible minor child healthcare benefits. TML IEBP will send notices to each attorney or other representative who may be identified in the order for correspondence.

Out of Pocket Amount Per Calendar Year

	Network
	$3000

Once the Network Out of Pocket maximum is satisfied per individual, the plan pays 100% of eligible Network charges.

Eligible Expenses incurred with a Non Network provider will never pay at 100%.

Once two individuals have satisfied the Out of Pocket, it will not apply for any other family member?s charges. Other family member?s charges previously applied toward the Out of Pocket will not be recalculated.

For a confinement that continues into a new calendar year, amounts applied toward the prior calendar year Out of Pocket will also count toward satisfying the next calendar year Out of Pocket for charges during that confinement.

Access Fees and Other Penalites
Emergency Room access fees, notification penalties and any other ineligible expenses do not apply to Deductible or Out of Pocket expenses.

BENEFIT PERCENTAGE PAYABLE

Network*
Non Network*

Specialty Physicians

70%
70%

Anesthesiologist, Pathologist, Radiologist, Emergency Room Physician related to services rendered in a Network hospital and/or outpatient surgery/radiology diagnostic clinic.

Facility Charges

Inpatient Hospital Benefits
Outpatient Surgical Benefits
Ambulatory Surgical Center

90%
70%
70%
50%
50%
50%

Emergency Room

Facility Charges after $50 access fee
Physician

70%
70%
50%
70%

Physician Services

70%
50%

Accident Benefit

70%
50%

Second Surgical Opinion

70%
50%

Preferred Lab Program

100%
N/A

Includes laboratory expenses from a Preferred Lab Provider and Preferred Lab drawing site.

Physician professional fee is payable as Other Physician Services if not done at a Preferred Lab drawing site.

70%
50%

Other Outpatient Lab and X-ray (Non-Preferred Lab)

70%
50%

Preventive Care Benefits

100%
100%

Routine physicals and tests for employees and dependents are limited to $300 per individual per calendar year.

If preventive care eligible expenses exceed $300, the expenses will not be paid.

Routine mammograms, Pap screening, PSA tests and Colon Cancer Screening do not apply to the $300 maximum. Routine mammograms, Pap screening and PSA tests are limited to one exam per calendar year.

Immunizations and Inoculations are paid at 100% and do not apply to the $300 maximum. (See Medical Benefits booklet for immunizations paid at 100%).

All Non Network provider expenses are subject to usual, reasonable and customary allowable amount.

Emergency Ambulance Services

70%
70%

Maximum payable for Ground Ambulance: $1,250 per occurrence.

Maximum payable for Air Ambulance: $7,500 per occurrence.

Home Health Care

70%
50%

Maximum payable per 2-hour visit is $100. Eligible supplies, equipment and therapy are not included in the $100 maximum and are eligible under other major medical expense benefit.

Hospice Care (Inpatient and Outpatient); Maximum of $30,000 payable per lifetime.

70%
50%

Mental/Nervous

70%
50%

Inpatient and Residential limited to 7 days per calendar year.

Day treatment limited to 14 days per calendar year.

Outpatient limited to 26 visits per calendar year.

Intensive Outpatient accumulates to the 26 outpatient visit limit per calendar year.

Medication checks are not included in the 26 outpatient visit limit per calendar year.

Chemical Dependency

70%
50%

Chemical Dependency benefit is limited to one treatment program per lifetime and will never increase to 100%.

Inpatient and Residential limited to 7 days per calendar year.

Day treatment limited to 14 days per calendar year.

Outpatient limited to 26 visits per calendar year.

Intensive Outpatient accumulates to the 26 outpatient visit limit per calendar year.

Medication checks are not included in the 26 outpatient visit limit per calendar year.

Serious Mental/Nervous Illness (Inpatient and Outpatient)

70%
50%

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

1. schizophrenia;
2. paranoia and other 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 (OCD); and
8. depression in childhood and adolescence.

