Guidance document appear at 77Fed Reg. 8668 and 8706 respectively (2-14-12). | Culturally Linguistic documents are available by calling (800) 282-5385 or e-mail Customer Care.

Summary of Benefits and Coverage (SBC)

Coverage Tiers. 4 Tier

This is only a Summary of Benefits and Coverage. For more information about your coverage, or to get a copy of the complete terms of coverage access www.iebp.org or call (800) 282-5385. For general definitions of common terms, such as allowed amount, balance billing, coinsurance/benefit percentage, copayments, deductible, provider, or other bolded terms see Glossary at www.iebp.org or call (800) 282-5385.

Frequently Asked Questions	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations and Exceptions
What is the overall deductible?	N/A	Individual: $1200 Family: $2400	Individual: $1450 Family: $2900	You must pay all of the deductible costs before the Plan will pay any portion of the eligible benefits. *Eligible Network preventive/wellness benefits pay at no cost share to the Covered Individual.*
Are there other deductibles for specific services?	N/A	Facility Inpatient: N/A	Facility Inpatient: N/A	You must pay all of the deductible costs before the Plan will pay any portion of the eligible benefits. *Eligible Network preventive/wellness benefits pay at no cost share to the Covered Individual.* For a confinement that continues into a new calendar year, amounts applied toward the prior calendar year deductible will also count toward satisfying the next calendar year deductible for charges during confinement. All other charges are subject to the new calendar year deductible amount. Health Savings Account/High Deductible family plans will require the minimum of the individual or family deductible to be met **before** plan benefit percentage is applied.
Is there an out-of-pocket limit on my expenses?	N/A	Individual: $3500 Family: $7000	Individual: $0 Family: $0 Never pays at 100%	Once the Network Deductible and out-of-pocket amount is satisfied per individual and/or family, the plan pays 100% of eligible Network charges. 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. For a confinement that continues into a new calendar year, amounts applied toward the prior calendar year out-of-pocket will also count toward satisfying the next calendar year out-of-pocket for charges during confinement. All other charges are subject to the new calendar year out-of-pocket amount. 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% medical and/or prescription. Medical and Prescription copayments for most cost effective eligible Network benefit and services will accumulate to the Federal Government H.S.A. or PPO maximum out of pocket (MOOP) amount. Once the Federal Government defined MOOP is met eligible network services within the scope of the benefit plan will be paid at 100%.
Is there a maximum out-of-pocket limit (MOOP) on all my expenses?	N/A	Plan years effective Jan.2015 thereafter		The Individual Deductible/Out of Pocket amount applies if you have no other family members covered under this plan. Charges are subject to the new calendar year deductible amount. Health Savings Account/High Deductible family plans will require the lesser of the individual or family deductible/out of pocket to be met before plan benefit percentage or 100% payment is applied. The maximum out-of-pocket (MOOP) limit for PPO plans and the 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

Frequently Asked Questions	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations and Exceptions
				paid at 100%. The PPO MOOP amount for **2016**: Individual: $6,850 Family: $13,700 H.S.A./High Deductible MOOP amount for **2016**: Individual: $6,550 Family: $13,100
What is not included in the out-of-pocket limit?	N/A			Access fees, penalties, ineligible, not most cost effective network eligible benefits and services will not accumulate to your plan maximum out-of-pocket amount. Network and Non-Network out-of-pocket dollars do not accumulate. The deductible plus the out-of-pocket expenses equals the Covered Individual's maximum plan out-of-pocket expense.
Is there an overall annual limit on what the plan pays?				No.
Does this plan use a network of providers?	N/A	Yes		Your deductible, out-of-pocket expenses, and benefit % will be different per Network and Non-Network services and do not accumulate. See www.iebp.org or call (800) 282-5385 for a list of participating providers.
Do I need a referral to see a Specialist?	N/A	No		You have the option to choose any provider. ***Note:*** *Network and Non-Network benefits*
Are there any services the plan does not cover?				Please refer to the excluded benefit information.
What is my copayment?	Office Visit: $35	Office Visit: $35	N/A	N/A

Common Medical Event	Services You May Need	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations, Exceptions and Exclusions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Plan Specific: 85%	Plan Specific: 80%	50%	N/A
	Specialist visit	Emergent/ Immediate: 85%	Emergent/ Immediate: 80%	80% up to U&R	N/A
		Scheduled Services: 85%	Scheduled Services: 80%	50% up to U&R	
	Other practitioner office visit	85%	80%	50%	Provider of Service must be licensed to perform services rendered to Covered Individual.
	Telehealth: Healthiest You | (866) 703-1259 | www.healthiestyou.com	N/A	Patient OOP Copay: $10.00	N/A	
	Preventive care/screening/ immunization	100%	100%	50%	N/A

Common Medical Event	Services You May Need	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations, Exceptions and Exclusions
If you visit an urgent care clinic	Urgent care visit to treat an injury or illness	85%	80%	50%	Urgent Care Services billed on a UB will be processed under Hospital benefit. Urgent Care Services billed on a HCFA will be processed under Office Visit Benefit.
If you have a test	Diagnostic test (x-ray, blood work)	85%	80%	50%	N/A
	Imaging (CT/PET scans, MRIs)	85%	80%	50%	Review 'Notification Requirements' section in SPD.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.iebp.org.**	Generic drugs	N/A	Retail: $5/$14; Mail: $30.00	N/A	**(Review Medication Therapy Mgm't Guide at www.iebp.org for other prescription drug services.)** $5.00 copay up to 34 day supply; $14.00 for 35 to 90 day supply and/or extended cycle
	Best Brand/Formulary List	N/A	Retail: $43.00; Mail: $100.00	N/A	**Retail** - Up to a 34 day supply; **Mail** - 35-90 day supply
	Non-Best Brand/Non-Formulary List	N/A	Retail: $65.00; Mail: $155.00	N/A	**Retail** - Up to a 34 day supply; **Mail** - 35-90 day supply
	Specialty drugs	N/A	Retail: N/A; Mail: $100.00	N/A	**Mail** - Up to a 34 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	85%	80%	50%	Review 'Notification Requirements' section in SPD.
	Physician/surgeon fees	85%	80%	50%	
If you need immediate medical attention	Emergency room services	85%	80%	80% up to U&R	
	Emergency medical transportation	85%	80%	80%	• Ground Max: $1,500/treatment episode • Air Max: $9,000/treatment episode
	Urgent care	85%	80%	80% up to U&R	
If you have a hospital stay	Facility fee (e.g., hospital room)	85%	80%	50%	Review 'Notification Requirements' section in SPD.
	Physician/surgeon fees	85%	80%	50%	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Plan Specific: 85%	Plan Specific: 80%	50%	Review 'Notification Requirements' section in SPD.
	Mental/Behavioral health inpatient services	Plan Specific: 85%	Plan Specific: 80%	50%	
	Substance use disorder outpatient services	Plan Specific: 85%	Plan Specific: 80%	50%	
	Substance use disorder inpatient services	Plan Specific: 85%	Plan Specific: 80%	50%	
If you are pregnant	Prenatal and postnatal care	Plan Specific: 85%	Plan Specific: 80%	50%	Review 'Notification Requirements' section in SPD.
	Delivery and all inpatient services	Plan Specific: 85%	Plan Specific: 80%	50%	
If you need help recovering or have other special health needs	Home Health Care	Plan Specific: 85%	Plan Specific: 80%	50%	Review 'Notification Requirements' section in SPD.
	Rehabilitation/Habilitation services	Plan Specific: 85%	Plan Specific: 80%	50%	
	Skilled nursing care	Plan Specific: 85%	Plan Specific: 80%	50%	
	Durable medical equipment	Plan Specific: 85%	Plan Specific: 80%	50%	
	Hospice services	Plan Specific: 85%	Plan Specific: 80%	50%	

Common Medical Event	Services You May Need	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations, Exceptions and Exclusions
If your child needs dental or eye care *(attained age of 19)*	Eye exam				Vision Acuity Screenings-paid as Preventive under Medical Plan-100% allowed U&R Vision screening services [for the detection of eye disease and refractive disorders and well-child visits that include visual acuity testing stereoacuity, cover-uncover tests, Hirschberg light reflects test, autorefraction and photoscreening may be done starting age three (3) to attained age of five (5) years] as required by law.
	Glasses	Ineligible under Medical Plan			
	Dental check-up				Dental Screenings-paid as Preventive under Medical Plan-100% allowed U&R Pediatric oral [application of fluoride varnish to the primary teeth of all infants starting at the age of primary tooth eruption; recommended at six (6), nine (9), twelve (12), eighteen (18), twenty-four (24), thirty (30) months, three (3) and six (6) years].

Excluded Services and Other Covered Services (This is not a complete list. Check your policy or plan document for other excluded services.)

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.

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: • 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). • A unique co-morbidity, or complication that precludes treatment with a proven medical procedure or therapy. > No other treatment available due to co-morbidities > Co-morbid Disease State Risk • Continuation and/or repeat of a previously approved successful treatment plan. • Concern for Complications due to treatment area. • Repeat of prior successful treatment intervention and disease state; disease state put in remission. • Treatment dose should be in compliance for best outcome. • Severity of illness defined as ongoing intensity and complication of disease state with lab value concerns.

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.

