



PLAN YEAR 2015-2016

HEALTHY INITIATIVES HEALTH PLAN BOOKLET

FOREWORD

October 2015

TML MultiState Intergovernmental Employee Benefits Pool (IEBP) has prepared this booklet to help you understand the medical benefits provided through your Employer. The Medical Plan described in this booklet provides coverage for a wide range of medical care, services and supplies. However, your benefits are affected by certain limitations and conditions that require you to be an informed consumer of health services and to use only those services you need. Benefits are not provided for non-medically evidence-based treatment or ineligible services, even if recommended by your physician. Please review the General Exclusions/Limitations section and the Medical Intelligence section. IEBP urges you to familiarize yourself with the provisions in the Plan description in order to understand your benefits.

Disclaimer: A new benefit booklet is distributed at the beginning of the plan year. Please verify annual date referenced on the front cover of the Healthy Initiatives Health Plan Booklet to make sure you are referring to the medical benefits that coordinate with the incurred service date.

*Dedicated to Services Measuring the Patient Healthcare Experience by
Managing the Integrity of the Healthcare Dollar Optimized by Performance Based Outcome*

**GROUP BENEFIT MEDICAL PLAN
FOR
TML MULTISTATE INTERGOVERNMENTAL EMPLOYEE BENEFITS POOL***

**Effective October 1, 1989
with Amendments through October 1, 2015**

This notice certifies that TML MultiState Intergovernmental Employee Benefits Pool (herein called IEBP) has accepted your Employer as a risk-participating member of IEBP. Your Employer has selected a plan of benefits and may have the responsibility for compliance with state and federal laws applicable to employee benefits. However, for most state and federal laws applicable to a health plan based upon the number of employees enrolled or eligible to enroll in the health plan, the size of the health plan is determined by the number of individuals enrolled in IEBP as a whole and not based on any one Employer's number of employees. This is a governmental plan excluded from coverage under ERISA (29 U.S.C.A. 1003(b)).

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

Resource	Contact Information	Accessible Hours
TML MultiState Intergovernmental Employee Benefits Pool (IEBP)	1821 Rutherford Lane, Suite 300 Austin, Texas 78754 PO Box 149190 Austin, Texas 78714-9190	
Customer Care Helpline:	(800) 282-5385	8:30 AM - 5:00 PM Central
Secured Customer Care E-mail:	Visit www.iebp.org click on the "Login" button click on "Online Customer Care" under the "My Tools" menu click on "Send a Secure Email"	8:30 AM - 5:00 PM Central
Provider Benefit Information Portal: Provider information can be found under the Provider Services menu. Member specific information such as Eligibility, Claims, Summary of Benefits and Coverage, Provider Coding Guidelines, Medication Therapy Management Guide, Member Rights and Responsibilities, Provider/Member Appeal Rights and IEBP Quality Improvement Plan information is also available.	Visit www.iebp.org to register, click on the "Sign Up" link under the provider section to login, click on the "Login" button at the top right hand side of the screen	
TML MultiState IEBP Internet Website:	www.iebp.org	Twenty-four (24) hrs
MyIEBP Mobile Access:	iPhone–App Store, Droid–Google Play, All other Phones– www.iebp.org	Twenty-four (24) hrs
Information on how IEBP evaluates new technology for inclusion as a covered benefit:	Visit www.iebp.org click on "About Us" click on "Technology"	
Medical Authorizations:	(800) 847-1213	8:30 AM - 5:00 PM Central
Prescription Authorizations:	RxResults Toll Free: (855) 892-0936 Local: (501) 686-7463	
Professional Health Coaches: Professional Health Coaches will answer basic health and medication questions and assist Covered Individuals with the Healthy Initiatives Incentive Program. Covered Individuals may enroll in professional health coaching.	(888) 818-2822	8:30 AM - 6:00 PM Central or Scheduled Appt.
Spanish Line:	(800) 385-9952	
Where to Mail Paper Medical Claims:	TML MultiState IEBP PO Box 149190 Austin, Texas 78714-9190	
Where to Mail Paper OptumRx Prescription Claims:	OptumRx PO Box 29044 Hot Springs, AR 71903	
OptumRx Prescription Pharmacist Service Center:	(800) 797-9791 www.optumrx.com	
OptumRx Prescription Member Customer Service:	(888) 543-1369	
OptumRx Prescription Mail Service Customer Service: Register at optumrx.com to receive e-mail reminders when it is time to refill your prescription.	(800) 788-7871 (TTY 711) www.optumrx.com	
OptumRx Specialty/Biotech Pharmacy:	(866) 218-5445 Fax: (800) 491-7997	
Telehealth:	Healthiest You (866) 703-1259 www.healthiestyou.com	
After Hours and/or Weekend Medical and Mental Healthcare Emergencies:	Call 911 or immediately go to the emergency department.	
Cultural Sensitive Counties: Summary of Benefits and Coverage (SBC) and benefit declinations can be requested in Spanish in the following counties. County list may be updated midyear.	Visit www.iebp.org click on the "Login" button click on "Online Customer Care" under the "My Tools" menu click on "Send a Secure Email"	
Counties for 2014: Andrews Atascosa Bailey Bastrop Bexar Brooks Calhoun Cameron Camp Castro Cochran Concho Crane Crockett Crosby Culberson Dallam Dallas Dawson Deaf Smith Dimmit Duval Ector Edwards El Paso Frio Gaines Garza Glasscock Gonzales Hale Hansford Harris Haskell Hemphill Hidalgo Howard Hudspeth Jeff Davis Jim Hogg Jim Wells Karnes Kenedy King Kinney Kleberg Knox Lamb La Salle Limestone Lipscomb Martin Matagorda Maverick McMullen Midland Moore Navarro Nueces Ochiltree Parmer Pecos Potter Presidio Reagan Reeves Sherman Starr Sterling Sutton Tarrant Terry Titus Travis Upton Uvalde Val Verde Ward Webb Willacy Winkler Yoakum Zapata Zavala		

* A Risk Pool created under and governed by the Texas Political Subdivisions Uniform Group Benefits Program (Chapter 172 Texas Local Government Code). Section 172.014 of that chapter provides that "A risk pool created under this Section is not insurance or an insurer under the Insurance Code or other laws of this state, and the State Board of Insurance [now the Texas Department of Insurance] does not have jurisdiction over a pool created under this Section."

Notice to Plan Participants

Regarding TML MultiState Intergovernmental Employee Benefits Pool (IEBP)

Election under 42 U.S.C. § 300gg-21

Chapter 172 Group health plans are regulated by federal laws named the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Health Care and Education Reconciliation Act of 2010. Generally, a group health plan must comply with the requirements of those laws that are listed below. However, the law permits State and local governmental health plans to elect to exempt the plan from these requirements if that plan is self-funded rather than provided through a health insurance policy. IEBP has elected to exempt the Plan from the following requirements:

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

Because of this election:

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

In addition to the above, on April 14, 2003 the Federal government imposed HIPAA Title II which pertains to administrative simplification of health plans. The administrative simplification process includes: standards for electronic transactions and code sets, national identifiers (Employers, health plans and Health Care Providers), security and electronic signature standards (Security Rule) and standards for privacy of individually identifiable health information (Privacy Rule).

A self-funded, non-federal, governmental health plan cannot exempt itself from any of the requirements of HIPAA Title II.

The intent of IEBP with regard to the Plan is to provide coverage that is compliant with State or Federal laws or regulations, including mid-plan year changes when mandated by law.

Table of Contents

How Benefits are Paid	6
Claims.....	6
Right to Receive and Release Necessary Information.....	7
No Replacement for Workers’ Compensation.....	7
Assignments.....	7
Legal Actions.....	7
Appeals.....	7
Privacy of Your Health Information.....	10
Security of Your Health Information.....	10
Medical Intelligence Features	11
How the Notification Process Works.....	11
Notification Requirements.....	11
Continued Stay Review.....	13
Medical Intelligence Utilization Management/Catastrophic Care.....	13
Population Health Engagement.....	14
Self-Audit Reimbursement.....	14
Description of Plan Benefits	15
Deductible Requirements.....	15
Copay Requirements.....	15
Out of Pocket Requirements.....	15
Federal Government Maximum Out of Pocket (MOOP).....	15
Usual and Reasonable.....	15
Eligible Benefits	16
Hospital.....	16
Outpatient Hospital.....	16
Facility Outpatient.....	16
Physician.....	16
Prescription.....	17
Major Medical.....	17
Accidental Injury Benefit.....	20
Preventive/Routine Care Benefit (Calendar Year).....	21
Immunizations.....	21
Onsite Biometric Screening Options.....	22
Hospice Care Benefit.....	22
Home Health Care Benefit.....	22
Transplant Benefit.....	23
Morbid Obesity Benefit.....	24
Mental Health Conditions.....	24
Serious Mental Health Illness.....	25
Substance Use Disorder Benefit.....	25
General Exclusions or Limitations	27
Dates of Eligibility and Coverage	30
Enrollment Requirements.....	30
Employee.....	30
Retiree.....	30

Dependent	30
Active Duty Reservists	31
Newborn Children	32
Enrollment	32
Qualifying Event/Special Enrollment	32
Other Issues Affecting Eligibility and Coverage	33
Required New Hire and Qualifying Event Benefit Eligibility Documentation	34
Termination Date of Coverage	36
Rescission of Coverage	36
Employee	36
Employee Dependent	36
Retiree	37
Retiree Dependent	37
COBRA Continuation of Coverage	37
COBRA Continuation of Coverage (COC) Rights	38
Introduction	38
You may have other options available to you when you lose group health coverage	38
What is COBRA Continuation of Coverage?	38
When is COBRA Continuation of Coverage available?	39
You must give notice of some Qualifying Events	39
How is COBRA Continuation of Coverage provided?	39
Active Duty Reservists extension of COBRA Continuation of Coverage	40
Disability extension of COBRA Continuation of Coverage	40
Second Qualifying Event extension of COBRA Continuation of Coverage	40
Are there other coverage options besides COBRA Continuation of Coverage?	40
Adding Dependents	40
If you have questions	41
Keep Your Plan Informed of Address Changes	41
Non-Duplication of Benefits	42
Integration of Benefits	42
Application	42
Definitions for the purpose of Integration of Benefits	42
Special Rules	43
Other Party Liability	44
Overpayment Provisions	46
Integration with Medicare	46
Definitions	48
Index	60

How Benefits are Paid

IEBP relies mainly on information provided when a claim is submitted. If IEBP finds that additional information is needed to determine if benefits are payable or for Right of Recovery under the Plan, a written request for such information will be made to the Covered Individual, or if necessary, the Health Care Provider. If the information is submitted and IEBP submits the claim for audit, the Network provider will be reimbursed for eighty-five percent (85%) of the eligible charges. The audit will be conducted within one-hundred and eighty (180) days of the receipt of the clean claim and any additional payment due to the Network provider or any refund due to IEBP will be made no later than the thirtieth (30th) day after the completion of the audit. If the information is not provided, the claim will be denied. If the claim is denied because requested information is not provided, the information may be filed as long as the required information is filed within the twelve (12) months from the date the expense was incurred, unless it was not reasonably possible to furnish the information within the filing deadline as determined by IEBP. Additional information may also be submitted within ninety (90) days after a decision is made by the Employer's workers' compensation carrier or by the Workers' Compensation Division of the Texas Department of Insurance, that the medical expense sought to be claimed is due to an injury that is non-compensable, whichever is later. To avoid a prompt pay penalty, required information must be received by IEBP no later than the prompt pay contract deadline.

Claims

Requests for Reimbursement. No benefits are payable for claims submitted by the employee or a provider unless the requirements of this paragraph are met. Requests for reimbursement for a covered benefit should be received by IEBP within ninety (90) days of date of service but not later than twelve (12) months from the date the expense was incurred, unless it was not reasonably possible to furnish the information within the filing deadline as determined by IEBP, or within ninety (90) days after a decision is made by the Employer's workers' compensation carrier or by the Workers' Compensation Division of the Texas Department of Insurance, that the medical expense sought to be claimed is due to an injury that is non-compensable, whichever is later.

Determination of "reasonably possible" is at the sole discretion of IEBP.

Requests for reimbursement must include:

1. the employee's name, address, unique subscriber identification number and group name;
2. the Covered Individual's name and relationship to the employee;
3. the Health Care Provider's name, tax ID/national provider identifier (NPI), or unique identification number and address; and
4. a description of the service rendered including charge(s), diagnosis code(s), applicable procedure code(s), and the date(s) of service.

Requests for reimbursement must be legible. If a request is not legible, it may be returned with a request to submit a legible copy. Electronic claim submissions must meet the standards for electronic transactions and codes set forth by the appropriate regulatory body. Claims will be considered for payment in the order received.

Claims may be mailed to:

TML 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".

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

Claim forms are not required for benefits to be payable under the Plan. IEBP may request specific information from the Covered Individual or Employer in order to complete processing of the claim or to verify eligibility in the Plan.

The information requested may include but is not limited to:

1. verification of employment status;
2. information related to accidental injuries;
3. information related to work related accidents or illness; and/or

- information regarding any other source of benefits.

Covered Individuals must keep IEBP informed in writing of any change in address, phone number or dependents. IEBP may rely on United States Postal Service and/or the Employer demographic information for a Covered Individual's last known address.

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

Right to Receive and Release Necessary Information

All personnel involved in the processing of claims are advised of the need to treat all personal and medical information as confidential. However, IEBP has the right to disclose information to or obtain information regarding a Covered Individual from any organization or person if necessary to determine benefits payable under the Plan or if allowed by state or federal statute or regulation.

No Replacement for Workers' Compensation

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

Assignments

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

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

Legal Actions

No legal action (including arbitration) may be brought against IEBP prior to the expiration of sixty (60) days after a written request for reimbursement has been furnished to IEBP in accordance with the requirements of the Plan, **and** all appeal rights available to the Plan have been exhausted. No such action may be brought after the expiration of two (2) years from the date service was incurred. This paragraph shall be applicable where a medical provider makes a complaint that a prompt payment contract was not followed. Venue for any dispute arising under the terms of the Plan, including but not limited to claims and subrogation disputes or declaratory judgment actions, shall be in Austin, Travis County, Texas.

IEBP reserves the right to take any legal action available against a Covered Individual to recover expenses incurred by IEBP to defend frivolous lawsuits or actions brought before all appeal rights have been exhausted.

