



PLAN YEAR 2015-2016

VISION B BENEFITS BOOKLET

FOREWORD

October 2015

TML MultiState Intergovernmental Employee Benefits Pool (IEBP) has prepared this booklet to help you understand the vision benefits provided through your Employer. The Vision Plan described in this booklet provides coverage for routine vision care. However, your benefits are affected by certain limitations and conditions which require you to be an informed consumer of vision services. Benefits are not provided for certain treatments and ineligible services, even if recommended by your eye care professional. IEBP urges you to familiarize yourself with the provisions in the Plan description in order to understand your benefits. For most state and federal laws applicable to a vision plan based upon the number of employees enrolled or eligible to enroll in the vision plan, the size of the vision 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.

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 Vision Benefit Booklet to make sure you are referring to the vision 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*

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Schedule of Vision Benefits

	Maximum Benefit
Annual Eye Examination (contact lenses fitting included)	\$85
Frames (one (1) set every calendar year).....	\$85
Lenses (one (1) set every calendar year)..... (per pair)	
Single Vision	\$70
Bifocal.....	\$85
Trifocal	\$100
Progressive.....	\$140
Lenticular	\$190

Contact Lenses (non-cosmetic; one (1) year supply every calendar year)..... \$175 per set

- ▶ Disposable contact lenses are covered up to the maximum benefit if purchased at the same time.
- ▶ Contact fittings will be considered under the eye exam benefit.

Eye Examinations. One (1) complete analysis of the eyes and related structures is covered every calendar year.

Frames. One (1) set of frames is covered every calendar year. The Plan will not cover a set of contacts and frames in the same calendar year.

Lenses. One (1) prescription for framed lenses or contact lenses is covered every calendar year. The Plan will not cover both framed lenses and contact lenses in the same calendar year.

Waiting Period before Benefits are Payable

Employees

There is no waiting period for covered employees before benefits are payable.

Dependents

There is no waiting period for covered dependents before benefits are payable.

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 under the Plan, a written request for such information will be made to the Covered Individual, or if necessary, the vision care provider. 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 of service 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 vision expense sought to be claimed is due to an injury that is non-compensable, whichever is later.

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 vision 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 vision 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 pre-existing services;
4. information related to work related accidents or illness; and/or
5. 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 vision information as confidential. However, IEBP has the right to disclose or obtain information regarding a Covered Individual from any organization or person if necessary to determine benefits payable under the Plan or if allowed by state or federal statute or regulation.

Assignments

The benefits provided under the Plan are payable to the Covered Individual. IEBP may pay benefits directly to the vision care provider if they are assigned by the Covered Individual.

Legal Actions

No legal action (including arbitration) may be brought against IEBP prior to the expiration of sixty (60) days after written proof of services incurred 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 vision 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.

Claim Appeals

If a claim for benefits is wholly or partially denied, an Explanation of Benefits (EOB) will be furnished to the Covered Individual and the provider of services. This EOB will give the reason(s) the claim was denied. If the Covered Individual or provider of services does not agree with the claim decision or alleges that a contractual prompt payment requirement was not followed in the administration of a claim, he or she may submit an appeal. The appeal must be in writing and received by IEBP within one-hundred eighty (180) days of the date of the EOB. Relevant information supplied by the Covered Individual or vision care provider should be included with the appeal.

An appeal requested without proper documentation may not be considered. All written appeals should be sent to IEBP's address printed on the ID cards. 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 a denial or reduction in benefits within thirty (30) days after receipt of all necessary information to make a determination. Failure to provide such written notice will not grant the appeal. All available vision 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 individual does not agree with the decision, the appeal may be elevated to the Board of Trustees, TML MultiState IEBP, 1821 Rutherford Lane, Suite 300, Austin, TX 78754-5151. Usually within sixty (60) days of receipt of the denial of appeal, a committee of Trustees will schedule a meeting and hear the appeal. The appealing party may submit additional information and/or appear before the committee. The appealing party will be notified of the date, time, and place the committee will meet at least five (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 usually within thirty (30) days after the receipt of the request, but in no case more than one-hundred twenty (120) days after the request for review is received. The Appeals Committee's final decision will be in writing and include specific references to the Plan provisions on which the decision was based.