General Exclusions or Limitations - No benefits shall be payable under any part of the Plan with respect to any charges. This is not a complete list. Refer to the Medical Plan Book for a complete list of Exclusions and Limitations: Login: www.iebp.org • Select: My Tools • Select: MyBenefits on Demand • Select: Benefits • Select: Medical • Medical Plan Book

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;

Other Covered Services. This is not a complete list. Check your plan document for other covered services and your costs for these services.

The Plan Document covers eligible medical expenses that include: Ambulatory Surgical Center (ASC); Anesthesia; Artificial Limbs or Prosthetic Appliances; Autism Screenings; Blood Storage; Breast Oncology; Breast Reduction; Cardiac Rehabilitation; Cataract Surgery (Lenses: initial contact lenses or glasses required following cataract surgery, $200 maximum per surgery).

Your Rights to Continue Coverage. Federal and State laws may provide protections that allow you to continue health coverage after it 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 does not accept late enrollees.

COBRA Continuation of Coverage (COC). 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.

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.

Does the Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy [does/does not] provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage [does/does not] meet the minimum value standard for the benefits it provides.

Language Access Services. Spanish (español): Para obtener asistencia en español, llame al (800) 385-9952.

Your Grievance and Appeals Rights. If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For more information about your rights, this notice, or assistance, contact TML MultiState IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385.

Claims 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 appeal filing deadline below could be superseded by network contractual obligations. The appellant may request an independent review from an independent state licensed external review organization that is credentialed under URAC. 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) Prior to Claim Submission		
Type of Request for Benefits or Appeal	**Internal/External Appeal Process**	**Business Hours/Days**
If the appellant appeals the adverse notification determination or declination of notification, the appellant must appeal within:	**Internal**	**one hundred eighty (180) days** after receiving the denial based on a completed review process
If the appellant's request for emergent benefits is incomplete IEBP will send the ***urgent/emergent***	**Internal**	**twenty-four (24) hours** of receipt of appellant's information

Appeal of Urgent/Emergent Request for Benefits (Adverse Pre-Determination/Notification Request) Prior to Claim Submission		
Type of Request for Benefits or Appeal	**Internal/External Appeal Process**	**Business Hours/Days**
incomplete pre-determination/notification information declination letter within:		
The appellant must provide a completed information request within:	**Internal**	**forty-eight (48) hours** 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 ***urgent/emergent pre-determination/notification denial letter*** within:	**Internal**	**seventy-two (72) hours**
If the request for concurrent review is complete and not approved, IEBP will send a concurrent review denial:	**Internal**	**twenty-four (24) hours**
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) days** of receipt of the original denial or response to your appeal
The IRO will complete the review and IEBP will submit the response of ***an expedited urgent/emergent pre-determination/notification*** of a benefit appeal within:	**External**	**seventy-two (72) hours**

Appeal of Non-Emergent Request for Benefits (Adverse Pre-Determination/Notification Request) Prior to Claim Submission		
Type of Request for Benefits or Appeal	**Internal/External Appeal Process**	**Business Hours/Days**
The appellant must appeal the denial no later than:	**Internal**	**one hundred eighty (180) days** after receiving the denial
If the **request for a pre-determination/notification** is ***benefit information incomplete***, IEBP will notify the appellant within:	**Internal**	**five (5) days**
If the **request for pre-determination/notification** is ***clinical information incomplete***, IEBP will notify you within:	**Internal**	**fifteen (15) days**
The appellant must then provide completed information within:	**Internal**	**forty-five (45) days** after receiving an extension notice*
IEBP will notify you of the **first level appeal decision** within:	**Internal**	**fifteen (15) days** after receiving the first level appeal
The appellant must appeal the first level appeal (file a second level appeal) within:	**Internal**	**sixty (60) days** after receiving the first level appeal decision
IEBP will notify you of the second level appeal decision within:	**Internal**	**fifteen (15) days** 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) days** 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) days**
* 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 Hours/Days**
The appellant must appeal the claim denial no later than:	**Internal**	**one hundred eighty (180) days** after receiving the denial
If the appellant's claim is incomplete, IEBP will notify the appellant within:	**Internal**	**thirty (30) days**
The appellant must then provide completed claim information within:	**Internal**	**forty-five (45) days** after receiving an extension notice
IEBP will notify the appellant of the first level appeal decision within:	**Internal**	**thirty (30) days** after receiving the first level appeal
The appellant must file the second level appeal within:	**Internal**	**sixty (60) days** after receiving the first level appeal decision
The appellant will be notified of the second level appeal decision generally within:	**Internal**	**thirty (30) days** after receiving the second level appeal

Post-Service Claims		
Type of Claim or Appeal	**Internal/External Appeal Process**	**Business Hours/Days**
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) days** 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) days**
The IRO must complete a requested expedited review of an emergent claim or benefit appeal within:	**External**	**seventy-two (72) hours**

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:

• admission history and physical • the discharge summary • 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.

Ombudsman Services. Availability of Consumer Assistance/Ombudsman Services: There may be other resources available to help you understand the appeals process. For questions about your appeal rights, an adverse benefit determination, or for assistance, you can contact the Employee Benefits Security Administration at (866) 444-EBSA (3272). Your state consumer assistance program may be able to assist you at the Texas Consumer Health Assistance Program Texas Department of Insurance (855) TEX-CHAP (839-2427).

About these Coverage Examples. These examples show how this plan might cover medical care in a few situations and show how deductibles, copayments, and benefit percentage/coinsurance can add up. Use these examples to see, in general, how much financial protection a sample patient might get from coverage under this plan compared to other plans by comparing the "Covered Individual Pays" section for the same example under each plan's Summary of Benefits and Coverage. **This is not a cost estimator.** Do not use these examples to estimate your actual costs under this plan. Treatments shown are just examples and your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Also, costs do not include premiums you pay to buy coverage under a plan.

Having a Baby (normal delivery)	
• Amount owed to Providers: $13,772.46 • Plan pays: $11,247.46 • Covered Individual/Patient pays: $2,525.00	
Sample Care Costs	
Hospital charges (mother)	$5,829.57
Routine obstetric care	$3,313.16
Hospital charges (baby)	$1,505.65
Anesthesia	$2,200.00

Managing Type 2 Diabetes (routine maintenance of a well-controlled condition)	
• Amount owed to Providers: $8,673.52 • Plan pays: $7,441.18 • Covered Individual/Patient pays: $1,232.34	
Sample Care Costs	
Prescriptions	$7,138.32
Medical Equipment and Supplies	$208.32
Office Visits and Procedures	$858.20
Education	$204.50

Simple Fracture (with emergency room visit)	
• Amount owed to Providers: $3,383.56 • Plan pays: $2,252.62 • Covered Individual/Patient pays: $1,130.94	
Sample Care Costs	
Emergency Services	$2,319.54
Medical Equipment and Supplies	$128.10
Office Visits and Procedures	$598.13
Physical Therapy	$307.74

Having a Baby (normal delivery)	
Laboratory tests	$325.96
Prescriptions	$45.00
Radiology	$553.12
Vaccines, other preventive	
Total	**$13,722.46**
Covered Individual/Patient Pays	
Deductible	$500.00
Copayments: Medical/Rx	$25.00/$0.00
Coinsurance/Benefit Percentage	$2,000.00
Plan/Max Plan OOP	$2,500.00
Federal Maximum OOP	$2,525.00
Limits or Exclusions	$0.00
Total	**$2,525.00**

Managing Type 2 Diabetes (routine maintenance of a well-controlled condition)	
Laboratory tests	$116.54
Vaccines, other preventive	$147.64
Total	**$8,673.52**
Covered Individual/Patient Pays	
Deductible	$170.34
Copayments: Medical/Rx	$150.00/$912.00
Coinsurance/Benefit Percentage	$0.00
Plan/Max Plan OOP	$167.04
Federal Maximum OOP	$1,232.34
Limits or Exclusions	$0.00
Total	**$1,232.34**

Simple Fracture (with emergency room visit)	
Laboratory tests	$0.00
Prescriptions	$30.05
Total	**$3,383.56**
Covered Individual/Patient Pays	
Deductible	$500.00
Copayments: Medical/Rx	$75.00/$0.00
Coinsurance/Benefit Percentage	**$455.94**
Plan/Max Plan OOP	$955.94
Federal Maximum OOP	$1,030.94
Limits or Exclusions	$100.00
Total	**$1,130.94**

Questions and Answers about the Coverage Examples.

What are some of the Assumptions behind the Coverage Examples? Costs do not include premium/contributions; sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and are not specific to a particular geographic area or health plan; the patient's condition was not an excluded or preexisting condition; all services and treatments started and ended in the same coverage period; there are no other medical expenses for any member covered under this plan; out-of-pocket expenses are based only on treating the condition in the example; the patient received all care from in-network providers, if the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example Show? For each treatment situation, the Coverage example helps you see how deductibles, copayments, and coinsurance/benefit percentage can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment is not covered or payment is limited.

Does the Coverage Example Predict my Own Care Needs? No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example Predict my Future Expenses? No. Coverage Examples are not cost estimators. You cannot use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to Compare Plans? Yes. When you look at the Summary of Benefits and Coverage of other plans, you will find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other Costs I should Consider when Comparing Plans? Yes. An important cost is the premium/contribution you pay. Generally, the lower your premium/contribution, the more you will pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance/benefit percentage. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement arrangements (HRAs) that help you pay out-of-pocket expenses.