Appeals

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

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

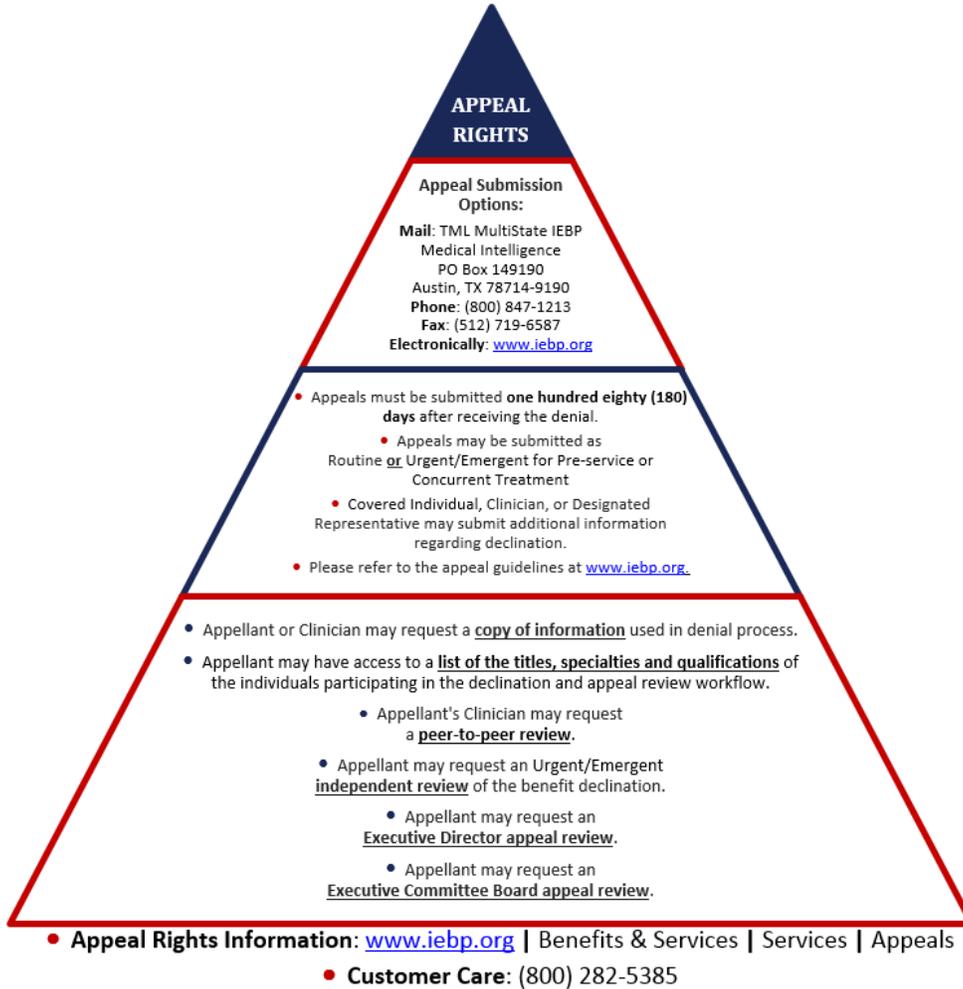
Once the review is complete, if the denial is maintained, the appellant will receive a written explanation of the reasons and facts relating to the denial.

Appeal of Urgent/Emergent Request for Benefits (Adverse Pre-Determination/Notification Request)		
Type of Request for Benefits or Appeal	Internal/External Appeal Process	Business Hrs/Dys
If the appellant appeals the adverse notification determination or declination of notification, the appellant must appeal within:	Internal	one hundred eighty (180) dys after receiving the denial based on a completed review process
If the appellant's request for emergent benefits is incomplete IEBP will send the <u>urgent/emergent incomplete pre-determination/notification information declination letter</u> within:	Internal	twenty-four (24) hrs of receipt of appellant's information
The appellant must provide a completed information request within:	Internal	forty-eight (48) hrs after receiving the IEBP declination due to incomplete information
If the request for urgent/emergent benefits is complete and not approved, IEBP will send an <u>urgent/emergent pre-determination/notification denial letter</u> within:	Internal	seventy-two (72) hrs
If the request for concurrent review is complete and not approved, IEBP will send a concurrent review denial:	Internal	twenty-four (24) hrs
If the appellant requests an Independent Review Organization (IRO), the external review appeal request must be submitted for the review within:	External	one hundred twenty (120) dys of receipt of the original denial or response to your appeal
The IRO will complete the review and IEBP will submit the response of <u>an expedited urgent/emergent pre-determination/notification</u> of a benefit appeal within:	External	seventy-two (72) hrs

Appeal of Non-Emergent Request for Benefits (Adverse Pre-Determination/Notification Request)		
Type of Request for Benefits or Appeal	Internal/External Appeal Process	Business Hrs/Dys
The appellant must appeal the denial no later than:	Internal	one hundred eighty (180) dys after receiving the denial
If the request for a pre-determination/notification is <u>benefit information incomplete</u> , IEBP will notify the appellant within:	Internal	five (5) dys
If the request for pre-determination/notification is <u>clinical information incomplete</u> , IEBP will notify you within:	Internal	fifteen (15) dys
The appellant must then provide completed information within:	Internal	forty-five (45) dys after receiving an extension notice*
IEBP will notify you of the first level appeal decision within:	Internal	fifteen (15) dys after receiving the first level appeal
The appellant must appeal the first level appeal (file a second level appeal) within:	Internal	sixty (60) dys after receiving the first level appeal decision
IEBP will notify you of the second level appeal decision within:	Internal	fifteen (15) dys after receiving the second level appeal*
The appellant may request the appeal be submitted to an IRO. The External Review Request must be submitted within:	External	one hundred twenty (120) dys of receipt of the original denial or response to your appeal
The IRO must complete the review of a <u>non-emergent claim or benefit appeal</u> within:	External	thirty (30) dys
* A one-time extension of no more than 15 days only if more time is needed due to circumstances beyond the appellant's control.		

Post-Service Claims		
Type of Claim or Appeal	Internal/External Appeal Process	Business Hrs/Dys
The appellant must appeal the claim denial no later than:	Internal	one hundred eighty (180) dys after receiving the denial
If the appellant's claim is incomplete, IEBP will notify the appellant within:	Internal	thirty (30) dys
The appellant must then provide completed claim information within:	Internal	forty-five (45) dys after receiving an extension notice
IEBP will notify the appellant of the first level appeal decision within:	Internal	thirty (30) dys after receiving the first level appeal
The appellant must file the second level appeal within:	Internal	sixty (60) dys after receiving the first level appeal decision

Post-Service Claims		
Type of Claim or Appeal	Internal/External Appeal Process	Business Hrs/Dys
The appellant will be notified of the second level appeal decision generally within:	Internal	thirty (30) dys after receiving the second level appeal
The appellant may request an appeal be submitted to an IRO. This request must be submitted for the review within:	External	one hundred twenty (120) dys of receipt of the original denial or response to your appeal
The IRO must complete the review of a non-emergent claim or benefit appeal within:	External	thirty (30) dys
The IRO must complete a requested expedited review of an emergent claim or benefit appeal within:	External	seventy-two (72) hrs



Covered Individuals have access to all documents and records used in making the decision. Medical consultants used in making the decision must be disclosed.

If a claim for benefits is wholly or partially denied, an Explanation of Benefits (EOB) will be furnished to the Covered Individual and the provider of services. This EOB will give the reason(s) the claim was denied. If the Covered Individual or provider of services does not agree with the claim decision or alleges that a contractual prompt payment requirement was not followed in the administration of a claim, he or she may submit an appeal within defined timelines. Relevant information supplied by the Covered Individual or Health Care Provider should be included with the appeal.

For claims denied or partially denied for not being notified, the appeal must include:

- the admission history and physical;
- the discharge summary; and
- the operative and pathology reports (if applicable).

An appeal requested without proper documentation may not be considered. All written appeals should be sent to IEBP's address printed on the Medical/Prescription ID cards or complete the appeal form online at www.iebp.org. Your request must contain the employee's name, social security or subscriber ID number and the exact reason(s) for requesting the appeal and include any supporting documentation. IEBP will notify you of the results of the review within thirty (30) days, unless IEBP informs you that special circumstances require an extended review process. These appeal provisions shall be applicable where a provider makes a complaint that a prompt payment contract was not followed.

The appealing party will be notified in writing of the results of an appeal for failure to provide Notification, and/or a denial or reduction in benefits after receipt of all necessary information to make a determination. All available medical information must be provided at no cost to the Plan. IEBP shall be under no obligation to respond to an appeal of a claim based upon complaints that have previously been addressed by a prior appeal.

If the appealing party does not agree with the results of any appeal, the appeal may be elevated to the Plan's Board of Trustees. To appeal a decision to the Board of Trustees, the appealing party must send their appeal in writing to: TML MultiState IEBP Board of Trustees, 1821 Rutherford Lane, Suite 300, Austin, TX 78754-5151. Unless the appeal specifically requests a Board Appeal, IEBP shall have the discretion to consider the appeal on an internal staff basis. 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 (5) 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. The Appeals Committee's final decision will be in writing and include specific references to the Plan provisions on which the decision was based.

Privacy of Your Health Information

A Federal regulation, called the "Privacy Rule," requires IEBP to protect the privacy of each Covered Individual's identifiable health information. Under the Privacy Rule, IEBP 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 IEBP needs to use or disclose a Covered Individual's health information for a purpose not permitted under the Privacy Rule, IEBP must first obtain a written authorization signed by the Covered Individual.

IEBP has administrative, physical and technical safeguards in place to protect the privacy of health information. IEBP will notify you regarding privacy breaches per Health and Human Services requirements.

In addition to restrictions on how IEBP 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.

IEBP's Notice of Privacy Practices explains fully how IEBP may use and disclose a Covered Individual's identifiable health information and a Covered Individual's rights under the Privacy Rule. IEBP's Notice of Privacy Practices is available on IEBP's website at www.iebp.org, or an individual may request a paper copy of the notice by calling IEBP's Customer Care at (800) 282-5385.

Security of Your Health Information

A Federal regulation, called the "Security Rule", requires IEBP to ensure the confidentiality, integrity and availability of a Covered Individual's identifiable health information that IEBP receives, creates, maintains or transmits electronically. IEBP has implemented administrative, physical and technical safeguards that meet both Federal requirements and industry standards for the security of electronic health information.

Medical Intelligence Features

Medical Intelligence is designed to assist you in making informed healthcare decisions. Occasionally, proposed healthcare or the scheduled length of stay or setting is not an Eligible Benefit. Please read this provision so that you understand the admission, continued stay and Notification process and are not faced with an out of pocket cost, penalty or denial for failure to provide Notification. Even when Notification is provided, reimbursement is subject to the terms and conditions of the Plan including, but not limited to, all Plan exclusions and limitations. Notification does not constitute verification of eligibility for benefits. Notification is required for Integration of Benefits when the Plan is secondary to other coverage.

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

How the Notification Process Works

The Twenty Three (23) Hour Rule. For the purpose of Notification, inpatient means treatment or confinement in a hospital or other medical facility for more than twenty-three (23) hours. Outpatient means treatment or confinement in a hospital or other medical facility for twenty-three (23) hours or less.

What is an admission? When the hospital or facility submits a claim, the length of time the Covered Individual was in their facility and a designation of inpatient, outpatient or observation is included. The number of hours, not the classification, determines if the stay is twenty-three (23) hours observation or inpatient. If it appears that the Covered Individual will stay more than twenty-three (23) hours, Notification of the stay must be provided to Medical Intelligence.

Medical Intelligence must be called for any inpatient expectant mother admission.

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

Responsibilities of the Covered Individual. Between the hours of 8:30 AM - 5:00 PM Central time, **call the Medical Intelligence number on the Medical/Prescription ID card** to provide Notification to Medical Intelligence prior to any healthcare service that requires Notification. After hours, Voice Mail records your Notification twenty-four (24) hours-a-day and the Medical Intelligence Intake Staff will return your call the next business day.

Notification Requirements

Notification enables clinical support and educations, such as:

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

Notification to IEBP is required for the following admissions and/or procedures regardless if the IEBP Plan is primary or secondary:

Service	Notification	Late Notification Penalty
Inpatient Admissions		
Scheduled Specialty Admissions <ul style="list-style-type: none"> • Orthopedic/Spine Surgeries (spinal surgeries, total knee replacements, and total hip replacements) • Transplants: At least ten (10) working days prior to any pre-transplant evaluation, the Covered Individual or a family member must provide Notification to Medical Intelligence; failure to do so will result in a Late Notification Penalty of \$400 or a reduction in benefits. • Reconstructive/Potentially Cosmetic procedures • Bariatric Surgery: after the approved six (6) consecutive months (within the most recent twelve (12) months) physician 	Facility: twenty-four (24) hours after actual admission or by 5 pm the next business day for weekend/holiday admissions	\$400

Service	Notification	Late Notification Penalty
supervised weight management treatment plan with a psychiatric evaluation <ul style="list-style-type: none"> • Congenital Heart Disease 		
<u>Other Inpatient Admissions</u> <ul style="list-style-type: none"> • Skilled Nursing Facility • Mental Health/Substance Use Disorder Inpatient • Mental Health/Substance Use Disorder Residential Treatment • Acute Care Hospital/Facility • Long Term Acute Care Facility • Acute Rehabilitation Facility • Scheduled Cesarean Section Delivery 	Three (3) working days prior to services Facility: twenty-four (24) hours after emergency admission or by 5 pm the next business day for weekend/holiday admissions	\$400
<u>Inpatient Pregnancy/Maternity (Delivery Admission)</u> <ul style="list-style-type: none"> • Vaginal delivery in excess of forty-eight (48) hours • Cesarean delivery in excess of ninety-six (96) hours • Inpatient antepartum care or other undelivered admissions • Newborns who remain in the hospital after mother is discharged 	Facility: twenty-four (24) hours after actual admission or by 5 pm the next business day for weekend/holiday admissions	\$400
<u>Pregnancy/Maternity</u> <ul style="list-style-type: none"> • Sonogram/Ultrasound in excess of three (3) • Home Health (uterine monitoring) 	Three (3) working days prior to commencement for office, outpatient and Home Health procedures	\$200
Scheduled Outpatient/Office Surgical Procedures		
<ul style="list-style-type: none"> • Blepharoplasty (eyelid surgery) • Breast Surgery (excludes Breast Biopsies) • Carpal Tunnel Release (nerve decompression) • Jaw Surgery (including mandibular joint) • Joint Surgery (excluding fingers & toes) • Laparoscopy (except sterilization) • Nasal Surgery • Uvulopalatoplasty • Reconstructive Surgery • Spinal Surgery • Cochlear Device and/or Implantation • Bariatric Surgery: after the approved six (6) consecutive months (within the most recent twelve (12) months) physician supervised weight management treatment plan with a psychiatric evaluation 	Three (3) working days prior to procedures	\$200
Outpatient/Office/Medication Therapy		
<ul style="list-style-type: none"> • Pain Therapy (IV) • Oncological Chemotherapy (IV/Injectable/Oral) 	Prior to commencement	\$200
Miscellaneous		
<ul style="list-style-type: none"> • Mental Health/Substance Use Disorder Day Treatment and Intensive Outpatient Treatment • Hospice • Home Health Care • Physician Home Visit • Cardiac Rehabilitation • Pulmonary Rehabilitation • Positron Emission Tomography (PET) scans • Computerized Axial Tomography (CAT) scans • Computerized Tomographic Angiography (CTA) scans • Magnetic Resonance Imaging (MRI) scans • Magnetic Resonance Angiography (MRA) scans • Single Photon Emission Computed Tomography (SPECT) • Dental Injury (inpatient and outpatient) • Dialysis for Kidney/Renal Failure • Hyperbaric Oxygen Therapy • Radiation Therapy • Medically Necessary Evidence-Based Genetic Testing to direct treatment (after diagnosis has been established) 	Three (3) working days prior to procedures	\$200

Service	Notification	Late Notification Penalty
<ul style="list-style-type: none"> Durable Medical Equipment 	Three (3) working days prior to dispensing/delivery of durable medical equipment for charges in excess of \$1,000 per base piece of durable medical equipment prior to purchase, lease, or rental	\$200

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

What Happens on Treatment in Excess of Twenty-Three (23) Hours? The Covered Individual must provide Notification to Medical Intelligence, (800) 847-1213, of a scheduled admission per Notification Requirements. If the Notification is made after the above-referenced time frames, a Late Notification Penalty or reduction of benefits will apply. Concurrent stay review requirements apply to all inpatient confinements. Failure to provide Notification to Medical Intelligence will result in no paid benefits for facility or related charges.

What Happens if Outpatient Services Go Over the Twenty-Three (23) Hour Limit?

Outpatient Surgery not on the Outpatient Surgery List

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

Outpatient Surgery on the Outpatient Surgery List

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

Emergent or Immediate Care (Unscheduled) Medical Admission/Services

If Notification is provided to Medical Intelligence for emergent or immediate care, no Late Notification Penalty will apply.