Chiropractic Care ~ Maximum of $1,000 payable per calendar year.

70%
50%

Medical Supplies

70%
50%

Durable Medical Equipment (never pays at 100%)

70%
50%

Prosthetic/Non Foot Orthotics and/or Implants (never pays at 100%)

70%
50%

Wigs for Oncology Patients ~ Maximum of $150 payable per lifetime.

70%
50%

Prosthetic Bra for Oncology Patients ~ Maximum of $150 payable per lifetime.

70%
50%

Custom Molded Foot Orthotics ~ One pair per lifetime.

70%
50%

Hearing Appliance ~ Maximum of $1,000 payable per lifetime.

70%
50%

Speech Therapy ~ Outpatient maximum of $2,000 payable per calendar year.

70%
50%

Physical and/or Occupational Therapy

70%
50%

Outpatient maximum combined of $2,000 payable per calendar year.

Morbid Obesity Treatment Predetermination Approval and Designated Center

50%
0%

Other Major Medical Expenses

70%
50%

Prescription Drugs (see Prescription Drug Benefit schedules)

50%

Outpatient prescriptions that are available through the Pharmacy Benefit Manager or Specialty Pharmacy Benefit Manager but accessed through the Medical plan will be reviewed for claims processing at the Non Network benefit percentage or 50% for indemnity plans and will not, at any time, pay at 100% for any prescription services under the out of pocket provision of the Plan.

*** All provider expenses are subject to usual, reasonable and customary allowable amount.**

Filing Deadline
No benefits are payable for claims submitted by the employee or a provider more than twelve (12) months after 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 Workers' Compensation. All requested additional information relating to the claim must also be received within the same time frame. Benefits will not be recalculated to allow a better benefit for charges incurred at a later date.

Extenuating Circumstances
If a Covered Person requires immediate care until stabilized or if a specialist care provider is required but there is not a Network specialist care provider within a seventy-five (75) mile radius from the employee's place of business, the provider would be paid at 70% subject to the Network Deductible, Network Out of Pocket and subject to usual, reasonable and customary allowable amounts.

Integration of Benefits
Applies when a covered person may receive benefits for medical expenses from more than one source. The benefits payable under this plan will not exceed 100% of the eligible benefit when combined with all other plans.

Continuation of Coverage (COC)
The right to COC was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COC can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan book or contact TML IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754, (512) 719-6500.

Right of Recovery
A Right of Recovery Form will need to be completed on all accidents. The Covered Individual specifically delegates to the Group Benefits Administrator the right to make a claim or assert a cause of action on the Covered Individual's behalf against any source of recovery, and assign to the Group Benefits Administrator the right to any proceeds from the claim or cause of action.

Self-Audit Reimbursement
Any Covered Individual, 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 Individual will be reimbursed 30% of the amount of savings generated. The reimbursement may not exceed the Covered Individual's individual calendar year Deductible and Out of Pocket amount.

Claims Appeals
If a claim for benefits is wholly or partially denied, an Explanation of Benefits (EOB) will be furnished to the Covered Individual and the Provider of Services. This EOB will give the reason(s) the claim was denied. If the Covered Individual or provider of services does not agree with the claim decision, he or she may submit an appeal. The appeal must be in writing and received by the Pool within one-hundred eighty (180) days of the date of the EOB. Relevant information supplied by the Covered Individual or healthcare provider should be included with the appeal. For claims denied or partially denied for not being notified, the appeal must include the admission history and physical, the discharge summary and the operative and pathology reports (if applicable) before it can be considered. An appeal requested without proper documentation may not be considered. All written appeals should be sent to the address printed on the Covered Individual's TML IEBP ID card.

The appealing party will be notified in writing of the results of an appeal for failure to provide Notification and/or a denial or reduction in benefits within 30 days after receipt of all necessary information to make a determination. Failure to provide such written notice will not grant the appeal. All available medical information must be provided at no cost to the Plan.