Summary of Plan Description (SPD)

Helpful Resources

Resource	Contact Information and Accessible Hours
TML MultiState Intergovernmental Employee Benefits Pool (IEBP)	**Physical:** 1821 Rutherford Lane, Suite 300 **|** Austin, Texas 78754 **Mailing:** 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: Medical	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
Secured Customer Care E-mail: Dental	dental-mail@iebp.org
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
*My*IEBP 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 **|** Fax: (855) 851-5799 **|** 7:00 AM - 7:00 PM Central
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 **|** 9:30 AM - 6:00 PM Central or Scheduled Appt.
Spanish Line	(800) 385-9952 **|** Spanish_cc@iebp.org *(There is an underscore between Spanish and cc.)*
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 Member Customer Service	(888) 543-1369
OptumRx Prescription Pharmacist and 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.
IEBP Performance Improvement Plan	Visit www.iebp.org ▸ click on the "Login" button ▸ click on "My Tools" ▸ click on "Quality Improvement Program"
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" ▸ 8:30 AM - 5:00 PM Central

Counties for 2016: Andrews | Atascosa | Bailey | Bastrop | Bexar | Briscoe | Brooks | Cameron | Camp | Castro | Cochran | Collingsworth | 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 | Menard | Midland | Moore | Navarro | Nueces | Ochiltree | Parmer | Pecos | Presidio | Reagan | Reeves | San Saba | Sherman | Starr | Sterling | Sutton | Terry | Titus | Travis | Upton | Uvalde | Val Verde | Ward | Webb | Willacy | Winkler | Yoakum | Zapata | Zavala

TML MultiState
Intergovernmental Employee Benefits Pool

Summary of Plan Description (SPD)

Common Medical Event	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations, Exceptions, and Exclusions
Primary care visit to treat an injury or illness	85%	80%	50%	N/A
What is my copayment?	Office Visit: $35	Office Visit: $35	N/A	N/A
Specialist visit	Emergent/Immediate: 85%	Emergent/Immediate: 80%	80% up to U&R	N/A
	Scheduled Services 85%	Scheduled Services 80%	50% up to U&R	
Other practitioner office visit	85%	80%	50%	Provider of Service must be licensed to perform services rendered to Covered Individual.
Urgent care visit to treat an injury or illness	85%	80%	50%	Urgent Care Services billed on a UB will be processed under Hospital benefit. Urgent Care Services billed on a HCFA will be processed under Office Visit Benefit.
Diagnostic test (x-ray, blood work)	85%	80%	50%	N/A
Facility Charges				
Inpatient Hospital	85%	80%	50%	Review Notification Requirements
Outpatient Hospital	85%	80%	50%	
Ambulatory Surgical Center	85%	80%	50%	
Physician Charges	85%	80%	50%	
Emergency Room for Emergent/Immediate Care				Non-Network Emergent and Immediate Care are paid at Network Benefit up to U&R Rate of 110% of RBRVS. A U&R 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 Reference-Based Pricing Fee Schedule.
Facility charges after $100 access fee (waived if admitted)	85%	80%	80% up to U&R	
Physician	85%	80%	80% up to U&R	
Emergency Ambulance Services	85%	80%	80%	Maximum payable for Ground Ambulance is $1,500 per treatment episode.
	85%	80%	80%	Maximum payable for Air Ambulance is $9,000 per treatment episode.
Outpatient Lab and X-Ray	85%	80%	50%	N/A

Summary of Plan Description (SPD)

Common Medical Event	Services You May Need	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations & Exceptions
Calendar Year: **Preventive/screening/ annual exam/ immunizations**	Annual Exam Benefit Immunizations/ Inoculations Women's Health Reproductive Health	N/A	100%	50%	**Effective Date: Calendar Year 2017** **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 U&R 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.
Calendar Year: **Preventive/screening/ annual exam/ immunizations**	Annual Exam Benefit Immunizations/ Inoculations Women's Health Reproductive Health	N/A	100%	50%	Preventive/routine care benefits **also** includes: ▸ Annual Examination ▸ Autism Screening – eighteen (18) and twenty-four (24) months of age ▸ Comprehensive Metabolic Test ▸ Developmental Screening for Children under three (3) years of age ▸ 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 The following Network eligible immunizations and administrative fees are reimbursable at 100% of the allowable. Non-Network eligible billings will be subject to U&R 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** ▸ Diphtheria and Tetanus Toxoids (DT) ▸ DtaP Diphtheria, Tetanus Toxoids and Pertussis ▸ Haemophilus Influenza B (HIB) ▸ Hepatitis A & Hepatitis B ▸ Herpes Zoster ▸ Human Papillomavirus (HPV) ▸ Influenza (flu shot) ▸ Measles, Mumps, Rubella (MMR booster) ▸ Meningococcal ▸ Oral Polio ▸ Pediarix (Diphtheria and Tetanus Toxoids and Acellular Pertussis Absorbed, Hepatitis B (Recombinant) and Inactivated Poliovirus Vaccine Combined) ▸ Pneumococcal (Pneumonia) ▸ Poliomyelitis Vaccine ▸ Rotavirus ▸ Td (Tetanus) booster ▸ Varicella Vaccine (Chicken Pox) ▸ Zostavax (Shingles Vaccine) ▸ Any other immunization required by federal or state law or regulation

Common Medical Event	Services You May Need	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations & Exceptions
If you have mental health needs Serious Mental Health Conditions are treated as any other medical condition. A Serious Mental Health Condition is: schizophrenia; paranoia and other psychotic disorders; bipolar disorder (hypomanic, manic depressive, and mixed); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); obsessive compulsive disorder (OCD); and depression in childhood and adolescence.	Mental/Behavioral Health Outpatient Services	85%	80%	50%	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. **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.
	Mental/Behavioral Health Inpatient Services	80%	80%	50%	**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: ‣ Covered Individual must have a mental health condition which would otherwise necessitate hospital confinement; ‣ services must be based on an individual treatment plan; and ‣ providers of services must be properly licensed.

Summary of Plan Description (SPD)

Common Medical Event	Services You May Need	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations & Exceptions
If you have substance use disorder needs	Substance Use Disorder Outpatient Services	85%	80%	50%	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. **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.
	Substance Use Disorder Inpatient Services	85%	80%	50%	**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: ‣ Covered Individual must have a substance use disorder which would otherwise necessitate hospital confinement; ‣ services must be based on an individual treatment plan; and ‣ providers of services must be properly licensed.
If you are pregnant	Prenatal and Postnatal Care	85%	80%	50%	**Pregnancy/Maternity** ‣ Sonogram/Ultrasound in excess of three (3) ‣ Home Health (uterine monitoring) Notification Requirement Three (3) working days prior to commencement for office, outpatient and Home Health procedures Late Notification Penalty: $200
	Delivery and all Inpatient Services	85%	80%	50%	**Inpatient Pregnancy/Maternity (Delivery Admission)** ‣ Vaginal Delivery admission in excess of forty-eight (48) hours ‣ Cesarean Section delivery admission in excess of ninety-six (96) hours ‣ Inpatient antepartum care or other undelivered admissions ‣ Newborns who remain in the hospital after mother is discharged Notification Requirement Facility: Twenty-four (24) hours after actual admission or by 5 pm the next business day for weekend/holiday admissions

Summary of Plan Description (SPD)

Common Medical Event	Services You May Need	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations & Exceptions
					Late Notification Penalty: $400 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. 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.
If your child needs dental or eye screenings *(attained age of 19)*	Eye exam				Vision Acuity Screenings are paid as Preventive Benefits under the Medical Plan at 100% of the allowed U&R cost. Vision screening services [for the detection of eye disease and refractive disorders and well-child visits that include visual acuity testing stereoacuity, cover-uncover tests, Hirschberg light reflects test, autorefraction and photoscreening may be done starting age three (3) to attained age of five (5) years] as required by law.
	Glasses	Ineligible under Medical Plan			
	Dental check-up				Dental Screenings are paid as Preventive Benefits under the Medical Plan at 100% of the allowed U&R cost. Pediatric oral [application of fluoride varnish to the primary teeth of all infants starting at the age of primary tooth eruption; recommended at six (6), nine (9), twelve (12), eighteen (18), twenty-four (24), thirty (30) months, three (3) and six (6) years].

Common Medical Event	Prescription Services You May Need	OptumRx Network		Limitations & Exceptions
If you need drugs to treat your illness or condition (Refer to Medication Therapy Management Guide for information regarding the Cost Share, Step Therapy, and Prior Authorization prescription requirements.)	MAC A	**Retail**	**Mail**	**Prescription Benefits**. Coverage for eligible specialty/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%. **MAC A**. If a brand name drug is dispensed and a generic alternate drug exists, the **Covered Individual pays the difference between the brand name and generic** price in addition to the appropriate copayment for the brand name. The **cost difference between the brand name and generic price does not apply to any individual deductibles or out of pocket amounts**. The MAC differential applies to all prescriptions purchased through this program when a generic alternate is available. **Maximum Allowable Cost (MAC C)**. Covered Individual will pay the appropriate copayment amount of the prescription. **High Deductible H.S.A. Plans**. Preventive/Wellness Drug List can be accessed at copay level prior to deductible; all other drugs will be an out of pocket cost until deductible has been met.