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

Continued Stay Review

If the Covered Individual's treatment plan changes, the Health Care Provider must provide Notification to Medical Intelligence. Medical Intelligence will obtain an update on the treatment plan and will conduct a concurrent review regarding the additional length of stay.

Medical Intelligence Utilization Management/Catastrophic Care

Utilization Management services help you use your benefits wisely during periods of treatment due to serious sickness or injury. This is done through early identification of the need for Utilization Management, for catastrophic cases (chemotherapy, radiation therapy, transplants, NICU babies, brain injuries, multiple trauma etc.) that require intensive management. The UM/RNs are responsible for accurate and timely processing of requests for all events/services.

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

Population Health Engagement

Population Health Engagement supports members in all stages of health. This program provides information to 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, licensed professional counselors and registered dietitians.

The Personal Health Engagement Program includes. Opt In: Enrollment method by which Covered Individuals call the professional health coaching line and request a professional healthcare coach or agree to professional health coaching upon receipt of an outreach call or letter. Covered Individuals may enroll by calling (888) 818-2822.

Self-Assessment Tools and Healthy Living Resources. There are self-assessment tools located on the IEBP website including the Health Power Assessment and Wheel of Life. Healthy Living Resources include: Healthy Living Guides, Healthy Living Fact Sheets, and helpful website links.

Professional Health Information Line. Professional Health Coaches will answer basic health and medication questions and assist Covered Individuals with the Healthy Initiatives Incentive Program.

Self-Audit Reimbursement

(Refer to the Summary of Benefits and Coverage.)

Any Covered Individual who reviews eligible medical benefits and discovers an overcharge made by the medical facility or practitioner may provide IEBP with a copy of the original billing, corrected billing and an explanation. The Covered Individual will be reimbursed thirty percent (30%) of the amount of savings generated. The reimbursement may not exceed the Covered Individual's Plan calendar year deductible and out of pocket amount.

Description of Plan Benefits

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

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

Benefits payable for hospitalization, certain outpatient surgical procedures and certain other benefits are subject to Notification requirements. Please refer to the Medical Intelligence Section of this booklet.

Deductible Requirements

(Refer to the Summary of Benefits and Coverage.)

Network and Non-Network deductibles are separate and do not accumulate toward one another.

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

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

The Family Deductible is a cumulative dollar amount and applies collectively to all covered family individuals. Once the family deductible is satisfied, no further deductible requirements will be applied for any covered family individual within the calendar year. Health Savings Account/High Deductible family plans will require the minimum family deductible to be met **before** plan benefit percentage is applied.

Copay Requirements

Refer to the Summary of Benefits and Coverage.

Out of Pocket Requirements

(Refer to the Summary of Benefits and Coverage.)

Covered charges that are used toward satisfying the out of pocket amount must be incurred during the calendar year.

For the 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.

The family out of pocket is a cumulative dollar amount and applies collectively to all covered family individuals. Once the family out of pocket is satisfied, no further out of pocket requirements will be applied for any covered family individual during the remainder of the calendar year except for plan copayment requirements.

The Health Savings Account/High Deductible Family Health Plans will require the family out of pocket maximum to be met **before** the plan pays at 100%.

Federal Government Maximum Out of Pocket (MOOP)

The maximum out of pocket (MOOP) limit for PPO and High Deductible H.S.A. plans are defined per the Federal Government and updated per calendar year. Eligible network, most cost effective out of pocket expenses accumulate to the Federal Government MOOP. Once the H.S.A. or PPO Federal Government defined maximum out of pocket amount is met the medical and prescription most cost effective, eligible network services accessed within the scope of the benefit plan will be paid at 100%.

Usual and Reasonable

The Plan will pay up to billed/negotiated charges but not more than the Usual and Reasonable rate and average wholesale pricing as defined by the Plan Document and determined by IEBP.

Eligible Benefits

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

Hospital

Inpatient Hospital (See Notification Requirements):

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

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

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

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

Skilled Nursing Facility. Room and board including necessary medical services and supplies.

Outpatient Hospital

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

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

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

Facility Outpatient

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

Physician

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

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

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

Second Surgical Opinion Benefit – if a Covered Individual obtains and provides IEBP with a written second surgical opinion prior to a covered surgical procedure concerning the need for a surgical procedure, then the deductible will not apply to Eligible Benefits incurred for the opinion and Usual and Reasonable charges will be paid in full. This benefit does not include any diagnostic tests or x-rays ordered by the Physician making the second opinion. Such diagnostic tests and x-rays are subject to the deductible and benefit percentage.

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

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

Prescription

Coverage for eligible biotech and biosimilar prescriptions that are available through the Pharmacy Benefit Manager or from Network Providers will be paid per the Medication Therapy Management Guide.

For eligible prescriptions purchased outside of the Pharmacy Benefit Manager or the Network Providers, the Plan will pay at the Out of Network benefit percentage and will not, at any time, pay at 100%.

Refer to the Medication Therapy Management Guide for more information.

Major Medical

Artificial Limbs or Prosthetic Appliances – limited to the Usual and Reasonable charges of standard models as determined by Medical Intelligence; subject to the benefit maximum per the Summary of Benefits and Coverage.

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

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

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

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

Cardiac Rehabilitation – a program of clinically supervised exercise designed to strengthen the heart and improve cardiovascular functioning; requires Medical Intelligence Notification.

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

Chiropractor (DC) – charges for treatment of an illness or injury by manipulation of the spine and appropriate treatments; subject to the benefit maximum per the Summary of Benefits and Coverage.

Circumcision – services and related charges are Eligible Benefits not limited to age.

Corneal Transplant.

Cosmetic Procedures/Reconstructive Surgery – cosmetic surgery for eligible benefits in connection with medically necessary treatment of an accidental injury.

Cosmetic procedures/reconstructive surgery only if:

1. for the repair of an accidental injury;

2. for reconstruction incidental to or following surgery resulting from an injury or illness; or
3. for correction of congenital anomalies that result in a functional defect.

Custom Molded Foot Orthotics – medical, documented physiological change that requires a revised orthotic; subject to the benefit maximum per the Summary of Benefits and Coverage.

Diabetes Self-Management Education

1. Education provided after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetic equipment and diabetic supplies;
2. Additional education authorized on the diagnosis of a Health Care Provider of a significant change in the Covered Individual's symptoms or condition of diabetes that requires changes in the Covered Individual's self-management regime; and
3. Periodic or episodic continuing education when prescribed by an appropriate Health Care Provider as warranted by the development of new techniques and treatment for diabetes.

Durable Medical Equipment – standard rentals and purchases that are limited to the lesser of contractual charge, Usual and Reasonable fee schedule or cost of standard model items. Charges for the rental of Durable Medical Equipment in excess of the purchase price are not covered. Charges where purchase or rental exceeds \$1,000 per piece of equipment require Notification to Medical Intelligence.

If Medical Intelligence does not receive Notification prior to a rental or purchase of Durable Medical Equipment that exceeds \$1,000 per piece of equipment, claims for benefits for that equipment will not be considered unless a retrospective review request is filed and benefit eligibility is reviewed. If the benefits are eligible under the Plan, they will be paid, but the Late Notification Penalty will apply.

Eligible Care – provided during Clinical Trials.

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

Hearing Evaluation and Appliance Selection – a Physician-prescribed medically necessary hearing appliance is covered; subject to the benefit maximum per the Summary of Benefits and Coverage.

Infertility Diagnostic – initial diagnosis only.

Infusion Therapy.

Inpatient Physical, Occupational, and/or Aquatic Therapy – services prescribed by a Physician to restore or improve a previous level of body function. Inpatient therapy services must be performed or rendered at a hospital or licensed healthcare facility by a licensed physical or occupational therapist or Physician.

Inpatient Speech Therapy – services by a licensed therapist prescribed by a Physician to restore or rehabilitate speech loss or impairment caused by injury, physical illness, following surgery or congenital defect.

Lab & X-ray charges.

Lactation Support – comprehensive prenatal and postnatal lactation support, counseling and standard equipment/non-disposable supplies rental and/or purchase; standard equipment is provided for duration of breastfeeding.

Lenses – initial contact lenses or glasses required following cataract surgery. Implantable and removable ocular prosthetics to treat complex corneal diseases. (*Refer to the Summary of Benefits and Coverage.*)

Licensed Professional Ambulance – services to the nearest hospital or emergency care facility equipped to treat a condition requiring immediate care. This does not include transportation for non-emergency medical services; subject to the benefit maximum per the Summary of Benefits and Coverage.

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

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

Nursing Services

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

Nutritional Counseling – for three (3) visits per calendar year by a licensed dietitian or certified diabetes educator up to Usual and Reasonable; subject to the benefit maximum per the Summary of Benefits and Coverage.

Oophorectomy – evidence-based genetic testing for ovaries with positive results will be required before a prophylactic oophorectomy will be considered as an eligible benefit.

Oral Surgery – limited to the following maxillofacial surgical procedures:

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

Orthomolecular Medicine or Chelation Therapy – for acute metal poisoning.

Outpatient Physical, Occupational, and/or Aquatic Therapy – services prescribed by a physician to restore or improve a previous level of body function. Outpatient therapy services must be performed or rendered at a hospital, licensed healthcare facility or at home by a licensed physical or occupational therapist; subject to the benefit maximum per the Summary of Benefits and Coverage.

Outpatient Speech Therapy – services by a licensed therapist prescribed by a Physician to restore or rehabilitate speech loss or impairment caused by injury or physical illness, following surgery or congenital defect; subject to the benefit maximum per the Summary of Benefits and Coverage.

Podiatric Appliances – therapeutic footwear/shoes for the prevention of complications associated with diabetes; subject to the benefit maximum per the Summary of Benefits and Coverage.

Prosthetic Bra and Breast Prosthesis – for an oncology-related mastectomy; subject to the benefit maximum per the Summary of Benefits and Coverage.

Pulmonary Rehabilitation – a program of clinically supervised exercise and intervention designed to strengthen the lungs and improve pulmonary functioning; requires Notification to Medical Intelligence.

Registered Respiratory Therapist (RRT) – charges when specifically prescribed by a Physician as to type and duration but only to the extent that the therapy is for improvement of bodily function.

Surgical Sterilization – eligible benefits.

Telemedicine Services

1. Medical information that is communicated in real-time with the use of interactive audio and video communications equipment, and is between the treating physician and/or a distant physician or health care specialist with the patient present during the communication.
2. IEBP's contracted telemedicine services via the convenience of phone or online, video consultation, diagnostic and/or medication management services for many conditions including allergies, cold and flu symptoms, ear infection, and other minor medical conditions.

Testosterone Injections for evidence-based hormonal imbalance.

Ultrasound and/or Sonograms for pregnancy – in excess of three (3) per pregnancy will require Notification to Medical Intelligence.

Well Woman/Contraceptive Benefits. The following will be processed for Network reimbursement at 100% of Network allowable, (unless otherwise specified). The provider's bill must designate or outline a routine diagnosis code. Non-Network provider eligible billings will be subject to Usual and Reasonable charges and Non-Network deductible and benefit percentages.

Benefit	Retail Rx Medical Plan	Prescription Plan	Plan Ineligible
Oral Contraceptives Generic (<i>no cost share</i>)		X	
IUD Device (<i>no cost share</i>)	X	X	
Implant Device (<i>no cost share</i>)	X	X	
Permanent Implantable Contraceptive Coil (<i>subject to the appropriate deductible and benefit percentages</i>)	X		
Insertion and/or Removal of Contraceptive Devices (<i>no cost share</i>)	X		
Urine Pregnancy Test, Urinalysis, Sonogram to Detect Placement of Device (<i>no cost share</i>)	X		
Injectable Contraceptives (<i>no cost share</i>)	X	X	
Injectable Administration Fee (<i>no cost share</i>)	X		
Diaphragm (cervical), Hormone Vaginal Ring, Hormone Patch, Cervical Cap, Spermicides, Sponges (<i>no cost share</i>)		X	
Diaphragm (cervical) Instruction and Fitting Fee (<i>no cost share</i>)	X		
Emergency Contraceptives		X	
Over-The-Counter (OTC) Contraceptives not otherwise listed as covered			X
Contraceptive Management (<i>no cost share</i>)	X		
Female Condoms (<i>no cost share</i>)		X	
Medications for risk reduction of breast cancer in women who are at increased risk for breast cancer and at low risk for adverse medication effects: Tamoxifen or Raloxifene		X	

Accidental Injury Benefit

Covered charges due to an accidental injury will be subject to the deductible and paid according to the Summary of Benefits and Coverage percentage. An Accident/Injury Questionnaire will need to be completed on all accidents or possible accident situations.

Preventive/Routine Care Benefit (Calendar Year)

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

Access your **Personal Health Record** and **Health Power Assessment** by logging in at www.iebp.org.

Age & Gender Biometric Screenings	Female 18-29	Female 30-35	Female 36-39	Female 40-49	Female 50	Female 51-73	Female 74+	Male 18-39	Male 40-50	Male 51-70	Male 71+
Health Power Assessment Questionnaire	X	X	X	X	X	X	X	X	X	X	X
Preventive Office Visit CPT 99385-99397	X	X	X	X	X	X	X	X	X	X	X
Lipid Panel CPT 80061	X	X	X	X	X	X	X	X	X	X	X
Comprehensive Metabolic Blood Panel CPT 80053	X	X	X	X	X	X	X	X	X	X	X
Thyroid Stimulating Hormone (TSH) CPT 84443			X	X	X	X	X				
Prostate Cancer Screening (PSA) CPT 84152-84154										X	
Fecal Occult (including colonoscopy and sigmoidoscopy as a qualifier) CPT 82270				X	X	X	X		X	X	X
Mammogram (* one (1) per Calendar Year for females ages 40-49; ** 1 every two (2) Calendar Years for females ages 50-73) CPT 77052; 77057				X*	X**	X**					
PAP (every three (3) Calendar Years for females ages 30-50) CPT 88141; 88155; 88142-88154; 88164-88167; 88174-88175		X	X	X	X						

Colon-Rectal Exam Benefit. The following will be processed for Network reimbursement at 100% of Network allowable. Non-Network provider eligible billings will be subject to Usual and Reasonable charges and are subject to the Non-Network deductible and benefit percentage. To be considered as an eligible preventive/routine care benefit, the provider's bill must designate or outline a routine diagnosis code.

This benefit will include routine and diagnostic colon-rectal examinations.

- Colon-Rectal examination - coverage for medically-recognized screening examination for the detection of colorectal cancer. This includes colonoscopy (performed every ten (10) years); or flexible sigmoidoscopy (examination of the large intestine) performed every five (5) years.

Biopsy/polyp removal during preventive colonoscopy plans will be included in the 100% of Network allowable cost.

This benefit excludes coverage for virtual colonoscopies.

Preventive/Routine Care Benefits also includes:

- Annual Examination
- Autism Screening – eighteen (18) and twenty-four (24) months of age
- Comprehensive Metabolic Test
- Bone Density Screening
- General Health Panel
- HbA1c
- Hearing Screening
- Mammograms
- PAP Smear
- Prostate Specific Antigen (PSA)
- Rubella Screening
- Screening for Visual Acuity
- Skin Cancer Counseling
- TB Test
- TSH
- Urinalysis
- Venipuncture
- Well Baby Care/Well Child Care
- Women's Reproductive Health

Immunizations

The following Network eligible immunizations and administrative fees are reimbursable at 100% of the allowable. Non-Network eligible billings will be subject to Usual and Reasonable charges and are subject to the Non-Network deductible and benefit percentage. Allergy injections and expenses related to routine newborn care are not considered as part of this benefit. To be considered under this benefit, the provider's bill must designate a routine diagnosis code. This list is a guideline.