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.

Overpayment Provisions

Right of Offset. If IEBP makes any payment on behalf of a Covered Individual which is more than 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.

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 turn over its findings to an authorized governmental agency or department for further investigation and/or prosecution.

Exclusions or Limitations

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

1. for orthoptics or vision training and any associated or supplemental testing;
2. for treatment of any illness, injury or disability which (1) was incurred while working for wage, hire, or monetary gain, or (2) 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 including those individuals who could have been lawfully covered by workers' compensation as volunteers. In applying this exclusion, work on the Covered Individual's family farm or ranch is not considered an employment arrangement;
3. for non-prescription frames, lenses and contact lenses;
4. for vision or surgical treatment of the eyes, including any charge for prosthetic devices payable under the vision provision of any plan;
5. for services rendered by someone other than a Doctor of Optometry (O.D.), a Doctor of Ophthalmology (M.D.) or a dispensing Optician;
6. 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 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. Determination of reasonably possible is at the sole discretion of IEBP; or
7. for charges incurred as a result of travel outside of the United States or its territories specifically to receive vision treatment, unless otherwise specifically covered under the Plan.

Pre-Existing Conditions

No pre-existing condition limitation will apply to this Vision Care Benefit.

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 become an active employee (working at least twenty (20) hours a week); or
2. the date you complete the waiting period, if any, 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. 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.

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 Vision 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 employment 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 eligible for employee coverage; or
2. the date you acquire your dependent.

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 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 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. Coverage will become effective on the date of the qualifying event after the effective date before any benefits are payable. 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.

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.

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 have the child examined 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, <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"/> Adopted Child - to attained age 26	<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"/> 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)
	<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 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

This is an incurrence of expense plan that excludes payment for any service of any type incurred after coverage ends.

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 coverage with the Employer;
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; or
5. the date your Employer is no longer participating under the Plan.

**Exception: An Employer should have an official written policy on extended leave without pay and continuing vision care 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; or
5. the date the former Employer no longer provides group vision 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”	
Spanish Line:	(800) 385-9952	

Non-Duplication of Benefits

Benefits provided by the Vision Care Plan are payable in addition to any other coverage, individual, group and/or Workers’ Compensation.

Definitions

These terms define words that may be used in this booklet. These definitions shall not be construed to provide coverage under any benefit unless specifically provided.

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 Employees(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.

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.

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

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.

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, vision claims review is necessary, subrogation is pursued, where work related or where pre-existing conditions 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.

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

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 vision 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.

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.

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

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.

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.

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

HIPAA - A Federal law referred to as the Health Insurance Portability and Accountability Act of 1996. HIPAA went into effect for most group health plans on the anniversary that 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 creditable coverage, restrictions on pre-existing condition exclusions, special enrollments and non-discrimination based on Health Status Factors;

- ▶ HIPAA Title I **does not** apply to the vision plan.

Title II:

- ▶ Effective April 14, 2003, Administrative Simplification guidelines were mandated. The administrative simplification process includes standards for electronic transactions and code sets, national identifiers (for Employers, health plan and providers), Security and Electronic Signature Standards (Security Rule) and Standards for Privacy of Individually Identifiable Health Information (Privacy Rule);
- ▶ HIPAA Title II **does** apply to the vision plan.

Incurred Expense - An expense is deemed to be incurred on the date a service is rendered or a supply is obtained.

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.

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).

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.

Spouse - Individual legally married to the employee under the laws of any state and is the opposite gender from the employee.

Unproven Vision Procedures/Treatment - Experimental/Investigational/Unproven Services

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.

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