Summary of Plan Description (SPD)

Common Medical Event	Prescription Services You May Need	OptumRx Network		Limitations & Exceptions
	Over the Counter/ Behind the Counter	$0	N/A	**Prescribed Over the Counter Alternatives** Doctor Ordered: ▸ Smoking Cessation (Nicorette Gum), Quantity Limit - 3 months per plan year ▸ Aspirin, Folic Acid, Fluoride Chemoprevention Supplements, Iron Deficiency Supplements, and Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at an increased risk for falls; per prescription
	Generic	$5/$14	$30.00	$5.00 copay up to 34 day supply; $14.00 for 35 to 90 day supply and/or extended cycle
	Best Brand/Formulary List	$43.00	$100.00	Retail - Up to a 34 day supply; Mail - 35-90 day supply
	Non-Best Brand/Non-Formulary List	$65.00	$155.00	Retail - Up to a 34 day supply; Mail - 35-90 day supply
	Cost Share	$120.00	$300.00	Retail - Up to a 34 day supply; Mail - 35-90 day supply
	Specialty/Biotech Prescriptions	N/A	$100.00	Mail - Up to a 34 day supply
	Biosimilar Generic Prescriptions	N/A	$75.00	Mail - Up to a 34 day supply
	Prescription Refill Control Standards	75%	70%	

Summary of Plan Description (SPD)

Common Medical Event	Prescription Services You May Need	OptumRx Network		Limitations & Exceptions			
				Benefit	**Retail Rx Medical Plan**	**Prescription Plan**	**Plan Ineligible**
If you need drugs to treat your illness or condition (Refer to Medication Therapy Management Guide for information regarding the Cost Share, Step Therapy, and Prior Authorization prescription requirements.)	Women's Preventive Health Services	$0	$0	Oral Contraceptives Generic *(no cost share)*		X	
				IUD Device *(no cost share)*	X	X	
				Implant Device *(no cost share)*	X	X	
				Permanent Implantable Contraceptive Coil *(subject to the appropriate deductible and benefit percentages)*	X		
				Insertion and/or Removal of Contraceptive Devices *(no cost share)*	X		
				Urine Pregnancy Test, Urinalysis, Sonogram to Detect Placement of Device *(no cost share)*	X		
				Injectable Contraceptives *(no cost share)*	X	X	
				Injectable Administration Fee *(no cost share)*	X		
				Diaphragm (cervical), Hormone Vaginal Ring, Hormone Patch, Cervical Cap, Spermicides, Sponges *(no cost share)*		X	
				Diaphragm (cervical) Instruction and Fitting Fee *(no cost share)*	X		
				Emergency Contraceptives		X	
				Over-The-Counter (OTC) Contraceptives not otherwise listed as covered			X
				Contraceptive Management *(no cost share)*	X		
				Female Condoms *(no cost share)*		X	
				Female Surgical Sterilization	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	
				Women found to be at increased risk using a screening tool designed to identify a family history that may be associated with an increased risk of having a potentially harmful gene mutation must receive coverage w/o cost-sharing for genetic counseling, and, if indicated, testing for harmful BRCA mutations. This is true regardless of whether the woman has previously been diagnosed with cancer, as long as she is not currently symptomatic of receiving active treatment for breast, ovarian, tubal, or peritoneal. Jan 1, 2016 genetic counseling for BRCA testing is covered 100% as a preventive benefit.			
				Mandate to provide a list of the lactation counseling providers available within the network under the plan or coverage. Grandfathered plans cannot apply cost-share expenses for OON lactation services. Services for lactation support services w/o cost-sharing must extend for the duration of breastfeeding.			

Common Medical Event	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations, Exceptions, and Exclusions
Maximum Lifetime Benefit	N/A	N/A	N/A	None
Prosthetic Bra, Camisole and Breast Prosthesis for Oncology	85%	80%	50%	1 per Calendar Year (CY)
Treatment Episode of the Medically Necessary Hearing Appliance	85%	80%	50%	$3,500 Maximum Benefit (per three (3) calendar years)
Custom Molded Foot Orthotics	85%	80%	50%	1 molded orthotic per thirty-six (36) months, unless documented medical, physiological changes
Calendar Year Maximum for Diabetic Related Therapeutic Footwear/Shoes	85%	80%	50%	2 Pairs Calendar Year (CY)
Inpatient Private Duty Nursing Medical Management/Concurrent Review	N/A	50%	50%	$1,000 at 50% Calendar Year (CY)
Calendar Year Maximum for Chiropractic Care	85%	80%	50%	10 Visits Calendar Year (CY)

Summary of Plan Description (SPD)

Common Medical Event	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations, Exceptions, and Exclusions
Speech Therapy (ST)	85%	80%	50%	12 ST Outpatient Visits Calendar Year (CY)
Physical Therapy (PT)/Aquatic Therapy (AT)	85%	80%	50%	24 PT/AT Outpatient Visits Calendar Year (CY)
Occupational Therapy (OT)	85%	80%	50%	24 OT Outpatient Visits Calendar Year (CY)
Nutritional Counseling	N/A	100%	50%	3 Visits Calendar Year (CY)
Specialty Physicians for Emergent/Immediate Care. Anesthesiologist, Hospitalist, Pathologist, Radiologist, Emergency Room Physician Related to Emergent/Immediate Care services rendered at a Network/Non-Network hospital and/or outpatient surgery/radiology diagnostic clinic	85%	80%	80% up to U&R	The usual and reasonable (U&R) 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 Reference-Based Pricing Fee Schedule.
Specialty Physicians for Scheduled Services. Anesthesiologist, Hospitalist, Pathologist, Radiologist, Emergency Room Physician Related to Scheduled Services rendered at a Non-Network hospital and/or outpatient surgery/radiology diagnostic clinic	85%	80%	50%	Non-Network Providers paid at Non-Network benefit percentage up to U&R. A U&R 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 Reference-Based Pricing Fee Schedule.
Other practitioner office visit	85%	80%	50%	Provider of Service must be licensed to perform services rendered to Covered Individual.
Telehealth Services: Healthiest You (866) 703-1259 **|** www.healthiestyou.com	N/A	Patient OOP Copay: $10.00	N/A	
Accident Benefit	85%	80%	50%	N/A
Second Surgical Opinion		100%	50%	Providers are paid at 100% of Eligible Charges up to U&R. A U&R 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 Reference-Based Pricing Fee Schedule.
Home Health Care	85%	80%	50%	The maximum payable per visit is $100 for professional services. Nutritional Counseling and therapy services (physical, speech, occupational or aquatic) performed in the home setting will accumulate to the appropriate benefit maximum.
Medical Supplies	85%	80%	50%	N/A
Durable Medical Equipment and Related Supplies	85%	80%	50%	Notification is required three (3) working days prior to dispensing/delivery of standard durable medical equipment and prosthetics/non-foot orthotics for charges in excess of $1,000 per base piece of standard durable medical equipment and prosthetics/non-foot orthotics prior to purchase, lease, or rental; limited to the U&R charges of standard models as determined by Medical Intelligence. Parity payment with major services under employer medical plan. Late Notification Penalty: $200
Prosthetics/Non-Foot Orthotics	85%	80%	50%	Notification is required three (3) working days prior to dispensing/delivery of standard durable medical equipment and prosthetics/non-foot orthotics for charges in excess of $1,000 per base piece of standard durable medical equipment and prosthetics/non-foot orthotics prior to purchase, lease, or rental; limited to the U&R charges of standard models as determined by Medical Intelligence. Parity payment with major services under employer medical plan. Late Notification Penalty: $200

Common Medical Event	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations, Exceptions, and Exclusions
Morbid Obesity Treatment	N/A	50%	0%	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) of 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. 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 the plan document. 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. Lifetime Maximum of $30,000 and never pays at 100%.
Other Major Medical Expenses	85%	80%	50%	N/A

Common Medical Event	Services You May Need	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations & Exceptions
Major Radiology Services	Imaging (e.g. CT/PET scans, MRIs)	85%	80%	50%	Notification Requirement Three (3) working days prior to procedures: ▸ 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) Late Notification Penalty: $200
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	85%	80%	50%	Notification Requirement Three (3) working days prior to procedures: ▸ 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 Late Notification Penalty: $200

Summary of Plan Description (SPD)

Common Medical Event	Services You May Need	Tier 1 Network	Network Benefit	Non-Network Benefit	Limitations & Exceptions
If you need help recovering or have other special health needs	Home Health Care	85%	80%	50%	The maximum payable per visit is $100 for professional services. Nutritional Counseling and therapy services (physical, speech, occupational or aquatic) performed in the home setting will accumulate to the appropriate benefit maximum. Late Notification Penalty: $200
	Rehabilitation/ Habilitative services	85%	80%	50%	12 Speech Outpatient Visits, 24 PT/AT Outpatient Visits (Physical Therapy and/or Aquatic Therapy) Calendar Year (CY), 24 OT Outpatient Visits (Occupational Therapy) Calendar Year (CY)
	Skilled nursing care	85%	80%	50%	Notification Requirement Facility: Twenty-four (24) hours after emergency admission or by 5 pm the next business day for weekend/holiday admissions Late Notification Penalty: $400
	Durable medical equipment pays as other medical services.	85%	80%	50%	Notification Requirement Three (3) working days prior to dispensing/delivery of standard durable medical equipment and prosthetics/non-foot orthotics for charges in excess of $1,000 per base piece of standard durable medical equipment and prosthetics/non-foot orthotics prior to purchase, lease, or rental; limited to the U&R charges of standard models as determined by Medical Intelligence. Parity payment with major services under employer medical plan. Late Notification Penalty: $200
	Hospice service	85%	80%	50%	Six (6) month episode of care; Network Inpatient and Home Hospice will pay at Network Inpatient benefit percentage.