Immunizations/Inoculations

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

Onsite Biometric Screening Options

Screenings	Female 18-29	Female 30-35	Female 36-39	Female 40-49	Female 50	Female 51-73	Female 74+	Male 18-39	Male 40-50	Male 51-70	Male 71+
Lipid Panel CPT 80061	X	X	X	X	X	X	X	X	X	X	X
Comprehensive Metabolic Blood Panel CPT 80053	X	X	X	X	X	X	X	X	X	X	X
Thyroid Stimulating Hormone (TSH) CPT 84443			X	X	X	X	X				
Prostate Cancer Screening (PSA) CPT 84152-84154										X	
Fecal Occult CPT 82270				X	X	X	X		X	X	X
Routine Venipuncture CPT 36415	X	X	X	X	X	X	X	X	X	X	X
Urinalysis CPT 81000	X	X	X	X	X	X	X	X	X	X	X
HbA1c if BMI >30 CPT 83036 (If Comprehensive Metabolic Blood Panel or General Health Panel is performed HbA1c is not eligible.)	X	X	X	X	X	X	X	X	X	X	X
General Health Panel CPT 80050 (includes Comprehensive Metabolic Blood Panel and TSH)	X	X	X	X	X	X	X	X	X	X	X
October-March Influenza Immunization Vaccine Eligible CPT Codes: 90471-Immunization Administration, 90656- Trivalent, split virus, preservative free or 90658- Trivalent, split virus or 90672-Quadrivalent, live or 90686-Quadrivalent, split virus, preservative free	X	X	X	X	X	X	X	X	X	X	X

Hospice Care Benefit

(Please see Notification Requirements.)

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

Medical Intelligence must receive Notification prior to hospice care commencement; subject to the benefit maximum per the Summary of Benefits and Coverage.

Hospice care must be established, approved and reviewed in writing by the attending physician and meet all of the following:

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

Home Health Care Benefit

(Please see Notification Requirements.)

To be an Eligible Benefit, a home health care plan must be in writing and ordered by the attending Physician. Medical Intelligence must receive Notification prior to home health care commencement. Home health care services will be reviewed as an Eligible Benefit if the attending Physician states that proper treatment of the disability would otherwise require confinement as an inpatient in a hospital, Skilled Nursing Facility or rehabilitative hospital in the absence of the services and supplies provided as part of the home health care plan and certifies that the patient is confined to his/her home (homebound). Home health care charges are paid per the Summary of Benefits and Coverage.

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

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

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

If prescription medication is part of the home health care plan, please refer to the Medication Therapy Management Guide for more information.

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

Transplant Benefit

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

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

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

Transplant benefits are paid at the benefit percentage on the Summary of Benefits and Coverage as long as services are provided by an Optum Health Network physician at an Optum Health/Centers of Excellence/Designated Transplant Center and approved by Medical Intelligence.

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

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

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

This benefit will cover charges resulting from organ transplantation for:

1. travel (if more than two hundred (200) miles one way to hospital or facility from place of employment);
 - a. Private vehicle use will be reimbursed at the maximum allowable amount determined by the Internal Revenue Service and reimbursement is limited to travel between home and the Transplant Center. Airfare will be reimbursed at cost.
 - b. The Plan provides for ground or air transportation of the Covered Individual to and from the pre-transplant evaluation, organ transplantation and any other Eligible Benefit or follow-up appointment.
 - c. The Plan provides for ground or air transportation of each eligible companion to and from the pre-transplant evaluation, organ transplantation and any other eligible provider services or follow-up appointment.
 - d. Receipts will be required for reimbursement and submitted on an Expense Activity Report.
2. organ transportation;
3. donor medical benefits not covered under the donor's plan of benefits;
4. locating and preserving the tissue for the transplant procedure;
5. fees for maintenance on an organ transplant waiting list;
6. food for the Covered Individual and eligible companion to a maximum of thirty-five dollars (\$35) each per day (if more than two hundred (200) miles one way to the designated transplant facility from place of employment); and
 - a. The Plan will pay for the Covered Individual and eligible companion's (age eighteen years of age or older) food during transplant-related outpatient treatment that is an Eligible Benefit and the eligible companion's food during transplant-related inpatient.
 - b. Maximum food reimbursement rate of thirty-five dollars (\$35) each per day.
 - c. Receipts will be required for reimbursement and submitted on an Expense Activity Report.

7. lodging (if more than two hundred (200) miles one way to the designated transplant facility from place of employment).
 - a. The Plan will pay for the Covered Individual's and the eligible companion's eligible lodging when the patient is not confined to eligible facility.
 - b. The Plan will pay for the eligible companion's lodging when the patient is confined to an eligible facility.
 - c. Receipts will be required for reimbursement.

The maximum travel, food and lodging benefit for the Covered Individual is \$10,000 and \$5,000 for an eligible companion (per the medical Network Summary of Benefits and Coverage percentage). Eligible companion is a person of the Covered Individual's choice.

Morbid Obesity Benefit

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

Morbid Obesity is defined as a condition for which a Covered Individual, eighteen (18) years of age or older, is 200% over ideal weight or 100 pounds overweight with a Body Mass Index (BMI) of greater than 40. A Notification Review is required to review the eligibility for the medically evidence-based surgical procedure. This review requires documentation of six (6) consecutive months (within the most recent twelve (12) months) physician-supervised weight management program that may include but is not limited to nutritional education and a physical activity program and psychiatric evaluation. The Covered Individual, treating physician or family member must provide information for the Medical Intelligence notification review. Failure to do so will result in no benefit coverage for morbid obesity services. Medically evidence-based morbid obesity treatment will be an eligible benefit subject to the lifetime maximum morbid obesity benefit limitation per the Summary of Benefits and Coverage.

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

Under this provision, Morbid Obesity includes the pre-treatment evaluation, medical and surgical treatment and post treatment care including but not limited to evidence-based medicine device adjustments, device removal, and/or body sculpting services. The Morbid Obesity surgical treatment must be performed at a Designated Centers of Excellence Morbid Obesity Treatment Center by an American Bariatric Surgery accredited Network Provider, unless services are deemed emergent or immediate. The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) designates the facilities that are accredited. The Centers and physicians must also participate in the UnitedHealthcare Choice Plus Network for IEBP to consider them a designated provider.

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

Mental Health Conditions

The Plan provides benefits for the treatment of mental health conditions. Expenses for the treatment of serious mental health conditions are considered the same as any other illness for the Plan's deductible, benefit percentage per the Summary of Benefits and Coverage. Expenses not considered as serious mental health conditions will be reimbursed at the Plan's benefit percentage. An order by a court or state agency for treatment is not an indication of eligibility.

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

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

Inpatient Treatment. An inpatient confinement requires Notification to Medical Intelligence. Please see the Notification requirements in the Medical Intelligence section. The Plan will reimburse up to seven (7) inpatient days each calendar year for the eligible treatment of a mental health condition.

Alternative Settings Benefit. Residential Treatment requires Notification to Medical Intelligence. Please see the Notification requirements in the Medical Intelligence section.

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

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

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

Serious Mental Health Illness

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

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

Substance Use Disorder Benefit

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

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

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

Inpatient Treatment Series. All inpatient confinements require Notification to Medical Intelligence. Please see the Notification requirements in the Medical Intelligence section. The Plan will reimburse up to seven (7) inpatient days for the medically eligible treatment of a substance use disorder.

Alternative Settings Benefit. Residential Treatment requires Notification to Medical Intelligence. Please see the Notification requirements in the Medical Intelligence section.

The Plan will reimburse up to seven (7) alternative setting days for the eligible treatment of substance use disorders while confined in a residential treatment center and are subject to the following restrictions:

1. Covered Individual must have a substance use disorder which would otherwise necessitate hospital confinement;

2. services must be based on an individual treatment plan; and
3. providers of services must be properly licensed.

Day Treatment Series. The Plan will reimburse up to fourteen (14) days for the eligible treatment of a substance use disorder. The facility must treat a Covered Individual for a minimum of four (4) hours in any twenty-four (24) hour period and a minimum of five (5) days per week. The attending Physician must document that such treatment is in lieu of hospitalization. Notification to Medical Intelligence is required. Please see the Notification requirements in the Medical Intelligence section.

General Exclusions or Limitations

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

1. for which a Covered Individual is not financially responsible or are submitted only because medical 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 not performed for the diagnosis or treatment of an illness or injury unless covered as part of the Preventive/Routine Care Benefit;
3. for treatment of any injury or illness for which the Covered Individual is not under the regular care of a Physician or does not follow the attending Physician's treatment plan;
4. for expenses applied under the Plan toward satisfaction of any deductibles, copayments, benefit percentage or access charge, except for maximum out of pocket High Deductible H.S.A. benefit plans;
5. charges in excess of Usual and Reasonable for services and supplies;
6. for treatment of any injury, illness or disability, resulting from or sustained as a result of being engaged in a felonious act or transaction as defined by Texas law regardless of whether arrested, indicted or convicted. This exclusion will apply when the felonious act or transaction is proven by a preponderance of the evidence;
7. for treatment of any injury, illness or disability resulting from or sustained as a result of war or act of war, declared or undeclared;
8. for treatment of injuries resulting from Covered Individual's participation in a riot or insurrection;
9. for treatment of any illness, injury or disability which (a) was incurred while working for wage, hire, or monetary gain, or (b) could have been available if pursued under benefits for Workers' Compensation whether or not the Employer is a subscriber or non-subscriber in a Workers' Compensation Program and whether or not the injured person could have been lawfully covered by workers' compensation as a volunteer. In applying this exclusion, work on the Covered Individual's family farm or ranch is not considered an employment arrangement;
10. for eye examinations for the purpose of prescribing corrective lenses or determining visual acuity or for treatment of refractive errors, eye glasses or contact lenses (including the fitting thereof), orthopedics, vision therapy, or other special vision procedures including but not limited to Radial Keratotomy (RK), Laser Assisted In-Situ Keratomileusis (LASIK) and Excimer Laser Photorefractive Keratectomy (PRK);
11. incurred in connection with remedying a condition by means of cosmetic surgery unless otherwise specifically covered under the Plan;
12. prophylactic procedures and/or testing due to family history, unless otherwise specifically covered under the Plan;
13. for vocational evaluation, rehabilitation, or retraining;
14. for custodial care or maintenance care;
15. drug testing services that are not Evidence-Based Medicine or standard of practice;
16. for any services furnished by any institution providing primarily convalescent or custodial care;
17. for repair and maintenance or replacement of lost, missing or stolen (without documentation of a police report) Durable Medical Equipment, when previously purchased by the Plan, or for replacement of in warranty Durable Medical Equipment whether purchased by the Plan or not, except when necessitated by physiological changes or accidental destruction, subject to approval by IEBP;
18. for home healthcare expenses that are for:
 - a. custodial care;
 - b. transportation services; or
 - c. any period during which the Covered Individual is not under the continuing care of Physician;
19. for sex therapy, outpatient group family therapy, marriage counseling or any other social services unless otherwise specified;
20. connected with the treatment of infertility and assisted reproductive technology including but not limited to artificial, in-vitro, embryo transfer and insemination or any surgical procedure for the inducement of pregnancy;

21. for elective abortions for Covered Individuals except in the case of incest, rape or situations which are life threatening to the mother;
22. for services and/or medications related to gender, sex and/or intersex reassignment surgery (transsexual services) including any complications;
23. for treatment, non-surgical and surgical procedures to reverse sterilization;
24. for personal comfort, convenience or safety items; including but not limited to, the purchase or rental of telephones; televisions; guest meals or cots; orthopedic mattresses; allergy-free pillows, blankets and/or mattress covers; non-hospital adjustable beds; waterbeds; structural changes to a house including tub rails and portable or fixed shower benches; purchase, rental or modification of motorized transportation equipment, manual or electronic lifts; elevators; escalators; and ramps;
25. for air purification, humidifying, cooling or heating equipment;
26. for exercising equipment, vibratory equipment, swimming or therapy pools, health club memberships, massage therapy or hippo therapy;
27. incurred in connection with acupuncture or acupressure;
28. for education, educational testing, educational therapy, hypnosis, biofeedback, recreational therapy or any behavior modification and learning disability therapy;
29. for spinography or thermography;
30. for treatment of nicotine addiction (except as specifically covered under the prescription drug benefit) or for any treatment, service or supply incurred or any therapy or training designed to curb or alleviate a personal habit;
31. for any treatment of the temporomandibular joint (TMJ) or jaw-related neuromuscular conditions not listed as an Eligible Benefit;
32. for care or treatment to the teeth, alveolar processes, gingival tissue or for malocclusion and/or dental implants, unless eligible under accident benefit;
33. for any drug therapy, treatment, or procedures meeting the definition of an Unproven Medical Procedure as defined in this booklet;
34. for routine foot care services except for diabetic foot care;
35. for cosmetic hair loss treatment;
36. for drugs labeled: "Caution - limited by Federal law to investigational use" or experimental drugs;
37. for drugs and medicines lawfully obtainable without a Physician's prescription (even if prescribed by a Physician) including but not limited to vitamins, cosmetics, dietary supplements, nutritional formulas used as food replacement, over-the-counter home tests, sublingual allergy drops, homeopathic remedies and/or alternative remedies;
38. for prescription drugs, supplies and equipment dispensed on an outpatient basis which are covered under a Prescription Drug Program (including lifestyle medications, copayments and any required payment differentials between generic and brand name drugs);
39. for services rendered by any of the following relatives:
 - a. spouse;
 - b. parent(s), step-parent(s) or parent(s)-in-law;
 - c. child(ren) or child(ren)-in-law;
 - d. brother(s) or brother(s)-in-law;
 - e. sister(s) or sister(s)-in-law;
 - f. grandparent(s) or grandparent(s)-in-law;
 - g. grandchild(ren) or grandchild(ren)-in-law;
 - h. aunt(s) or uncle(s) or aunt(s) -or uncle(s)-in-law;
40. 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 IEBP, or within ninety (90) days after a decision is made by the Employer's workers' compensation carrier or by the Workers' Compensation Division of the Texas Department of Insurance, that the medical expense sought to be claimed is due to an injury that is non-compensable, whichever is later. Determination of reasonably possible is at the sole discretion of IEBP;
41. for cryotherapy machine to deliver cold therapy for home use;

42. for treatment of conditions specifically excluded by the Plan and for treatment of conditions incurred as a result of, or due to complications of a non-covered expense whether medically eligible or not. This exclusion does not apply to pregnancy that is connected with the treatment of infertility and assisted reproductive technology including but not limited to artificial, in-vitro, embryo transfer and insemination or any surgical procedure for the inducement of pregnancy;
43. for non-custom molded foot orthotics;
44. for services, medication, devices, and supplies relating to the lifestyle treatment of erectile dysfunction, impotence and decreased libido;
45. for medications purchased in a foreign country if purchased for non-immediate services;
46. for Employer-mandated immunizations, medical services and medical testing;
47. for charges incurred as a result of travel outside of the United States or its territories specifically to receive medical treatment, unless otherwise specifically covered under the Plan;
48. for virtual colonoscopies;
49. for convalescent care;
50. for infusion pumps for intralesional administration of narcotic analgesics and anesthetics and intra-articular administration of narcotic analgesics and anesthetics;
51. for treatment of any injury or illness during any extension of the time period of COBRA Continuation of Coverage which is attributable to the Employer's failure under the law or as required by contract to give timely notice of a qualifying event;
52. for treatment of any injury or illness during any time period following a lump sum or severance settlement of an employment termination unless COBRA Continuation of Coverage has been elected and then only for the time period required by law under COBRA Continuation of Coverage;
53. for charges for internet medical management services and/or telemedicine, unless medical information is communicated in real-time with the use of interactive audio and video communications equipment, and is between the performing physician and a distant physician or health care specialist with the patient present during the communication (IEBP offers contracted telemedicine services through the convenience of phone calls or online, video consultation. Services include diagnostic and/or medication management services for many conditions including allergies, cold and flu symptoms, ear infection, and other minor medical conditions);
54. for expenses related to a surrogate pregnancy;
55. for expenses that exceed (in scope, duration or intensity) that level of care which is needed;
56. for services or treatments that are excluded under any part of the Plan; or
57. for services, medication, devices and supplies that are utilized solely for the accreditation of the facility.