If the individual does not agree with the decision, the appeal may be elevated to the Board of Trustees, TML IEBP, 1821 Rutherford Lane, Suite 300, Austin, TX 78754-5151. Usually within forty-five (45) days of receipt of the denial of appeal, a committee of Trustees will schedule a meeting and hear the appeal. The appealing party may submit additional information and/or appear before the committee. The appealing party will be notified of the date, time, and place the committee will meet at least five days prior to the meeting date.

A final decision will be made by the Board of Trustees Appeals Committee and sent to the appealing party usually within ninety (90) days after the receipt of the request, but in no case more than one-hundred eighty (180) days

after the request for review is received. The Appeals Committee's final decision will be in writing and include specific references to the Plan provisions on which the decision was based.

Provider Overpayments - the Provider agrees to refund TML IEBP all duplicate or erroneous claim payments regardless of the cause. After thirty (30) days notice of any overpayment made by the Pool, the Provider agrees that the Pool has the right to offset unpaid refunds against future payments.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
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. TML IEBP has opted out of HIPAA Title I and is exempt from the Title I HIPAA requirements.

Title I:

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

Title II:

> Called the Administration Simplification Act, includes standards for electronic transactions and code sets, national identifiers (for employers, health plans and providers), Security Standards for the Protection of Electronic Protected Health Information (Security Rule), Electronic Signature Standards 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.

Privacy of Your Health Information

A Federal regulation, called the "Privacy Rule," requires TML Intergovernmental Employee Benefits Pool to protect the privacy of each Covered Individual's identifiable health information. Under the Privacy Rule, TML Intergovernmental Employee Benefits Pool may use and disclose a Covered Individual's identifiable health information only for certain permitted purposes, such as the payment of claims under the health plan. If TML Intergovernmental Employee Benefits Pool needs to use or disclose a Covered Individual's health information for a purpose not permitted under the Privacy Rule, TML Intergovernmental Employee Benefits Pool must first obtain a written authorization signed by the Covered Individual.

In addition to restrictions on how TML Intergovernmental Employee Benefits Pool may use and disclose a Covered Individual's identifiable health information, the Privacy Rule gives each Covered Individual certain rights. These include the right of a Covered Individual to access his or her health information, to amend his or her health information, and to receive an accounting of certain disclosures of his or her health information.

Reservation of Rights
This is a governmental plan excluded from coverage under ERISA.

The Plan covers employees, dependents of employees, elected officials, dependents of elected officials, retirees, and dependents of retirees of Pool Members who are eligible for the coverage, become covered, and continue to be covered, according to the terms of the Plan, Pool policies, and the policy of the Employer Member. Enrollment in the Group Medicare Supplement Plan requires that the Covered Individual be enrolled in Medicare Parts A and B. The terms of the Plan are described in the following pages. The Board of Trustees of the TML Intergovernmental Employee Benefits Pool reserves the right to amend this Plan if circumstances warrant and have given the Executive Director the discretionary authority to construe the terms of the plan.

Important Disclaimer
The information presented in this Schedule of Benefits **IS NOT** a guarantee of payment.

The benefits described are subject to all plan limitations, pre-existing information, filing deadlines, exclusions and eligibility requirements. All benefits are based on the plan document language.

If a Covered Individual is on continuation of coverage (COC), coverage could terminate retroactively if the individual's contribution is not made within the COC payment timeframe.

If a Covered Individual is receiving care or about to receive care and is identified as not actively at work, continuation of coverage benefits may be offered, but must be accepted and paid per the continuation of coverage time guidelines for provider services to be considered for eligible benefit payment.

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

All inpatient and outpatient facilities are required to be JCAHO/Medicare accredited for the bill to be considered for payment.

Notification is required prior to receiving certain types of health care services.

1. eligibility of any individual for coverage;
2. benefit coverage for services rendered pursuant to the notification; or
3. network status of the provider(s).

Claims Address:

PO Box 149190
Austin, Texas 78714-9190

Customer Service:

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

Care Management: (800) 847-1213

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