Eligible Covered Individuals & Other Coverage Limitations. This is not a complete list. Check your plan document for other excluded and unproven or experimental services.

Medical Support Order Managing Conservator of a Minor Child. IEBP will extend benefits to children of covered employees who are divorced, separated or born out of wedlock pursuant to a Medical Support Order as prescribed by Sections 154.186 & 154.187 of the Texas Family Code. If the child is covered under a Medical Support Order, the child will obtain Continuation of Coverage rights if coverage is lost due to a qualifying event. IEBP will require the Covered Individual to complete the application form to have benefits paid by the managing conservator of a minor child. Once the form is complete, IEBP will review the request and make a decision if the request meets the definition of a Medical Support Order for IEBP. Within thirty (30) days of receipt, IEBP will provide a written notice of the decision regarding managing conservatorship of an eligible minor child healthcare benefits. IEBP will send notices to each attorney or other representative who may be identified in the order for correspondence.

Filing Deadline. No benefits are payable for claims submitted by the employee or a 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. All requested additional information relating to the claim must also be received within the same time frame. Benefits will not be recalculated to allow a better benefit for charges incurred at a later date.

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 allowed eligible benefit when combined with all other plans.

Subrogation. The Plan pursues subrogation pursuant to (1) Chapter 140, Texas Civil Practices and Remedies Code, (2) contractual plan provisions, and (3) common law. The Plan language grants to the plan a first lien on any accident-related reimbursements that the plan participant may receive from any source. These sources include, but are not limited to any responsible third parties, third party liability insurance, and the participant's own insurance, such as med-pay, personal injury protection, or uninsured/underinsured motorist coverage. The plan participant will be asked to complete an Accident/Injury Questionnaire prescribed by the Plan. Payment on any accident-related claims may be withheld pending the completion of the questionnaire.

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.

Usual and Reasonable (U&R). A U&R 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 Reference-Based Pricing Fee Schedule.

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.

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

Assistant Surgeons. Assistant Surgeons (MD) are paid at 16%; non-MD at 14%

Multi-Anesthesiologists. Appropriate modifier will be paid at 50%; if no modifier, payment will be paid no more than 100% of allowable charge.

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 ▸ Refer patients to Centers of Excellence.

IEBP notification 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 • 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 procedures • 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 • Congenital Heart Disease	Facility: twenty-four (24) hours after actual admission or by 5 pm the next business day for weekend/holiday admissions	$400
Other Inpatient Admissions • 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 in excess of ninety-six (96) hours	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
Inpatient Pregnancy/Maternity (Delivery Admission) • Vaginal delivery in excess of forty-eight (48) hours • Cesarean Section 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
Pregnancy/Maternity • 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		
• Blepharoplasty (eyelid surgery) • Breast Surgery (excludes Breast Biopsies) • Carpal Tunnel Release (nerve decompression)	Three (3) working days prior to procedures	$200

Service	Notification	Late Notification Penalty
• 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		
Outpatient/Office/Medication Therapy		
• Pain Management Therapy (IV and spinal pain injections) • Oncological Chemotherapy (IV/Injectable/Oral)	Prior to commencement	$200
Miscellaneous		
• Mental Health/Substance Use Disorder Day Treatment and Intensive Outpatient Treatment • Hospice • Home Health Care • Physician Home Visit • Cardiac Rehabilitation • Pulmonary/Respiratory 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
• Durable Medical Equipment • Prosthetics and non-foot Orthotics • Implantable and/or removable ocular prosthetic lens	Three (3) working days prior to dispensing/delivery of standard durable medical equipment and prosthetics/non-foot orthotics for charges in excess of $1,000 per base piece of standard durable medical equipment and prosthetics/non-foot orthotics prior to purchase, lease, or rental	$200

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.

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. The Utilization Management Team will coordinate care and document Notification communication.

What Happens on Inpatient Treatment? The Covered Individual must notify Medical Intelligence per the Notification Requirements. If the Notification is made after the above-referenced time frames, a Late Notification Penalty will apply. Concurrent stay review requirements apply to all inpatient confinements. No benefits will be paid for any charges related to non-notified days or services.

Self-Audit Reimbursement. 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 individual calendar year deductible and out of pocket amount.

Health Insurance Portability and Accountability Act of 1996 (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; Notification of Breach.

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 number 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.

Reservation of Rights. This is a governmental plan excluded from coverage under ERISA. The Plan covers employees, dependents of employees, elected officials, dependents of elected officials, retirees, and dependents of retirees of the Pool who are eligible for the coverage, become covered, and continue to be covered, according to the terms of the Plan, Pool policies, and the policy of the employer enrollment in the Group Medicare Supplement Plan requires that the Covered Individual be enrolled in Medicare Parts A and B. The terms of the Plan are described in the following pages. The Board of Trustees of the IEBP reserves the right to amend the Plan if circumstances warrant and have given the Executive Director the discretionary authority to construe the terms of the Plan.

Summary of Plan Description (SPD)

Important Disclaimer. The information presented in this Summary of Benefits and Coverage (SBC) and Summary of Plan Description (SPD) **IS NOT** a guarantee of payment. The benefits described are subject to all plan limitations, qualifying events, late entrants, filing deadlines, exclusions and eligibility requirements. All benefits are based on the Plan document language. If a Covered Individual is on COBRA Continuation of Coverage, coverage could terminate retroactively if the individual's contribution is not made within the COBRA Continuation of Coverage payment timeframe. If a Covered Individual is receiving care or about to receive care and is identified as not actively at work, COBRA Continuation of Coverage benefits may be offered, but must be accepted and paid per the COBRA Continuation of Coverage time guidelines for provider services to be considered for eligible benefit payment. Requests for reimbursement for a covered benefit should be sent to IEBP within ninety (90) days of the date of service but not later than twelve (12) months. All inpatient and outpatient facilities are required to be licensed and/or accredited by Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), Medicare, Texas Commission on Alcohol and Drug Abuse (TCADA), or Accreditation Association for Ambulatory Health Care (AAAHC) for the bill to be considered for payment. You may be responsible for payment of all or part of any fees for healthcare services not covered by your Health Benefit Plan because the services received are provided by health care providers who are not members of the Plan's provider network. Notification is required prior to receiving certain types of health care services.

PPACA Healthcare Definitions

Glossary of Health Coverage and Medical Terms

This glossary has many commonly used terms, but is not a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.

Accountable Care Organizations (ACO): An ACO is a type of payment and delivery reform model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. A group of coordinated health care providers form an ACO, which then provides care to a group of patients. The ACO may use a range of different payment models (capitation, fee-for-service with asymmetric or symmetric shared savings, etc.). The ACO is accountable to the patients and the third-party payer for the quality, appropriateness, and efficiency of the health care provided. According to the Centers for Medicare and Medicaid Services (CMS), an ACO is "an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it."[1]While the ACO model is designed to be flexible, Dr. Mark McClellan, Dr. Elliott Fisher and others defined three core principles for all ACOs: 1) Provider-led organizations with a strong base of primary care that are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients; 2) Payments linked to quality improvements that also reduce overall costs; and, 3) Reliable and progressively more sophisticated performance measurement, to support improvement and provide confidence that savings are achieved through improvements in care. The ACO-model builds on the Medicare Physician Group Practice Demonstration and the Medicare Health Care Quality Demonstration, established by the 2003 Medicare Prescription Drug, Improvement, and Modernization Act. Kaiser Permanente and HealthCare Partners Medical Group are two notable examples of successful ACOs. While ACOs have become increasingly more common in the last few years, a recent study by the Medical Group Management Association (MGMA) has shown that the implementation of ACOs is one of the toughest challenges facing the MGMA members today. NCQA has been designated to launch the accreditation standards for ACO's in July 2012.

Accountable Health Networks: Proposed to provide high quality, lower-cost care to patients (DRG, capitated contracting - provider/payor sharing risk); PPACA bill promotes Medical Home Services to make primary care physician's payment equitable to specialist providers 01/01/12 – still developing state waivers, anti-kickback laws, self-referrals. (65 measures must be met and over 5,000 beneficiaries must be served) Rule should be published 04/07/11.

Accumulator: Out of pocket expenses that are added together to reach the covered individuals out of pocket maximum. Plan specific out of pocket accumulations in notes for the IEBP as stated below.