Dates of Eligibility and Coverage

Enrollment Requirements

The names, social security numbers, genders, and birth dates of all persons in a family enrolling in the Plan will be provided to IEBP on an enrollment form or a change form signed and dated by the employee and Employer and received by IEBP. Appropriate supporting documentation may be required.

Employee

To receive coverage, IEBP must receive enrollment information within thirty-one (31) days of the commencement of employment regardless if the Employer has a waiting or a waiting and orientation period. If an employee is not enrolled within thirty-one (31) days of hire, the employee cannot be added to the Plan until the next Open Enrollment period or a qualifying event occurs. Upon timely enrollment, coverage will begin the **later** of:

1. the date you became an Active Employee working at least twenty (20) hours per week; or
2. the date you complete any waiting period established by your Employer.

Employees must be enrolled within the initial enrollment period, a qualifying event or wait until the next Open Enrollment period. During the Open Enrollment period, changes in enrollment may occur without a qualifying event. Coverage will become effective on the date of the qualifying event.

If the new hire employee enrollment information and/or the Open Enrollment information is not received by IEBP within the designated plan document guidelines, the employee may not be enrolled. A late enrollment will only be eligible coverage during the Plan's annual Open Enrollment, within thirty-one (31) days of a qualifying event, **or if initial enrollment occurs and is received by IEBP between thirty-one (31) days, or sixty (60) working days after commencement of employment if the Employer has 100% participation in the IEBP Plan and pays 100% of the Employee's cost of coverage.** The Employer is required to provide the health insurance marketplace notice to each new hire within fourteen days (14) of hire and annually during Open Enrollment.

IEBP will exempt the following employees from the 100% participation requirement:

1. If an individual is hired to work for a political subdivision and can provide the Employer with documentation of benefits from prior employment due to retirement;
2. An employee who is accessing a parental healthcare plan to the attained age of twenty-six (26);
3. Employee chooses to be covered under the spouse's healthcare plan in place of the IEBP Plan;
4. An employee or employee's spouse accessing the TRICARE plan (Employer provided financial incentive is disallowed);
5. An employee who chooses to be on a Medicare plan with NO financial incentive;
6. An employee who accesses the coverage offered to tribal members;
7. An employee who accesses another plan due to Full Time Equivalency status with two Employers (30 hours a week, 130 hours a month or 120 seasonal days a year).

Retiree

1. To receive coverage, IEBP must receive the enrollment information within thirty-one (31) days of the commencement of your retirement. If you enroll, coverage will begin the date you become a Retiree.
2. Upon retirement, if the Covered Individual enrolls in COBRA Continuation of Coverage the Retiree Medical Benefit will not be an option at the termination of COBRA Continuation of Coverage.
3. Retiree Pool coverage is terminated upon Medicare eligibility age sixty-five (65).

Dependent

Existing eligible dependents must enroll and IEBP must receive an enrollment form within thirty-one (31) days of the commencement of your employment. Dependents acquired after your eligibility date must be enrolled within thirty-one (31) days of the date acquired or within sixty (60) days of the birth or adoption or placement for adoption of a child. Your dependents will be eligible for dependent coverage on the **later** of:

1. the date you become covered; or

2. the date a dependent is added.

Back-dated and retroactive requests are not acceptable. Dependent coverage cannot be effective before the date employee coverage is effective.

Please refer to the definition of dependent in the definitions section of the booklet to determine who is eligible for dependent coverage.

If IEBP does not receive the dependent information within the designated eligibility timeline specified, but the Employer provides IEBP with payroll documentation that contributions were deducted from the employee's paycheck appropriately, then IEBP will enroll the dependent per the payroll documentation.

IEBP may, in its discretion, request written proof of the eligibility of any dependent, including but not limited to, written proof that a spouse or natural child is an eligible dependent. These requests are to verify eligibility and to determine if the 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.

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, IEBP 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 IEBP 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 IEBP of the qualifying event and submit a copy of the employee's written order for call to duty.

If IEBP administers COBRA Continuation of Coverage, the Employer must notify IEBP 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.

If the Employer administers their own COBRA Continuation of Coverage, the Employer must notify IEBP of the termination if call to active duty is more than thirty-one (31) days. The Employer is responsible for all required notices.

Section 143.072, Texas Local Government Code may require an Employer to "continue to maintain" coverage on a police officer or 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.

Newborn Children

If you acquire a newborn child, an enrollment form for the newborn for dependent coverage must be completed and received by IEBP within sixty (60) days of the birth. Coverage for the newborn will be effective on the date of the birth. The fact that you have other dependent children or a spouse covered does not automatically extend coverage to a newborn.

Enrollment

1. You have the opportunity to enroll for coverage under the Plan: during the Plan's annual Open Enrollment;
2. within thirty-one (31) days of a qualifying event;
3. within sixty (60) days of the birth or adoption or placement for adoption of a child;
4. if initial or Open Enrollment occurs and eligibility information is received by IEBP between thirty-two (32) days and sixty (60) days after commencement of employment, the Employer must maintain 100% participation in IEBP Plan and the Employer must pay 100% of the employee's cost of coverage; or
5. if an employee who is eligible, but not enrolled, for coverage under the terms of the Plan (or a dependent of such an employee if the dependent is eligible, but not enrolled for coverage under such terms) enrolls for coverage under the terms of the Plan within sixty (60) days of loss of coverage, due to loss of eligibility, under Medicaid or a State Children's Health Insurance Program (SCHIP).

Qualifying Event/Special Enrollment

During the plan year, certain qualifying events will permit an employee to add a dependent(s) other than during Open Enrollment. Documentation must be submitted with enrollment paperwork.

These qualifying events are as follows:

1. marriage;
2. within sixty (60) days of the birth, adoption or placement for adoption of a child;
3. loss of coverage, due to loss of eligibility, under Medicaid or SCHIP;
4. becoming eligible for group health payment assistance through Medicaid or SCHIP;
5. loss of coverage due to termination of a spouse's employment;
6. loss of coverage because your spouse changes from full-time to part-time employment
7. loss of coverage because your spouse takes an unpaid leave of absence;
8. loss of coverage because a dependent no longer meets the Patient Protection and Affordability Act's definition of a full time equivalent employee: thirty (30) hours a week, one hundred thirty (130) hours a month and/or one hundred twenty (120) seasonal days a year for Employers with fifty (50) or more employees; or
9. significant change (10% or more) in the benefit coverage of your spouse's health plan.

Employees must enroll the eligible dependent(s) within thirty-one (31) days of the qualifying event (sixty (60) days if the qualifying event is the birth or adoption of a child or the loss of coverage under Medicaid or SCHIP) or wait until the next Open Enrollment period.

If the qualifying event is a loss of coverage under another plan or a significant change in the coverage under another plan and/or if the qualifying event is marriage, or the birth, adoption or placement for adoption of a child (within sixty (60) days), divorce, or death, the employee may enroll any eligible dependent within thirty-one (31) days of the qualifying event. No qualifying event will be recognized unless allowed by federal regulations.

Other Issues Affecting Eligibility and Coverage

Changes Requiring Notification. The following events may affect dependent coverage. You are required to notify IEBP within thirty-one (31) days of the below events:

1. marriage;
2. sixty (60) days of the birth or adoption or placement for adoption of a child;
3. divorce of the covered employee; or
4. death of the covered employee.

You must notify your Employer if you wish to voluntarily drop dependent coverage. Any drop of a dependent regardless of whether the coverage is paid for pursuant to pre-tax or post-tax payroll deduction will only be allowed following a qualifying event as prescribed by the Internal Revenue Service regulations and on these conditions:

1. any change in coverage must be consistent with the qualifying event; and
2. IEBP is notified in writing within thirty-one (31) calendar days of the event.

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

Mentally or Physically Handicapped Children. If a child of a Covered Individual attains the age of twenty-six (26) (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 IEBP within thirty-one (31) days of the date the child attains the age of 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.

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

Required New Hire and Qualifying Event Benefit Eligibility Documentation

The most updated form is located online at www.iebp.org. Login, select "My Tools" > "MyBenefits onDemand" > "Eligibility & Enrollment" > "Eligibility Requirements".

Active Employee/Continuation of Coverage Participant and Dependent Eligibility Checklist Form

Place an (x) in valid eligibility boxes.

STEP I Employee/Continuation of Coverage Participant Name (first, last): _____ Employer Name: _____
 Social Security #/Subscriber ID #: _____ Group #: _____

STEP II: To receive coverage, IEBP must receive enrollment information within thirty-one (31) days of the commencement of employment regardless if the Employer has a waiting or a waiting and orientation period. If an employee is not enrolled within thirty-one (31) days of hire, the employee cannot be added to the Plan until the next Open Enrollment period or a qualifying event occurs.

Event	Deadline for Documentation	Event	Deadline for Documentation
<input type="checkbox"/> New Hire	within 60 days of Date of Hire	<input type="checkbox"/> Annual Open Enrollment - Based on Group Anniversary	within 60 days of New Plan Year Effective Date
<input type="checkbox"/> Initial Enrollment - New Group	within 60 days of the New Groups Effective Date	<input type="checkbox"/> Qualifying Event	within 60 days of the Qualifying Event
<input type="checkbox"/> COC (Continuation of Coverage) Enrollment		<input type="checkbox"/> Birth of a Child	within 60 days of Birth

STEP III Employee/Continuation of Coverage Participant Only Coverage Employee/Continuation of Coverage Participant + Dependent Coverage

Dependent Documentation Requirements for Benefits Enrollment, Change, and Termination; Adding Dependent Coverage - A Social Security Number is required for all dependents covered under the group medical, dental &/or vision plan.	
STEP IV Dependent	STEP V Supporting Documentation (required for dependent eligibility)
<input type="checkbox"/> Spouse	<input type="checkbox"/> Marriage Certificate, or Certificate of Informal Marriage (issued by county clerk's office) or Joint Tax Return
<input type="checkbox"/> Natural Child - to attained age 26	<input type="checkbox"/> Birth Certificate
<input type="checkbox"/> Step Child - to attained age 26	<input type="checkbox"/> Birth Certificate <input type="checkbox"/> PLUS Marriage Certificate, or Joint Tax Return, or Certificate of Informal Marriage (issued by county clerk's office) (verification that the Employee is married to the child(ren)'s parent)
<input type="checkbox"/> Adopted Child - to attained age 26	<input type="checkbox"/> PLUS Divorce Decree (signed by Judge), or Custodial Orders (signed by Judge), or Attorney General (AG) Orders to determine who is ordered to carry coverage on child(ren) for claims purposes
<input type="checkbox"/> Foster Child - to attained age 26	<input type="checkbox"/> Birth Certificate and Court Issued Adoption Documents
<input type="checkbox"/> Other Child - to attained age 26	<input type="checkbox"/> Birth Certificate and Court Issued Foster Documents
<input type="checkbox"/> Grandchild - to attained age 26	<input type="checkbox"/> Birth Certificate and Legal Guardianship/Conservatorship Documents (signed by Judge)
<input type="checkbox"/> Incapacitated Child	<input type="checkbox"/> Birth Certificate, Tax Records, and/or Legal Guardianship/Conservatorship Documents (signed by Judge)
STEP VI Qualifying Event	STEP VII Supporting Documentation (copies acceptable)
<input type="checkbox"/> Divorce - Drop spouse and their child(ren)	<input type="checkbox"/> Birth Certificate and Social Security Disability Document
<input type="checkbox"/> Court Ordered Coverage/Benefits - Add Dependent Child(ren)	<input type="checkbox"/> Divorce Decree (finalized, signed by Judge)
<input type="checkbox"/> Court Order Expires - Drop Dependent Child(ren)	<input type="checkbox"/> Birth Certificate and Divorce Decree (signed by Judge), or Custodial Orders (signed by Judge), or Attorney General Order
<input type="checkbox"/> Ineligibility under Medicaid or SCHIP - Add Dependent Child(ren)	<input type="checkbox"/> Attorney General Order (if an AG order is on file with IEBP we must have a new order from AG office indicating child(ren) may be dropped), or Divorce Decree (signed by Judge), or Custodial Orders (signed by Judge)
<input type="checkbox"/> Eligibility for Medicaid - Drop Spouse &/or Dependent Child(ren)	<input type="checkbox"/> Copy of ineligibility letter with effective date from Medicaid or SCHIP
<input type="checkbox"/> Eligibility for Medicare - Drop Spouse	<input type="checkbox"/> PLUS appropriate dependent child documentation listed above
<input type="checkbox"/> Eligibility for Other Coverage - Regulated by the IRS	<input type="checkbox"/> Copy of eligibility letter with effective date from Medicaid
<input type="checkbox"/> Spouse Job Status Change - full time to part time, unpaid leave of absence, termination of employment, significant change (10% or more) in the benefit coverage of your spouse's health plan - Add Spouse & Dependent Child(ren)	<input type="checkbox"/> Copy of eligibility letter (or Medicare Card) with effective date from Medicare
	<input type="checkbox"/> Letter from Other Health Plan verifying enrollment
	<input type="checkbox"/> Documentation from their Employer of the change with effective date
	<input type="checkbox"/> PLUS Marriage Certificate, or Certificate of Informal Marriage (issued by county clerk's office), or Joint Tax Return and appropriate child documentation listed above

STEP VIII TML MultiState Intergovernmental Employee Benefits Pool (IEBP) reserves the right to request proof of required eligibility documentation. The undersigned Employee affirms that (1) he or she is/was employed an average of at least 20 hours a week by the Employer; (2) all legal relationship(s) of a spouse and/or dependent enrolled in the Plan are based in fact and correctly represented; and (3) to the best of the Employee's knowledge, the supporting documentation of such relationship(s) are true and correct copies of what the documents purport to be and unaltered from the original source. Employee acknowledges that the enrollment form is a governmental record, and that misrepresentation of information in the enrollment form might be considered to be a felony. Employee also agrees that should coverage of a spouse and/or dependent be rescinded within federal requirements, Employee will reimburse IEBP for the amount of claims paid by IEBP for the coverage period rescinded.

STEP IX Employee/Continuation of Coverage Participant: _____ Date: _____

Employer: _____ Date: _____

Form completed accurately, proof of supporting documentation has not been obtained.

The most updated form is located online at www.iebp.org. Login, select "My Tools" > "MyBenefits onDemand" > "Eligibility & Enrollment" > "Eligibility Requirements".

Pre Sixty-five Retiree and Dependent Eligibility Checklist Form

Retiree Pool coverage is terminated upon Medicare eligibility age sixty-five (65).
Once a Retiree moves to Continuation of Coverage and Continuation of Coverage terminates, the Retiree is not eligible for the IEBP Retiree benefits.

Place an (x) in valid eligibility boxes.

STEP I Pre Sixty-five Retiree Name (first, last): _____ Social Security #/Subscriber ID #: _____
Group #: _____

STEP II

Event	Deadline for Documentation	Event	Deadline for Documentation
<input type="checkbox"/> Retirement	within 31 days of commencement of retirement; IEBP will require qualifying definition of a benefit eligible Retiree from the Employer	<input type="checkbox"/> Annual Open Enrollment - Based on Group Anniversary	within 60 days of New Plan Year Effective Date
<input type="checkbox"/> Initial Enrollment - New Group	within 60 days of the New Groups Effective Date	<input type="checkbox"/> Qualifying Event	within 60 days of the Qualifying Event
		<input type="checkbox"/> Birth of a Child	within 60 days of Birth

STEP III Retiree Only Coverage Retiree + Dependent Coverage

Dependent Documentation Requirements for Benefits Enrollment, Change, and Termination; Adding Dependent Coverage - A Social Security Number is required for all dependents covered under the group medical, dental &/or vision plan.	
STEP IV Dependent	STEP V Supporting Documentation (required for dependent eligibility)
<input type="checkbox"/> Spouse	<input type="checkbox"/> Marriage Certificate, <u>or</u> Certificate of Informal Marriage (issued by county clerk's office) <u>or</u> Joint Tax Return
<input type="checkbox"/> Natural Child - to attained age 26	<input type="checkbox"/> Birth Certificate
<input type="checkbox"/> Step Child - to attained age 26	<input type="checkbox"/> Birth Certificate <input type="checkbox"/> PLUS Marriage Certificate, <u>or</u> Joint Tax Return, <u>or</u> Certificate of Informal Marriage (issued by county clerk's office) (verification that the Employee is married to the child(ren)'s parent) <input type="checkbox"/> PLUS Divorce Decree (signed by Judge), <u>or</u> Custodial Orders (signed by Judge), <u>or</u> Attorney General (AG) Orders to determine who is ordered to carry coverage on child(ren) for claims purposes
<input type="checkbox"/> Adopted Child - to attained age 26	<input type="checkbox"/> Birth Certificate and Court Issued Adoption Documents
<input type="checkbox"/> Foster Child - to attained age 26	<input type="checkbox"/> Birth Certificate and Court Issued Foster Documents
<input type="checkbox"/> Other Child - to attained age 26	<input type="checkbox"/> Birth Certificate and Legal Guardianship/Conservatorship Documents (signed by Judge)
<input type="checkbox"/> Grandchild - to attained age 26	<input type="checkbox"/> Birth Certificate, Tax Records, and/or Legal Guardianship/Conservatorship Documents (signed by Judge)
<input type="checkbox"/> Incapacitated Child	<input type="checkbox"/> Birth Certificate and Social Security Disability Document
STEP VI Qualifying Event	STEP VII Supporting Documentation (copies acceptable)
<input type="checkbox"/> Divorce - Drop spouse and their child(ren)	<input type="checkbox"/> Divorce Decree (finalized, signed by Judge)
<input type="checkbox"/> Court Ordered Coverage/Benefits - Add Dependent Child(ren)	<input type="checkbox"/> Birth Certificate and Divorce Decree (signed by Judge), <u>or</u> Custodial Orders (signed by Judge), <u>or</u> Attorney General Order
<input type="checkbox"/> Court Order Expires - Drop Dependent Child(ren)	<input type="checkbox"/> Attorney General Order (if an AG order is on file with IEBP we must have a new order from AG office indicating child(ren) may be dropped), <u>or</u> Divorce Decree (signed by Judge), <u>or</u> Custodial Orders (signed by Judge)
<input type="checkbox"/> Ineligibility under Medicaid or SCHIP - Add Dependent Child(ren)	<input type="checkbox"/> Copy of ineligibility letter with effective date from Medicaid or SCHIP <input type="checkbox"/> PLUS appropriate dependent child documentation listed above
<input type="checkbox"/> Eligibility for Medicaid - Drop Spouse &/or Dependent Child(ren)	<input type="checkbox"/> Copy of eligibility letter with effective date from Medicaid
<input type="checkbox"/> Eligibility for Medicare - Drop Spouse	<input type="checkbox"/> Copy of eligibility letter (or Medicare Card) with effective date from Medicare
<input type="checkbox"/> Eligibility for Other Coverage - Regulated by the IRS	<input type="checkbox"/> Letter from Other Health Plan verifying enrollment
<input type="checkbox"/> Spouse Job Status Change - full time to part time, unpaid leave of absence, termination of employment, significant change (10% or more) in the benefit coverage of your spouse's health plan - Add Spouse & Dependent Child(ren)	<input type="checkbox"/> Documentation from their Employer of the change with effective date <input type="checkbox"/> PLUS Marriage Certificate, <u>or</u> Certificate of Informal Marriage (issued by county clerk's office), <u>or</u> Joint Tax Return and appropriate child documentation listed above

STEP VIII TML MultiState Intergovernmental Employee Benefits Pool (IEBP) reserves the right to request proof of required eligibility documentation. The undersigned Retiree affirms that (1) he or she meets the definition of a Retiree as defined by the Employer; (2) all legal relationship(s) of a spouse and/or dependent enrolled in the Plan are based in fact and correctly represented; and (3) to the best of the Retiree's knowledge, the supporting documentation of such relationship(s) are true and correct copies of what the documents purport to be and unaltered from the original source. Retiree acknowledges that the enrollment form is a governmental record, and that misrepresentation of information in the enrollment form might be considered to be a felony. Retiree also agrees that should coverage of a spouse and/or dependent be rescinded within federal requirements, Retiree will reimburse IEBP for the amount of claims paid by IEBP for the coverage period rescinded.

STEP IX Retiree: _____ Date: _____

Termination Date of Coverage

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

Rescission of Coverage

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

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

Employee

Coverage will terminate on the **earliest** of:

1. the end of the month your employment terminates;
2. the end of the month in which you cease to be an Active Employee*;
3. the end of the month in which you are no longer eligible for coverage;
4. the date the group benefit Plan terminates coverage with the Employer; or
5. the date your Employer is no longer participating under the Plan.

** An Employer should have an official written policy on extended leave without pay and continuing healthcare coverage on file with IEBP at the beginning of the plan year. In these cases, IEBP will honor the Employer's policy up to the maximums set forth by IEBP's Board of Trustees. Please check with your Employer to determine if an extension of coverage is available in your particular situation or if the Family and Medical Leave Act of 1993 (P.L. 103-3) applies.*

Employee Dependent

Coverage will terminate on the **earliest** of:

1. the end of the month the Covered Individual's employment terminates, if contributions are paid, or the date the Covered Individual ceases to be an Active Employee;
2. the end of the month a dependent no longer meets the definition of dependent under the Plan;
3. the date the group benefit Plan terminates coverage with the Employer;
4. the date the dependent becomes enrolled in Medicaid;
5. the end of the month in which a dependent child attains age twenty-six (26);
6. the date the Employer is no longer participating under the Plan; or
7. the end of the month dependent coverage is voluntarily dropped pursuant to a qualifying event as prescribed by the Internal Revenue Service regulations provided IEBP receives written notice within thirty-one (31) days of the event.

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.

Retiree

If Pool Retiree coverage is offered by the Employer, coverage will terminate on the **earliest** of:

1. the end of the month in which coverage is voluntarily dropped;
2. the end of the month in which the group benefit Plan terminates coverage with the former Employer; or
3. the end of the month in which your former Employer is no longer participating under the Plan.

Retiree Dependent

If Pool Retiree coverage is offered by the Employer, coverage as a dependent will terminate on the **earliest** of:

1. the end of the month dependent coverage is voluntarily dropped;
2. the end of the month the Retiree is no longer eligible for coverage;
3. the end of the month a dependent no longer meets the definition of dependent under the Plan;
4. the date the group benefit Plan terminates coverage with the former Employer; or
5. the date the former Employer is no longer participating under the Plan.

Coverage for a dependent cannot extend beyond the date that coverage for the Retiree ends.

COBRA Continuation of Coverage

Coverage will terminate on the **earliest** of:

1. the end of the month you voluntarily drop coverage;
2. the last day for which any required COBRA Continuation of Coverage contribution is made;
3. the date the required period of COBRA Continuation of Coverage expires;
4. the date you become covered under another group plan that does not reduce benefits due to a pre-existing condition;
5. the date you become entitled to Medicare; or
6. the date the former Employer no longer provides group medical coverage to any other employees.

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

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

COBRA Continuation of Coverage (COC) Rights

Introduction

You're getting this notice because you have recently gained coverage under a group health plan (the Plan). This notice contains important information about your right to COBRA Continuation of Coverage (COC), which is a temporary extension of coverage under the Plan. **This notice 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.** When you become eligible for COBRA Continuation of Coverage, you may also become eligible for other coverage options that may cost less than COBRA Continuation of Coverage.

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 and other members of your family when your group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan booklet or contact TML MultiState IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385.

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

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

What is COBRA Continuation of Coverage?

COBRA Continuation of Coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA 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 for coverage depending on the policy of your Employer.

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

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

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

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

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

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

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

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

When is COBRA Continuation of Coverage available?

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

1. The end of employment or reduction of hours of employment;
2. Death of the employee;
3. Commencement of a proceeding in bankruptcy with respect to the Employer; or
4. The employee's becoming entitled to Medicare benefits (under Part A, Part B and/or Part C).

You must give notice of some Qualifying Events

For all 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 IEBP within sixty (60) days after the qualifying event occurs. You must provide notice 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 IEBP 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 lasts for only up to a total of eighteen (18) months. There are three (3) ways in which this eighteen (18) month period of COBRA Continuation of Coverage can be extended.

Active Duty Reservists extension of COBRA Continuation of Coverage

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 (COC) to be offered to the reservist or guard member.

If a fire fighter or police officer is called to active duty for any period, the 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, IEBP 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 IEBP that an employee has been called to active duty and submit a copy of the Employer member's active reservist policy to IEBP.

Disability extension of COBRA Continuation of Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify IEBP 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 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) or twenty-four (24) months of COBRA Continuation of Coverage, the spouse and dependent children in your family can get up to eighteen (18) additional months of COBRA Continuation of Coverage, for a maximum of thirty-six (36) months, if IEBP is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA Continuation of Coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B and/or Part C) gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. This extension is available only if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation of Coverage?

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

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 or sixty (60) days of the birth, 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 IEBP informed of any changes in addresses of family members. You should also keep a copy, for your records, of any notices you send to your Employer and IEBP.

Resource	Contact Information	Accessible Hours
TML MultiState Intergovernmental Employee Benefits Pool (IEBP)	1821 Rutherford Lane, Suite 300 Austin, Texas 78754 PO Box 149190 Austin, Texas 78714-9190	
Customer Care Helpline:	(800) 282-5385	8:30 AM - 5:00 PM Central
Secured Customer Care E-mail:	Visit www.iebp.org click on the "Login" button click on "Online Customer Care" under the "My Tools" menu click on "Send a Secure Email"	8:30 AM - 5:00 PM Central
Provider Benefit Information Portal: Provider information can be found under the Provider Services menu. Member specific information such as Eligibility, Claims, Summary of Benefits and Coverage, Provider Coding Guidelines, Medication Therapy Management Guide, Member Rights and Responsibilities, Provider/Member Appeal Rights and IEBP Quality Improvement Plan information is also available.	Visit www.iebp.org to register, click on the "Sign Up" link under the provider section to login, click on the "Login" button at the top right hand side of the screen	
TML MultiState IEBP Internet Website:	www.iebp.org	Twenty-four (24) hrs
MyIEBP Mobile Access:	iPhone—App Store, Droid—Google Play, All other Phones— www.iebp.org	Twenty-four (24) hrs
Information on how IEBP evaluates new technology for inclusion as a covered benefit:	Visit www.iebp.org click on "About Us" click on "Technology"	
Medical Authorizations:	(800) 847-1213	8:30 AM - 5:00 PM Central
Prescription Authorizations:	RxResults Toll Free: (855) 892-0936 Local: (501) 686-7463	
Professional Health Coaches: Professional Health Coaches will answer basic health and medication questions and assist Covered Individuals with the Healthy Initiatives Incentive Program. Covered Individuals may enroll in professional health coaching.	(888) 818-2822	8:30 AM - 6:00 PM Central or Scheduled Appt.
Spanish Line:	(800) 385-9952	
Where to Mail Paper Medical Claims:	TML MultiState IEBP PO Box 149190 Austin, Texas 78714-9190	
Where to Mail Paper OptumRx Prescription Claims:	OptumRx PO Box 29044 Hot Springs, AR 71903	
OptumRx Prescription Pharmacist Service Center:	(800) 797-9791 www.optumrx.com	
OptumRx Prescription Member Customer Service:	(888) 543-1369	
OptumRx Prescription Mail Service Customer Service: Register at optumrx.com to receive e-mail reminders when it is time to refill your prescription.	(800) 788-7871 (TTY 711) www.optumrx.com	
OptumRx Specialty/Biotech Pharmacy:	(866) 218-5445 Fax: (800) 491-7997	
Telehealth:	Healthiest You (866) 703-1259 www.healthiestyou.com	
After Hours and/or Weekend Medical and Mental Healthcare Emergencies:	Call 911 or immediately go to the emergency department.	
Cultural Sensitive Counties: Summary of Benefits and Coverage (SBC) and benefit declinations can be requested in Spanish in the following counties. County list may be updated midyear.	Visit www.iebp.org click on the "Login" button click on "Online Customer Care" under the "My Tools" menu click on "Send a Secure Email"	
Counties for 2014: Andrews Atascosa Bailey Bastrop Bexar Brooks Calhoun Cameron Camp Castro Cochran Concho Crane Crockett Crosby Culberson Dallam Dallas Dawson Deaf Smith Dimmit Duval Ector Edwards El Paso Frio Gaines Garza Glasscock Gonzales Hale Hansford Harris Haskell Hemphill Hidalgo Howard Hudspeth Jeff Davis Jim Hogg Jim Wells Karnes Kenedy King Kinney Kleberg Knox Lamb La Salle Limestone Lipscomb Martin Matagorda Maverick McMullen Midland Moore Navarro Nueces Ochiltree Parmer Pecos Potter Presidio Reagan Reeves Sherman Starr Sterling Sutton Tarrant Terry Titus Travis Upton Uvalde Val Verde Ward Webb Willacy Winkler Yoakum Zapata Zavala		

Non-Duplication of Benefits

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

Integration of Benefits

The Integration of Benefits (IOB) provision applies when a Covered Individual may receive medical benefits from more than one source. The benefits payable under the Plan will not exceed 100% of the Plan's allowable Eligible Benefit when combined with all other plans. For Medicare information, please refer to the Integration of Medicare section.

The Covered Individual may receive benefits under the Plan that will not exceed 100% of the Plan's allowable Eligible Benefit when combined with all other plans.

Example: Charge - \$100

- ▶ IEBP's allowable - \$100
- ▶ IEBP's normal liability - \$80
- ▶ Primary payer paid - \$75
- ▶ IEBP's liability as the secondary integrated payer would be \$5 (the balance between what we would have paid, if we were primary and what the primary carrier paid).

Application

IEBP will determine which plan is primary and which plan is secondary. The other plan will always be primary if that plan has no coordination or integration provision. When the Plan is primary, it will pay benefits as if it were the only plan. When the Plan is secondary or the Covered Individual accesses benefits through Active Employee status elsewhere, it will pay a reduced benefit, which when added to the benefits paid by all other plans, will not exceed 100% of the total allowable benefit covered by the Plan. An itemized bill and an Explanation of Benefits (EOB) from the primary plan must be provided to the secondary plan to review for payment.

Definitions for the purpose of Integration of Benefits

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

Custodial Parent. The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

The Plan. The medical benefits provided by your Employer through IEBP.