PPO Medical Plan and Prescription Benefit Accumulator Tracking

Out of Pocket Eligible Benefit Expense Accumulation

1. Accumulators: Track eligible out of pocket payments and/or health benefit plan limitations.
2. Deductible: The amount the covered individual pays for plan eligible healthcare services before the healthcare benefit plan begins to pay for eligible healthcare services.
   a. Individual: Eligible Individuals out of pocket payment for eligible healthcare services
   b. Family: Eligible family member out of pocket payment for eligible healthcare services
3. Out of Pocket Expense: The portion of benefit percentage payments for eligible healthcare services required to be paid by the covered individual and/or family.
   a. Individual: Eligible individuals out of pocket payment for eligible plan benefit percentage payments after the deductible out of pocket cost have been met.
   b. Family: Eligible family member out of pocket payment for eligible plan benefit percentage payments after the deductible out of pocket cost have been met.
4. Maximum Out of Pocket Expense: The maximum out of pocket payments for eligible healthcare services required to be paid by the covered individual before the plan will pay 100% of eligible benefit services. The maximum out of pocket expenses includes the deductible and the covered individual's out of pocket benefit percentage.
   a. Individual: Individual's out of pocket payments for eligible plan benefit services.
   b. Family: Family's out of pocket payments for eligible benefit services.

Medical and Prescription Out of Pocket Expenses	Accumulates to Network Deductible	Accumulates to Non-Network Deductible	Accumulates to Network Out of Pocket	Accumulates to Non-Network Out of Pocket Maximum	Accumulates to Network Maximum Out of Pocket	Accumulates to Non-Network Maximum Out of Pocket
Medical Copays	No	No	Yes	No	Yes	No
Prescription Copays	No	No	Yes (if most cost effective)	No	Yes (if most cost effective)	No
Biotech/Biosimilar Drug Copays	No	No	Yes (if most cost effective)	No	Yes (if most cost effective)	No
Prescription Benefit Percentage	No	No	Yes (if most cost effective)	No	Yes (if most cost effective)	No
Network Deductible Expenses	Yes	No	No	No	Yes	No
Non-Network Deductible	No	Yes	No	No	No	Yes
Network Benefit Percentage Out of Pocket	No	No	Yes	No	Yes	No
Non-Network Benefit Percentage Out of Pocket	No	No	No	No	No	No
Ineligible Benefit expenses	No	No	No	No	No	No
Access Fees	No	No	No	No	No	No
Notification Penalties	No	No	No	No	No	No

PPACA Healthcare Definitions

IEBP High Deductible Health Savings Account Benefit Plan

Out of Pocket Eligible Benefit Expense Accumulation

1. Accumulators: Track eligible out of pocket payments and/or health benefit plan limitations
2. High Deductible: The amount the covered individual pays for plan eligible healthcare services before the healthcare benefit plan begins to pay for eligible healthcare services. Preventive and/or Wellness medical and prescription services may be plan paid prior to the covered individual's out of pocket high deductible is paid.
   a. Individual: Eligible Individuals out of pocket payment for eligible healthcare services
   b. Family: Eligible family member out of pocket payment for eligible healthcare services
3. Out of Pocket Expense: The portion of benefit percentage payments for eligible healthcare services required to be paid by the covered individual and/or family.
   a. Individual: Eligible individuals out of pocket payment for eligible plan benefit percentage payments after the deductible out of pocket cost have been met.
   b. Family: Eligible family member out of pocket payment for eligible plan benefit percentage payments after the deductible out of pocket cost have been met.
4. Maximum Out of Pocket Expense: The maximum out of pocket payments for eligible healthcare services required to be paid by the covered individual before the plan will pay 100% of eligible benefit services. The maximum out of pocket expenses includes the deductible and the covered individual's out of pocket benefit percentage.
   a. Individual: Individual's out of pocket payments for eligible plan benefit services.
   b. Family: Family's out of pocket payments for eligible benefit services.

Medical and Prescription Out of Pocket Expenses	Accumulates to Network Deductible	Accumulates to Non-Network Deductible	Accumulates to Network Out of Pocket	Accumulates to Non-Network Out of Pocket Maximum	Accumulates to Network Maximum Out of Pocket	Accumulates to Non-Network Maximum Out of Pocket
Medical Copays	No	No	Yes	No	Yes	No
Prescription Copays	No	No	Yes (if most cost effective)	No	Yes (if most cost effective)	No
Biotech/Biosimilar Drug Copays	No	No	Yes (if most cost effective)	No	Yes (if most cost effective)	No
Network Deductible Expenses	Yes	No	No	No	Yes	No
Non-Wellness Prescription and Biotech/ Biosimilar Drug Out of Pocket	Yes	No	No	No	Yes	No
Non-Network Deductible	No	Yes	No	No	No	Yes
Network Out of Pocket	No	No	Yes	No	Yes	No
Non-Network Out of Pocket	No	No	No	No	No	No
Ineligible Benefit expenses	No	No	No	No	No	No
Access Fees	No	No	No	No	No	No
Notification Penalties	No	No	No	No	No	No

Actuarial Value: Underwriting and Benefit equivalency.

Allowed Amount: maximum amount on which payment is based for covered health care services; this may be called "eligible expense," "plan allowed amount," "plan eligible amount," "payment allowance" or "negotiated rate". If your provider charges more that the allowed amount, you may have to pay the difference. *See Balance Billing*.

Alphanumeric HCPCS: stands for alphanumeric Health Care Financing Administration Procedure Coding System, HCPCS has three levels.

1. Level 1, CPT, is developed and maintained by the American Medical Association (AMA) and captures physician services; The "D" codes in the HCPCS system are dental codes created by the ADA and published as CDT. The ADA is the sole source of the authoritative version of CDT.
2. Level 2, alphanumeric HCPCS, contains codes for products, supplies and services not included in CPT.
3. Level 3, local codes, includes all the codes developed by insurers and agencies to fulfill local needs. HHS states local codes will be eliminated once regulatory compliance begins.

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Business Associate: means a person (not a member of a covered entity's workforce) who helps a covered entity with a function or activity involving the use or disclosure of individually identifiable health information.

Capitation: In the strictest sense, a stipulated dollar amount established to cover the average cost of health care delivered for a person. The term usually refers to a negotiated per person rate to be paid periodically, usually monthly, to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.

PPACA Healthcare Definitions

Care Management: A process whereby members at the highest risk are identified and a plan which effectively utilizes health care resources is formulated and implemented to achieve optimum patient outcome in the most cost effective manner.

Care Manager: An experienced professional (e.g., nurse, physician or social worker) who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

Carve Out: A decision to purchase separately a service which is typically a part of an indemnity or HMO plan. Example: an HMO may "carve out" the behavioral health benefit and select a specialized vendor to supply these services on a stand-alone basis.

Case Mix: The relative frequency and intensity of hospital admissions or services reflecting different needs and uses of hospital resources. Case mix can be measured based on patients' diagnosis or the severity of their illnesses, the utilization of services and the characteristics of a hospital.

Claim: A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance/Benefit Percentage: is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, you coinsurance/benefit percentage payment of 20% would be $200. This may change if you haven't met your deductible. The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount,** you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. This is called **balance billing**. The plan may encourage you to use network providers by charging you lower **deductibles, copayments and coinsurance** amounts.

CDS: Controlled dangerous substance

CHIP: Children's Health Insurance Program

CMS: Centers of Medicare & Medicaid Services

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section are not complications of pregnancy.

Concurrent Review: An assessment which determines medical necessity or appropriateness of services are they are being rendered.

Consumer-Driven Health Care/Consumer Centered Health Plan: An approach that encourages employees to take more control over their health care spending through such devices as a Health Reimbursement Arrangements (HRA) and/or Health savings accounts (H.S.A.)

Continuation of Coverage: COBRA Consolidated Omnibus Budget Reconciliation Act of 1985. This law includes the federal mandate that requires employers to offer continuation health coverage to certain former employees and their covered spouses and dependents.

Continuum of Care: A range of clinical services provided to an individual which may reflect treatment rendered during a single inpatient hospitalization, or care for multiple conditions over a lifetime, or care across settings (acute--skilled--home care--self care). The continuum provides a basis for analyzing quality, cost and utilization over the long term.

Copayments: are fixed dollar amounts (for example $15) you pay for covered health care usually when you received the services.

Cost-Sharing: Section 125, HRA, H.S.A Interface. The general term that refers to the share of costs for services covered by a plan or health insurance that you must pay out of you own pocket (sometimes called "out-of-pocket costs"). Some examples of types of cost-sharing include copayments, deductibles, and coinsurance/benefit percentage. Other costs, including your premiums/contributions, penalties you may have to pay or the cost of care not covered by a plan or policy are usually not considered cost-sharing.

Cost-Sharing Reductions: Discounts that lower cost-sharing for certain services covered by individual health insurance purchased through the Marketplace. You can get these discounts if your income is below a certain level, and you choose a Silver level health plan. If you are a member of a federally recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation, you can qualify for cost-sharing reductions on certain services covered by a Marketplace policy of any metal level and may qualify for additional cost-sharing reductions depending upon income.

Covered Services: Those professional medical, hospital, and related services which (i) have been determined to be appropriate for the patient, AND (ii) are considered covered by the applicable benefits plan. Health benefit payors do not consider every available service a covered service.

CPT: stands for Physician's Current Procedural. CPT is used by physicians and other health care professionals to code their services for administrative transactions. CPT is level one of the Health Care Financing Administration Procedure Coding System (HCPCS). CPT codes are updated annually by the AMA.

Credentialing Program: The goals, criteria, policies and procedures for credentialing physicians who desire to become or remain participating with a network or health plan.