Other Plan means any of the following arrangements that provide medical benefits or services:

1. insurance or any arrangement of benefits for groups;
2. individual plans that offer medical and hospitalization coverage that qualifies as minimum essential coverage under 26 USC 5000A(f)(1). This would exclude limited reimbursement policies such as supplemental policies under 26 USC 5000A(f)(3);
3. prepayment coverage or any coverage toward the cost of which any Employer makes contributions;
4. a labor-management plan, union welfare plan, Employer organization plan or employee organization plan;
5. any governmental program or coverage required by statute;
6. dependent ineligible Employer sponsored healthcare benefit information; or

7. coverage for expenses due to accidental bodily injury or disease to the extent to which payment as a settlement, judgment or otherwise is made by any person or their insurers without regard to whether or not liability is admitted.

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

Secondary Plan. A plan that integrates payments so that the total payments from all plans shall not exceed 100% of the Plan's allowable benefit.

Special Rules

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

	IEBP Pays Primary when...	IEBP Pays Secondary when...
Rule 1 - Non-Dependent/Dependent: <ul style="list-style-type: none"> The benefits of the plan that covers the Covered Individual as an Active Employee is primary to benefits accessed as a dependent. 	Active, pre sixty-five Retiree or former employee on COBRA Continuation of Coverage of IEBP Plan	IEBP will pay secondary to a spouse's or dependent child's Employer's plan
Rule 2a - Dependent Child/Parents, (natural or adoptive), are married or are living together, whether or not they have ever been married: <ul style="list-style-type: none"> The benefits of the plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the plan of the parent whose birthday falls later in that Calendar Year If both parents have the same birthday, the plan which has covered one parent for the longer period of time will be primary 	<ol style="list-style-type: none"> Natural or adoptive parent is an employee of IEBP Plan and birthday falls earlier in the year; and If parents share the same birthday, IEBP Plan has covered the dependent child for the longest period of time 	<ol style="list-style-type: none"> Natural or adoptive parent is an employee of IEBP Plan and birthday falls later in the year; and If parents share the same birthday IEBP Plan has covered the dependent child for the shortest period of time
2b - Dependent Child/Parents, (natural or adoptive), are divorced or separated or not living together, whether or not they have ever been married: <ul style="list-style-type: none"> Dependent child covered under both parents' group health plans. If a court decree states both parents have responsibility for the health care expenses or health care coverage: The benefits of the plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the plan of the parent whose birthday falls later in that Calendar Year; If both parents have the same birthday, the plan which has covered one parent for the longer period of time will be primary 	<ol style="list-style-type: none"> Natural or adoptive parent is an employee of IEBP Plan and birthday falls earlier in the year; and If parents share the same birthday, IEBP Plan has covered the dependent child for the longest period of time 	<ol style="list-style-type: none"> Natural or adoptive parent is an employee of IEBP Plan and birthday falls later in the year; and If parents share the same birthday IEBP Plan has covered the dependent child for the shortest period of time
2b - Dependent Child/Parents, (natural or adoptive), are divorced or separated or not living together, whether or not they have ever been married: <ul style="list-style-type: none"> If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, rule 2a will determine the order of benefits 	<ol style="list-style-type: none"> Natural or adoptive parent is an employee of IEBP Plan and birthday falls earlier in the year; and If parents share the same birthday, IEBP Plan has covered the dependent child for the longest period of time 	<ol style="list-style-type: none"> Natural or adoptive parent is an employee of IEBP Plan and birthday falls later in the year; and If parents share the same birthday IEBP Plan has covered the dependent child for the shortest period of time
2b - Dependent Child/Parents, (natural or adoptive), are divorced or separated or not living together, whether or not they have ever been married: <ul style="list-style-type: none"> Dependent child covered under both parents group health plans and if the court decree expires due to dependent child's age, the order of benefits for the child are as follows: <ol style="list-style-type: none"> The plan that has covered the Covered Individual for the longest period of time is primary 	IEBP Plan has covered the dependent child for the longest period of time	IEBP Plan has covered the dependent child for the shortest period of time
2b - Dependent Child/Parents, (natural or adoptive), are divorced or separated or not living together, whether or not they have ever been married: <ul style="list-style-type: none"> If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, and the child is under the age of 19 years, the order of benefits for the child are as follows: <ol style="list-style-type: none"> The plan covering the Custodial parent; The plan covering the spouse of the Custodial parent; The plan covering the non-custodial parent; and then The plan covering the spouse of the non-custodial parent 	<ol style="list-style-type: none"> Employee of IEBP Plan is the custodial parent; or Employee of IEBP Plan is the custodial step parent, (where custodial parent does not cover the dependent child); or Employee of IEBP Plan is the non-custodial parent, (where custodial parent or step parent do not cover the dependent child) 	<ol style="list-style-type: none"> Employee of non-IEBP plan is either the custodial step parent, non-custodial parent or non-custodial step parent; or Employee of non-IEBP plan is either the non-custodial parent or non-custodial step parent; or Employee of non-IEBP plan is the non-custodial step parent
2b - If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, and the dependent child attains the age of 19 years, the order of benefits for the child are as follows:	IEBP Plan has covered the dependent child for the longest period of time	IEBP Plan has covered the dependent child for the shortest period of time

	IEBP Pays Primary when...	IEBP Pays Secondary when...
<ul style="list-style-type: none"> The plan that has covered the dependent child for the longest period of time is primary 		
<p>2b - Individual covered as a dependent child under a natural, adoptive or step parent plan and also covered as a dependent under a spouse's plan. The order of benefits will be determined by the following:</p> <ul style="list-style-type: none"> The plan that has covered the dependent child for the longest period of time is primary 	IEBP Plan has been in effect the longest period of time	IEBP Plan has been in effect for the shortest period of time
<p>Rule 3 - Active/Inactive Employee:</p> <ul style="list-style-type: none"> The benefits of the plan that covers the Covered Individual as an Active Employee who is neither laid off nor retired are determined before those of a plan which covers that same person as laid off or retired employee. The same would hold true if the Covered Individual is a dependent of an Active Employee and that same person is a dependent of a Retiree or laid off employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this paragraph does not apply. 	IEBP Plan is the Active Employee Plan	IEBP Plan is the Retiree Plan (for the same person who is an Active Employee under another plan)
<p>Rule 4 - COBRA Continuation of Coverage:</p> <ul style="list-style-type: none"> If a person has coverage provided under COBRA Continuation of Coverage pursuant to federal or state law and is also covered under another plan, the following shall be the order of benefit determination: <ul style="list-style-type: none"> First, the benefits of a plan that covers the Covered Individual as an employee, a Member or a subscriber (or as a dependent of an employee, member or subscriber). Second, the benefits under the COBRA Continuation of Coverage. This rule does not apply if rule 1 determines the order of benefits. If the other plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this paragraph does not apply 	IEBP Plan is the Active Employee Plan	IEBP Plan is the COBRA Continuation of Coverage Plan (for the same person who is an Active Employee under another plan)
<p>Rule 5:</p> <ul style="list-style-type: none"> If none of the above rules determine the order of benefits, then the plan that has covered the Covered Individual for the longest period of time is primary 	IEBP Plan has covered the Covered Individual for the longest period of time	IEBP Plan has covered the Covered Individual for the shortest period of time

When a primary plan is a High Deductible Health Plan attached to a Health Savings Account, Integration of Benefits as the secondary carrier will occur after the IRS Guidance deductible has been satisfied.

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

Recovery of Integration of Benefits (IOB) Overpayments. If the amount of the payments made by the Plan for IOB administration is more than it should have paid under this IOB provision, it will recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Individual. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Other Party Liability

This section applies if you:

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

Contractual Right of Reimbursement. If a Covered Individual:

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

In addition, the Covered Individual specifically delegates to IEBP the right to make a claim or assert a cause of action on the Covered Individual's behalf against any source of recoveries, and assigns to IEBP the right to any proceeds from the claim or cause of action.

"Source of recovery" shall include, but not be limited to:

1. any third party;
2. any liability or other insurance covering the third party;
3. uninsured motorist, underinsured motorist, no-fault, or medical payments which are paid or payable of a non-immediate family member; or
4. any other responsible party. IEBP may seek direct reimbursement for benefit coverage from any source of recovery.

By enrolling in the Plan, the Covered Individual agrees to abide by the provisions in one (1) through ten (10) following this paragraph. IEBP may suspend payment of claims for the injury or illness based on the amount of the claim, indication of other insurance, indication there may be another source to pay for the medical services required as a result of the injury or illness, or evidence that the claim may not be covered because it is work-related.

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

1. provides any and all information requested by IEBP; and
2. agrees in writing not to settle damages whether by legal action, settlement or otherwise and only after consulting with IEBP to determine the full and potential medical charges; and
3. agrees that should the Covered Individual settle for damages as a result of an injury/illness with a third party or insurer, prior to securing such written permission, IEBP and the Employer's health benefits Plan is relieved of any liability for medical benefits resulting from the injury/illness; and
4. agrees that IEBP may provide any medical bills or payment information related to the injury/illness to the Covered Individual's attorney, any insurer or any other person who will be reimbursing IEBP for medical benefits; and
5. agrees in writing to reimburse IEBP immediately upon collection of damages whether by legal action, settlement or otherwise including, but not limited to, first party and third party motor vehicle insurance; and
6. agrees in writing to provide IEBP with a first lien on all proceeds recovered for this injury to the extent of benefits provided by the Plan; and
7. agrees in writing that venue for all subrogation disputes shall be in Travis County, Texas; and
8. agrees in writing to provide IEBP with a copy of any settlement agreement relating to this injury/illness if requested; and
9. agrees to cooperate fully with IEBP in asserting its right to subrogate. This means the Covered Individual must supply IEBP with all information and sign and return all documents reasonably necessary to carry out IEBP's right to recover from the third party any benefits paid under the Plan which are subject to this provision; and
10. agrees to all provisions of the benefit Plan.

If the Covered Individual accepts reimbursement or assigns benefits for an injury or illness for which money or benefits were received or paid by another source, and payment has also been made by IEBP, the Covered Individual must reimburse IEBP the amount paid to the Covered Individual or any provider for services or treatment for the injury or illness. If the Covered Individual does not reimburse IEBP, the amount not reimbursed may be withheld from future benefits.

Automobile/Homeowners Liability and/or Medical Payments Insurance Benefits. Benefits payable under the Plan may be adjusted by IEBP for any first party or third party insurance benefits available for medical benefits, including no-fault medical payments uninsured motorist coverage which are paid or payable by a non-immediate family member whether or not any party has admitted liability.

Right of Recovery. IEBP has the right to seek reimbursement on any overpayment from one or more of the following:

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

In addition, the Covered Individual specifically delegates to IEBP the right to make a claim or assert a cause of action on the Covered Individual’s behalf against any source of recovery, and assigns to IEBP the right to any proceeds from the claim or cause of action.

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

Overpayment Provisions

Right of Offset. If IEBP makes any payment on behalf of a Covered Individual exceeding the amount needed to satisfy its obligation under the terms of the Plan, then IEBP reserves the right to offset the overpayment against future benefits otherwise payable to a Covered Individual or provider.

Facility of Payment. When another plan makes a payment which should have been made under the Plan, IEBP reserves the right to decide:

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

Any such payment made by IEBP will fulfill IEBP's responsibility in the amount paid.

Fraudulent or Erroneous Billing. IEBP reserves the right to conduct its own investigation of any person or organization suspected of filing fraudulent claims and to turn over its findings to an authorized governmental agency or department for further investigation and/or prosecution.

Integration with Medicare

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

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

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

Status	Age	Primary Plan	Status	Age	Primary Plan
Retired	65+	Medicare	Active	65+	Employer
Spouse of Retiree	65+	Medicare	Spouse of Active EE	65+	Employer
Spouse of Retiree	<65	Employer	Spouse of Active EE	<65	Employer

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

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

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

IEBP will determine which plan is primary. The determination is based on the status of the Covered Individual on the date expenses are incurred.

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

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

IEBP submits electronic eligibility information to Medicare as required by law and secondary payor regulations.

Definitions

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

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

Active Employee - Is an employee who works and is paid by the Employer for at least twenty (20) hours per week or is accessing vacation, sick, personal, paid time off, or paid/unpaid Family Medical Leave Act of 1993 (FMLA) and is receiving the same benefits as all other employees. Persons who are receiving long or short term disability payments or workers' compensation income benefits are not otherwise on the payroll of the Employer are not Active Employees, nor do those benefits accrue toward the twenty (20) hour requirement.

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

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

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

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

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

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

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

Aquatic Therapy - Services prescribed by a Physician to restore or improve a previous level of body function. Inpatient/Outpatient therapy services must be performed or rendered at a hospital or licensed healthcare facility by a licensed aquatic physical therapist or Physician.

Benefit - The amount payable by the Plan for Eligible Benefits.

Benefit Percentage - The percentage of Eligible Benefits payable by the Plan after deductible and copay.

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

Board of Trustees - The Board of Trustees is IEBP's governing body as established by Section 172 of the Local Government Code.

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

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

Child - The term "child" means:

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

Clean Claim - A claim for covered services that is received from a Network provider that reflects the standard claim format, and accurately contains the following information: patient name, patient's date of birth, unique subscriber identification number, provider's name, address and tax ID number, national provider identification number, date(s) of service, diagnosis narrative or ICD code, procedure narrative or CPT-4 codes, services and supplies provided, physician name and license number, provider charges and an itemized bill if the bill is in excess of \$15,000 outpatient and \$20,000 inpatient. Such itemized bill will be required to adjudicate the claim. Claim must be submitted by provider no later than the filing deadline. A "Clean Claim" does not include a claim where 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.

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

1. Phase I Trials – Medical researchers test the drug with a small group of people to discover its metabolic and pharmacologic actions in humans, as well as its safety, dosage and side effects. They also test the impact of increasing doses and early evidence of effectiveness. This trial may include healthy participants or patients.
2. Phase II Trials – This stage is a controlled clinical study that evaluates the effectiveness of the drug for a particular indication or indications in patients with the condition under study. During this stage, researchers test the new drug with a slightly larger group of people (100 to 300) to collect more information about its common short-term side effects, efficacy and risks.

3. Phase III Trials – The third stage expands controlled and uncontrolled trials after preliminary evidence suggests the effectiveness of the drug has been determined. Its purpose is to gather more information to evaluate the overall risk – benefit of the drug and provide a satisfactory basis for physician labeling. Researchers give the drug to an even bigger group (between 1000 to 3000 people) monitor its use, compare it to other treatments and further ensure its safety.
4. Phase IV Trials – Post marketing studies to identify additional uses for an FDA approved medication. The studies also identify the drug’s risks, benefits and optimal use.
5. Well Conducted Clinical Trials – Trials in which two or more treatments are compared to each other, and the patient or provider is not allowed to choose which treatment is received.

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

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.

Copay - A specified dollar amount that is the Covered Individual’s responsibility to pay to a Health Care Provider. Copays are usually connected with specific benefits and may be in addition to or in lieu of the Plan deductible.

Cosmetic Procedures - Procedures performed solely to improve appearance.

Covered Benefits - See **Eligible Benefits**.

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

Covered Individual - An employee, dependent, Retiree, Retiree dependent, elected official and elected official’s dependent who is eligible and has enrolled in the Plan.

Crisis Stabilization Unit - A twenty-four (24) hour residential program, usually short-term in nature that provides intensive supervision and highly structured activities to persons who are demonstrating an acute mental health/substance use disorder crisis of moderate to severe proportions.

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

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

Day Treatment - A mental health/substance use disorder treatment facility that meets all of the following requirements:

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

Deductible - Eligible Benefits in a given calendar year, which are the responsibility of the employee before benefits become payable by the Plan.

If an individual is accessing a High Deductible Health Savings Account Family Plan, the Plan is required to ensure the minimum family deductible dollar amount is paid prior to benefit percentage Plan payments. The IEBP Plan design for the minimum family deductible regulations will require the covered family individual’s dollars accumulate to the minimum family deductible and no individual deductible will be included in the minimum family deductible requirement. The deductible out of pocket expense must be met prior to benefit Plan percentage payment.