DEA: Drug Enforcement Agency

Deductible: The amount you owe for health care services before your health benefit plan begins to pay. For example, if your deductible is $1,000, your plan will not pay anything until you have met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Diagnostic Test: Tests to detect what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Discharge Planning: The process, usually beginning upon admission which plans for the physical, social, emotional and medical needs of the patient upon discharge from an inpatient facility.

DOL: US Department of Labor

TML MultiState
Intergovernmental Employee Benefits Pool

PPACA Healthcare Definitions

Drug Formulary: A listing of prescription medications which are preferred for use by a health plan and which will be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan. A plan that has adopted an "Open or voluntary" formulary allows coverage for both formulary and non-formulary medications. A plan that has adopted a "closed, select or mandatory" formulary limits coverage to those drugs in the formulary.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

EHB: Essential Health Benefits.

Emergency Medical Condition: The sudden and unexpected onset of an acute illness or accidental injury which is life threatening or likely to result in permanent disability if the patients fails to obtain medical treatment immediately or as soon as possible after the accident or injury.

Emergency Medical Transportation: Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan or health benefits payer may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care: Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Employee Assistance Program: An employer maintained program that provides counseling and referral services for the treatment of drug abuse, alcoholism, emotional, mental and physical problems and financial or legal difficulties that can affect job performance.

Encounter: A face-to-face meeting between a Covered Individual and a health care provider where services are provided.

Encounter Form: The method of reporting services rendered to patients which are eligible for reimbursement. An encounter form is the same format as a HCFA1500 and UB92.

Encounters per Member per Month: The number of encounters related to each Covered Individual on a monthly basis. The measurement is calculated as follows: Total # of encounters per month/total # of members per month.

ERISA: Employee Retirement Income Security Act of 1974. Federal law that sets minimum standards for most voluntarily established pension and health plans in the private sector to protect plan participants. ERISA sets requirements for individuals and employers that administer, supervise or mange pension plan funds.

Excluded Services: Healthcare services that your health benefit plan does not pay for or cover.

Family Medical Leave: Family Medical Leave Act of 1993. Requires covered employers to allow eligible employees to take up to 12 weeks of unpaid leave in a 12-month period for the birth or adoption of a child, or for a serious health condition of the employee or family member. FMLA applies to private employers with 50 or more employees for each working day of 20 or more weeks in the current or preceding calendar year, all public employers, and private elementary and secondary schools.

FDA: US Food and Drug Administration

FEDVIP: Federal Employee Dental and Vision Insurance Program

FEHBP: Federal Employees Health Benefits Program

Fee for Service Equivalency: A quantitative measure of the difference between the amount a physician and/or other provider receives from an alternative reimbursement system (e.g., capitation) compared to fee-for-service reimbursement.

Fee for Service Reimbursement: The traditional health care payment system, under which physicians and other providers receive a payment that does not exceed their billed charges for each unit of service provided.

Fee Schedule: A listing of codes and related services with pre-established payment amounts which could be percentage of billed charges, flat rates or maximum allowable amounts.

FICA: Federal Insurance Contributions Act

Formal Complaints: A patient problem presented for resolution which cannot be resolved immediately to the patient's satisfaction.

Formulary: A list of drugs your health benefit plan covers. A formulary may include how much you pay for each drug. If the plan uses "tiers", the formulary may list which drugs are in which tiers. For example, a formulary may include generic drug and brand name drug tiers.

Grievance: A written expression by a patient of a formal complaint which after being presented to the health plan has not been resolved to the patient's satisfaction and is presented for further investigation and resolution.

Group Model: A health care model involving contracts with physicians organized as a partnership, professional corporation or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and the group is responsible for compensation its physicians and contracting with hospitals for the care of their patients.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't waling or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HCFA 1500: A universal form, developed by the government agency known as the Health Care Financing Administration (HCFA) for providers of service to bill professional fees to health carriers.

HCFA Common Procedural Coding System (HCPCS): A listing of services, procedures and supplies as ordered by physicians and other providers. The national codes are developed by HCFA in order to supplement CPT4 codes. They include physician services not included in CPT as well as non-physician services such as ambulance, physical therapy, and durable medical equipment. The local codes are

developed by Medicare carriers in order to supplement the national codes. HCPCS codes are five digit codes, the first digit a letter followed by four numbers. HCPCS codes beginning with A through V are national and those beginning with W through Z are local.

Health Insurance: A contract that requires your health insurer/benefit carrier to pay some or all of your healthcare costs in exchange for a premium.

Health Insurance and Portability Act: Under Federal laws known as 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, group health plans, , generally must comply with the eligible benefit and security requirements. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements if that plan is self-funded by the employer, rather than provided through a health insurance policy. HIPAA also will require HITECH compliance electronic healthcare transaction standardization from 4010 to 5010**.** This transition will impact the subscriber if separate ID numbers, Provider physical address, service type improvement

Health Maintenance Organization (HMO): An organization that provides a range of health care services for a specific group of individuals for a fixed periodic fee. A legal entity consisting of participating medical providers that provide or arrange for care to be furnished to a given population group for a per-person fixed fee. HMOs are used as alternatives to traditional indemnity plans as a way to manage costs and reduce health care expenses.

Health Plan Employer Data and Information set (HEDIS): A core set of performance measures to assist employers and other health purchasers in understanding the value of health care purchases and evaluating health plan performance.

HEDIS: Healthcare Effectiveness Data and Information Set

HHS: US Department of Health and Human Services

High Deductible Health Plan: A plan in which the annual deductible is at least $1,100 of individual coverage and at least $2,200 for family coverage, adjusted for inflation. Coverage under an HDHP is a requirement for creating a health savings account. (H.S.A.)

HIOS: Health Insurance Oversight System

Home Health Care: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

HSA: Health Savings Account

HRA: Health Reimbursement Arrangement

Hybrid Entity: is a voluntary designation for a single covered entity that performs both covered and non-covered functions. A covered entity may designate itself a hybrid entity to avoid imposition of the privacy rules on its non-health care-related functions. A hybrid entity must ensure that an entity's health care component complies with applicable privacy provisions and the entity must have policies and procedures to ensure covered information is protected from inappropriate disclosure.

In-Area Services: Health care received within the authorized service area from a participating provider of care.

Incurred But Not Reported (IBNR): Costs associated with a medical service that has been provided, but for which a claim has yet to be received by the health plan. IBNR reserves are recorded by the carrier to account for estimated liability based on studies of prior lags in claims submissions.

Independent Medical Evaluation (IME): An examination carried out by an impartial health care provider generally board certified, for the purpose of resolving a dispute related to the nature and extent of an injury or illness.

Independent Practice Association (IPA): A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule or fee for service basis.

Independent Review Organization: Medical Plan external review organization to verify accuracy of benefit plan and clinical review adjudication process

Individual Responsibility Requirement: Sometimes called the "individual mandate". The duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you do not have minimum essential coverage, you may have to make a payment when you file your federal income tax return. You may not have to meet the requirement if no affordable coverage is available to you, or if you have a short gap in coverage during the year for less than three consecutive months, or qualify for a minimum essential coverage exemption.

***In-Network Coinsurance/Benefit Percentage*:** The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with the health benefit plan. In-network benefit percentage/coinsurance usually costs you less than out-of-network benefit percentage/co-insurance.

In-Network Copayment: A fixed amount (for example $15) you pay for covered health care services to providers who contract with your health benefit plan. In-network copayments usually are less than out-of-network co-payments.

Integrated Delivery System: A generic term referring to a joint effort of physician/hospital integration for a variety of purposes. Some models of integration include physician hospital organization (PHO), management services organization (MSO), group practice without walls, integrated provider organization and medical foundation.

International Classification of Diseases, 9th Edition (Clinical Modification) ICD-9-CM: A listing of diagnosis and identifying codes used by physicians for reporting diagnosis of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnosis and provide for reliable, consistent communication on claim forms.

PPACA Healthcare Definitions

International Classification of Diseases, 10th Edition (Clinical Modification) ICD-10-CM: Specificity and Manifestation ICD-9 transition to ICD-10. This will increase diagnosis specificity and allow manifestation to be identified. Clinical quality and coordinated care: 5X more diagnosis codes 69,000 (3-7 characters), 20x more injury codes, 15x more AMA professional procedure code (7 digits) 71,000 codes

IOM: Institute of Medicine

IRS: Internal Revenue Service

JCAHO: The Joint Commission on Accreditation of Healthcare Organizations.

JCI: The Joint Commission International.

Length of Stay: The number of days that a patient stayed in an inpatient facility.

Mandated Providers: Providers of medical care, such as psychologists, optometrists, podiatrists and chiropractors whose licensed services must under a State law or Federal law be included for coverage offered by a health plan.

Marketplace: A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace (**See** *Premium Tax Credits* and *Cost-Sharing Reductions*), and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace is accessible through websites, call centers, and in-person assistance. In some states the Marketplace is run by the state. In others, it is run by the federal government.

Maximum Out-of-Pocket Limit: Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medical Loss Ratio: The cost of health benefits used, compared to revenue received.

Medically Necessary: Those medical treatments, supplies or services ordered by a physician to treat a patient's sickness, bodily injury or complication of pregnancy or pregnancy that are:

1. Consistent with symptoms, or diagnosis and treatment of the condition, disease, ailment or injury; and
2. Appropriate with regard to standards of good medical practice prevailing in the community where treatment occurs at the time such treatment is required; and
3. Not primarily for the convenience of the patient, patient's family or the treating physician.