Dentist - Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is a member or eligible member of the state Dental Association or eligible for membership in such association.

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

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

Designated Transplant Center (Centers of Excellence) - An Optum Health Network hospital or facility of a particular organ transplant procedure. The hospital or facility selected must meet all of the following requirements:

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

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

Disability - Any of the following conditions:

1. illness;
2. bodily malfunction (impairment, disturbance or abnormality of the functioning of an organ or limb);
3. accidental injury;
4. pregnancy;
5. mental health conditions; or
6. substance use disorder.

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

Durable Medical Equipment - Equipment that is eligible and appropriate only in the treatment or management of an illness or injury and is accepted in the medical community as safe and effective. Standard model items refer to the base model without added options and/or accessories.

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

Emergency Services - See **Immediate Care**.

Emergency/Immediate Care - Benefit eligible services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

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

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

Enroll - To make written application for coverage on the prescribed forms. Enrollment is not completed until such forms are accepted by the Employer and received by IEBP within required timelines.

Essential Health Benefits (EHB) - The Patient Protection Affordable Care Act defines essential benefits to include items and services within the following ten (10) benefit categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including mental health treatment, prescription drugs (plan must offer one drug for each United States Preventive Service Task Force (USPTF) category and class or the number of drugs in the EHB benchmark Plan), rehabilitative and habilitative services and devices, laboratory

services, preventive and wellness services and chronic disease management and pediatric oral and vision screening services as required by law.

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

Exclusions - Those charges for which benefits are not provided. Such charges are listed in “General Exclusions or Limitations.”

Extenuating Circumstances - If a Covered Person requires care from a specialist care provider, but there is not a Network specialist care provider within a seventy-five (75) mile radius from the employee’s place of business, the provider would be paid at Network benefits subject to U&R allowable amounts.

Filing Deadline - The latest date a claim may be received by IEBP in order to be considered eligible for payment. All requested additional information relating to the claim must also be received within the same time frame unless the information is required for contractual prompt pay compliance. The Plan’s filing deadline is twelve (12) months from the date the expense was incurred, unless it was not reasonably possible to furnish the information within the filing deadlines as determined by IEBP, or within ninety (90) days after a non-compensable claim decision is made by the Employer’s Workers’ Compensation carrier or by the Workers’ Compensation Division of the Texas Department of Insurance, whichever is later.

Genetic Testing - Involves the examination of human DNA for an anomaly associated with a disease or disorder. DNA is taken from a sample of the Covered Individual’s blood, body fluid, or tissue.

Habilitation Services - Services designed to assist individuals in acquiring, retaining, and improving the self-help socialization, and adaptive skills necessary to reside successfully in home and community settings. The definition of “habilitation services” does not contain the requirement that the services be “medical or remedial” and recommended by a physician or other licensed practitioner of the healing arts.

Handicapped Child/Total Disabled/Incapacitated Child - A dependent child age twenty-six (26) or older who is mentally or physically incapable of supporting himself/herself and is primarily dependent upon the Covered Individual for financial support. IEBP may require satisfactory proof of the continued incapacity documented as a disability by the Social Security Administration (SSA). IEBP may have a physician examine the child or may request proof to confirm the incapacity, but not more often than once a year. If you fail to submit proof when reasonably required or refuse to allow IEBP to have the child examined, then coverage for the child will terminate.

He, Him, His - Whenever the masculine pronoun is used in the Plan it shall include the feminine gender as well, unless the context clearly indicates otherwise.

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

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

High Risk Pregnancy - A high risk pregnancy is one in which some condition puts the mother, the developing fetus, or both at higher-than-normal risk for complications during or after the pregnancy and birth.

A pregnancy can be considered a high-risk pregnancy for a variety of reasons:

- ▶ multiple birth diagnosis;
- ▶ maternal age younger than fifteen (15) or older than thirty-five (35) years of age;
- ▶ pre-pregnancy weight under one hundred (100) pounds or obesity;
- ▶ history of complications during previous pregnancies (including stillbirth, fetal loss, preterm labor and/or delivery, pre-eclampsia or eclampsia);
- ▶ Rh incompatibility;
- ▶ gestational diabetes; or
- ▶ prenatal tests indicate that the baby has a serious health problem (for example, a heart defect).

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

Title I:

- ▶ Refers to healthcare coverage reform and includes provisions for special enrollments and non-discrimination based on Health Status Factors;
- ▶ A self-funded, non-federal, governmental plan may exempt itself from HIPAA's provisions for standards relating to benefits for mothers and newborns, parity in the application of certain limits for mental health benefits, coverage for reconstructive surgery following mastectomy/lumpectomy and coverage of dependent students on medically necessary leave of absence. The Plan has opted out of and is exempt from these provisions. However, the Plan may comply voluntarily, in part or in whole, with some of the HIPAA requirements listed.

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 (Security Rule) and Standards for Privacy of Individually Identifiable Health Information (Privacy Rule);
- ▶ A self-funded, non-federal, governmental health plan cannot exempt itself from the Title II requirements.

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

Home Health Care Agency - A public or private agency or organization licensed by the state in which it is located to provide skilled nursing services and other therapeutic services under the supervision of a Physician or Registered Nurse.

Home Health Care Plan - A program for care and treatment of the Covered Individual:

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

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

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

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

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

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

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

Hospitalist - A medical specialty dedicated to the delivery of comprehensive medical care to hospitalized patients. Practitioners of hospital medicine include physicians ("hospitalists" and non-physician providers who engage in clinical care, teaching, research or leadership in general hospital medicine).

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

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

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

Immediate Care - Those benefit eligible services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

1. placing the Covered Individual's life in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Incapacity - See **Disability**.

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

Infusion Therapy - Medications administered intravenously (IV).

Injury - See **Accidental Injury**.

Inpatient - Treatment or confinement to a medical facility where a Covered Individual has been admitted to the hospital for bed occupancy with the expectation they will remain overnight for the purposes of receiving inpatient hospital services.

Inpatient Physical, Occupational, and/or Aquatic Therapy - Services prescribed by a Physician to restore or improve a previous level of body function. Inpatient therapy services must be performed or rendered at a hospital or licensed healthcare facility by a licensed physical or occupational therapist or Physician.

Integration of Benefits - Applies when a covered person may receive benefits for medical expenses from more than one source. The benefits payable under the Plan will not exceed 100% of the Plan's allowable Eligible Benefit when combined with all other plans.

Example:

- ▶ Charge - \$100
- ▶ IEBP's allowable - \$100
- ▶ IEBP's normal liability - \$80

- ▶ Primary Payer paid - \$75
- ▶ IEBP's liability as the secondary integrated payer would be \$5 (the balance between what we would have paid, if we were primary and what the primary carrier paid).

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

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

Long Term Acute Care (LTAC) Facility - A long-term acute care hospital that provides extended, intensive medical care to patients who are clinically complex and suffering from multiple acute or chronic conditions. Such patients typically require a longer than usual hospital stay because of the severity of illness or the chronic nature of the disease process.

Maintenance Care - All services, equipment and supplies which are provided solely to maintain a Covered Individual's condition and from which no functional improvement can be expected.

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

Medical Intelligence Services - A system that includes notification, concurrent review, discharge planning and retrospective review of healthcare services. Medical Intelligence Services does not include elective requests for clarification of coverage.

Medical Intelligence Utilization Management/Catastrophic Care - Utilization Management services help you use your benefits wisely during periods of treatment due to serious sickness or injury. This is done through early identification of the need for Utilization Management for catastrophic cases (chemotherapy, radiation therapy, transplants, NICU babies, brain injuries, multiple trauma etc.) that require intensive management. The UM/RNs are responsible for accurate and timely processing of requests for all events/services.

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

Medically Justified - A service that falls under the Plan definition of UNPROVEN MEDICAL PROCEDURES/THERAPY, but that can be justified for an individual patient due to:

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

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

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

Mental Health - Those conditions or illnesses that are classified by the most recent edition of either a DSM (Diagnostic & Statistical Manual of mental health disorders) diagnostic code or an ICD (International Classification of Disease) code for mental health disorders.

Mental Health/Substance Use Disorder Intensive Outpatient Treatment - Conditions that require more frequent outpatient services in a short period of time; subject to the benefit maximum per the Summary of Benefits and Coverage.

Mental Health Treatment Facility - A facility constituted and operated under law which includes all of the following:

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

Network - Treatment or services rendered by providers that are included as contracted providers in the preferred provider Network.

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

Non-Network - Treatment or services rendered by providers that are not included as contracted providers in the preferred provider Network.

Notification - The process for notifying Medical Intelligence of the need for medical treatment or services.

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

Nurse Midwife/Certified Professional Midwife (CPM) - A licensed registered nurse (RN) who is certified as a nurse midwife by the American College of Nurse-Midwives and is authorized to practice as a nurse midwife under state regulations.

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

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

Out of Network - See **Non-Network**.

Out of Pocket Amount - The portion of Eligible Benefits for which a Covered Individual is responsible to pay.

Outpatient - Treatment or confinement in a medical facility where the Covered Individual has not been admitted as inpatient. If you notify Medical Intelligence within forty-eight (48) hours of an outpatient surgery that exceeds the twenty-three (23) hour limit, it will be considered an admission and a late review will be performed.

Outpatient Observation - Treatment or confinement in a medical facility with the purpose of observing the Covered Individual to determine the need for further outpatient treatment or for inpatient admission.

Outpatient Physical, Occupational, and/or Aquatic Therapy - Services prescribed by a physician to restore or improve a previous level of body function. Outpatient therapy services must be performed or rendered at a hospital, licensed healthcare facility or at home by a licensed physical or occupational therapist; subject to the benefit maximum per the Summary of Benefits and Coverage.

Pharmacy Benefit Manager - The Plan's prescription carrier.

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

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

Plan Administrator - IEBP has been designated to serve as the Plan Administrator.

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

Pool - TML MultiState Intergovernmental Employee Benefits Pool (IEBP).

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

Pregnancy - Under the terms of the Plan, pregnancy includes one or more of the following:

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

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

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

Rehabilitative Hospital - An institution constituted and operated under law which:

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

Residential Treatment Center - The term residential treatment center for children and adolescents means an accredited child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation (COA), the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) or the American Association of Psychiatric Services for Children (AAPSC).

Retiree - An employee who has ceased active, benefit eligible employment with the Employer and meets the Employer's guidelines to qualify as a Retiree and draws all other applicable Retiree benefits.

Routine - Being in accordance with an established procedure.

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

Skilled Nursing Facility - An institution or a distinct part of an institution which meets all of the following criteria:

1. is primarily engaged in providing for inpatient skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation service for the rehabilitation of injured or sick persons;
2. has policies which are developed with the advice of (and with provision for review of such policies from time to time) by a group of professional personnel, including one (1) or more Physicians and one (1) or more Registered Nurses (RNs), to govern the skilled nursing care and related medical care or other services provided;
3. has a Physician, a Registered Nurse (RN) and a medical staff responsible for the execution of such policies;
4. has a requirement that the healthcare of every patient must be under the supervision of a physician and provides for having a Physician available to furnish necessary medical care in case of emergency;
5. maintains clinical records on all patients;
6. if required, provides twenty-four (24) hour nursing care under the supervision of a Registered Nurse (RN);
7. provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
8. has in place a utilization review plan which provides for the review of admissions to the institution, the duration of stays and the professional services furnished with respect to eligibility;
9. is licensed by the appropriate state or local agency; and
10. is Medicare or Medicaid eligible.

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

Skilled Nursing Services - Nursing services performed by an RN, LVN, or LPN for health services.

Spouse - Individual legally married to the covered employee under the laws of any state. IEBP may request written proof of the spousal relationship, such as a copy of the marriage certificate. Proof of a properly filed declaration of informal marriage is required for an informal marriage to be recognized by the Plan.

Sublingual Immunotherapy - Sublingual Immunotherapy involves the administration of antigen drops under the tongue. The antigen drops are administered in gradually increasing doses in an effort to build up individual tolerance to the allergy-causing substance.

NOTE: *This is considered Unproven Medical Procedures/Treatment.*

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

Substance Use Disorder Treatment Facility - A facility which provides a program for the treatment of substance use disorder pursuant to a written treatment plan approved and monitored by a physician and which facility meets the requirements under #1, #2 and #3 below or the requirements under #4 below:

1. affiliated with a hospital under a contractual agreement with an established system for Covered Individual referral;
2. accredited as such a facility by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO); and
3. licensed as a substance use disorder treatment program by the Texas Commission on Alcohol and Drug Abuse (TCADA); or
4. licensed, certified or approved as a substance use disorder treatment program or center by any other state agency having legal authority to so license, certify or approve and is also an approved healthcare facility.

Telemedicine

1. Medical information that is communicated in real-time with the use of interactive audio and video communications equipment, and is between the performing physician and/or a distant physician or health care specialist with the patient present during the communication.
2. IEBP's contracted telemedicine services via the convenience of phone or online, video consultation, diagnostic and/or medication management services for many conditions including allergies, cold and flu symptoms, ear infection and other minor medical conditions.

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

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

United States Preventive Services Task Force (USPSTF) - Quality Improvement preventive services task force that works with other national organizations.

PHS Act section 2713 and the interim final regulations require non-grandfathered group health plans in the individual or group benefits prohibit the cost-sharing requirements with respect to, the following:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the Covered Individual;
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the Covered Individual;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
4. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

Unproven Medical Procedures/Treatment - Experimental/Investigational/Unproven Services: medical, surgical, diagnostic, mental health, substance use disorder, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time IEBP makes a determination regarding coverage in a particular case, are determined to be any of the following:

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

Usual and Reasonable - A Usual and Reasonable charge is deemed to be 110% of the amount prescribed by the Centers for Medicare and Medicaid Services (CMS), Resource-Based Relative Value Scale (RBRVS), other specialty CMS fee schedules and the Ingenix Essential RBRVS Fee Schedule.

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

Index

A

Active Duty Reservists · 31, 40
Appeals · 7
Assignments · 7

C

Care Management · 13
COBRA Continuation of Coverage · 30, 44
COBRA Continuation of Coverage (COC) Rights · 38
Colon-Rectal Exam Benefit · 21
Continued Stay Review · 13
Copay Requirements · 15

D

Dates of Eligibility and Coverage · 30
Deductible Requirements · 15
Definitions · 48
Description of Plan Benefits · 15

E

Eligible Benefits · 16
Employee Coverage · 36
Employee Dependent Coverage · 36
Enrollment · 32
Enrollment Requirements · 30

F

Facility Outpatient · 16

G

General Exclusions or Limitations · 27

H

Home Health Care Benefit · 22
Hospice Care Benefit · 22
How Benefits are Paid · 6
How the Notification Process Works · 11

I

Integration of Benefits · 11, 42
Integration with Medicare · 46

L

Legal Actions · 7

M

Major Medical · 17
Medical Intelligence Features · 11
Mental Health Conditions · 24
Morbid Obesity Benefit · 24

N

Newborn Children · 32
Non-Duplication of Benefits · 42
Notification Requirements · 11

O

Other Party Liability · 44
Out of Pocket Requirements · 15
Overpayment Provisions · 46

P

Prescription · 17
Preventive/Routine Care Benefit · 21, 27
Privacy of Your Health Information · 10

R

Rescission of Coverage · 36
Retiree Coverage · 37
Retiree Dependent Coverage · 37

S

Self-Audit Reimbursement · 14
Serious Mental Health Illness · 25
Special Rules · 43
Substance Use Disorder Benefit · 25

T

Termination Date of Coverage · 36
Transplant Benefit · 23

U

Usual and Reasonable · 15