Member Month: A count which records one Member for each month the Member is effective.

Minimum Essential Coverage: Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance that is available through the Marketplace or other individual market policies: Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Essential Coverage Exemption: A status that allows you to not have to make a payment for not having minimum essential coverage. You must meet certain eligibility requirements to get an exemption. Some exemptions require an application, while others may be available through the federal income tax filing process.

Minimum Value Standard: The Affordable Care Act generally establishes certain value standards for plans and health insurance. For example, "bronze level" individual insurance is designed to pay about 60% of the total cost of certain essential medical services, on average, for a standard population. Plans are subject to a minimum value standards that is similar to that 60% standard, although the benefits covered by the plan may differ from those covered under individual insurance.

NAIC: National Association of Insurance Commissioners

Network: An organization consisting of physicians and/or hospitals and/or ancillary providers formed through contractual relationships.

Network Coinsurance/Benefit Percentage: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health benefit plan. Network benefit percentage/co-insurance usually costs you less than out-of-network benefit percentage/co-insurance.

Network Copayment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health benefit plan. Network co-payments usually are less than out-of-network co-payments.

Network Provider/Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be a great, and you may have to pay more.

NCQA: The National Committee for Quality Assurance. NCQA is the accrediting body for managed care organizations with processes for auditing and reviewing similar to JCAHO.

NDC: National Drug Codes. NCS are used in reporting prescription drugs in retail pharmacy transactions, but, in February 2003, HHS eliminated the requirement for their use in other transactions. The 11-digit codes are assigned when the drugs are approved or repackaged and may be found on the packaging of drugs. The codes are established by the Food and Drug Administration.

Non-Covered Services: Those health care services that are not listed under the applicable benefit plan.

Non-Participating (Non-Par Non-Preferred) Provider: A term used to describe a provider of care that has not contracted with the health benefits carrier or a participating network.

NPDB: National Practitioner Databank which is a Federal entity that was established in 1986 to collect and release certain information relating to the professional competence and conduct of physicians, dentists, and other health care professionals.

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OMB: Office of Management and Budget
OPM: US Office of Personnel Management
Open Access: A self-referral arrangement allowing Members to see participating providers of care without a referral from a Primary Care Physician. Typically found in IPA HMO. Also called open pan, self-referral programs.
ORT: Open Refill Transfers for prescriptions
Orthotics and Prosthetics: Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.
Out of Area: Coverage for treatment obtained by a covered person outside of the network service area. 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.
Out-of-Network Coinsurance/Benefit Percentage: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health benefit plan. Out-of-network benefit percentage/coinsurance payments usually are more than in-network copayments.
Out-of-Network Copayment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health benefit plan. Out-of-Network copayments usually are more than in-network copayments.
Out-of-Network Provider/Non-Preferred Provider: A provider who does not have a contract with your health plan to provide services. You will pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health plan or if your health plan has a "tiered" network and you must pay extra to see some providers.
Out-of-Pocket Expenses: The portion of payments for health services required to be paid by the enrollee, including copayments, benefit percentage, and deductibles.
Out-of-Pocket Limit: The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium/contribution, balance-billed charges or health care your health insurance or plan does not cover. Some health insurance plans do not count all of your copayments, deductibles, coinsurance/benefit percentage payments, or other expenses toward this limit.
Outcome Measures: Assessments which gauge the effect or result of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life, and functional status, as well as objective measures of mortality, morbidity and health status.
Outcomes Research: Studies aimed at measuring the effect of a given product, procedure or medical technology on health or costs.
Outlier: An observation in a distribution that is outside a certain range, often defined as two or three standard deviations from the mean or exceeding a specific percentile. Frequently refers to a case of hospital stay that is unusually long or expensive for its type, or to a physician practice that uses an abnormally high or low volume of resources.
Patient Protection and Affordable Care Act of 2010 (PPACA): Is a federal statute that was signed into United States law by President Barack Obama on March 23, 2010. This Act and the Health Care and Education Reconciliation Act of 2010 (signed into law on March 30, 2010) made up the health care reform of 2010. The laws focus on reform of the private health insurance market, provide better coverage for those with pre-existing conditions, improve prescription drug coverage in Medicare and extend the life of the Medicare Trust fund by at least 12 years.
Partial Hospitalization Services: A mental health or substance abuse program operated by a hospital which provides clinical services as an alternative or follow-up to inpatient hospital care.
Payor: The purchaser of covered services which may include claims administrators, employers, insurance carriers, third party employee benefit plan administrators, self-funded plans and groups, and other similar arrangements.
Peer Review Organization (PRO): An entity established by the Tax Equity and Fiscal Responsibilities Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, re-admissions, and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates, and reducing lengths of stay while insuring against inadequate treatment. Also known as professional standards review organizations.
PHS Act: Public Health Service Act
Physician Hospital Organization (PHO): A legal entity formed and owned by one or more hospitals and physician groups in order to obtain payor contracts and to further mutual interests. Physicians maintain ownership of their practices while agreeing to accept managed care patients under the terms of the PHO agreement. The PHO serves as a negotiating, contracting and marketing unit.
Physician Services: Health care services a licensed medical physician (M.D.-Medical Director or D.O.-Doctor of Osteopathic Medicine) provides or coordinates.
Plan: A benefit your employer, union or other group sponsor provides for your health care services.
Plan Allowed Amount: The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, *Usual and Reasonable (U&R)*, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. This is called balance billing.
Point of Service (POS): A health plan allowing the covered person the opportunity to choose to receive a service from a participating or a non-participating provider, with different benefit levels associated with the use of participating providers. Point of service can be provided in several ways:

1. An HMO may allow Member to obtain services from non-participating providers;
2. An HMO may provide non-participating benefits through a supplemental plan;
3. A PPO may be used to provide both participating and non-participating levels of coverage/access; or

4. Various combinations of the above.

Pool: A defined account (e.g. defined by size, geographic location, claim dollars that exceed X level per individual, etc.) to which revenue and expenses are posted. A risk pool attempts to define expected claims liabilities of a given defined account as well as required funding to support the claim liability.

PRA: Paperwork Reduction Act

Practice Guidelines: Systematically developed standards on medical practice that assist a practitioner and a patient in making decisions about appropriate health care for specific medical conditions.

Preauthorization/Notification: A decision by the health plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. The benefit plan may require Preauthorization/Notification for certain services before you received the, except in an emergency situation. Preauthorization/Notification is not a promise the health benefit plan will cover the cost.

Preferred Provider Organization (PPO): A program in which contracts are established with providers of medical care. Providers under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly better benefits (lower out of pocket responsibility) for services received from preferred providers, thus encouraging covered persons to use these providers. Covered persons are generally allowed benefits for non-participating providers' services, usually on an indemnity basis with significant copayments. A PPO arrangement can be insured or self-funded. Providers may be, but are not necessarily, paid on a discounted fee for services basis.

Premium/Contribution: The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Premium Tax Credits: Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium/contribution costs.

Prescription Drug Coverage: Health benefit plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Preventive Care: Routine health care including screenings, check-ups, and patient counseling to prevent or discover illness, disease, or other health problems.

Primary Care Physician: A physician (M.D. – Medical Director or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Primary Care Provider: A physician (M.D. – Medical Director or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Provider: A physician (M.D. – Medical Director or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Provider Network: The plan encourages you to access network providers by charging a lower out-of-pocket network deductible and benefit percentage.

Quality Assurance (Improvement): A formal set of activities to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies in the quality or direct patient, administrative and support services.

Quality Improvement Program: The program established by a health plan at least annually to gather and analyze the performance data specific to care received by Members and/or provided by participating providers.

QHP: Qualified Health Plan

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accident, injuries or medical conditions.

Referral: A written order from your primary care provider for you to see a specialist or get certain health care services. In many Health Maintenance Organization (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you do not get a referral first, the plan or health insurance may not pay for the services.

Referral Access: A type of health plan in which covered persons are required to select a PCP from the plan's participating listing. The patient is required to see the selected PCP for care and referrals to other health care providers within the plan. These types of health plans are typically found in the staff, group or network model POS. Also called closed access, closed pane, coordinator or gatekeeper model.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Reserves: Funds for incurred but not reported health services or other financial liabilities. Also refers to deposits and/or other financial requirements that must be met by an entity as defined by various state or federal regulatory agencies.

Resource Based Relative Value Scale (RBRVS): A fee schedule introduced by HCFA to reimburse physicians' Medicare fees based on the amount of time and resources expended in treating patients, with adjustments for overhead costs and geographical differences.

Retention: That portion of the cost of a medical benefit program which is kept by the health plan to cover internal costs or to return a profit.

Retrospective Review: A determination of medical appropriateness and/or appropriate billing practices for services already rendered.

Screening: A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs or prevailing medical history of a disease or condition.

Service Area: The geographic area serviced by the health plan as approved by State regulatory agencies and/or as detailed in the certification of authority (state approval to do business document).

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

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Specialist: A physician specialist focuses on a specific are of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific are of health care.

Specialty Drug/Biotech Prescription: A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. If the plan's formulary uses "tiers", and specialty drugs are included as a separate tier, you will likely pay more in cost-sharing for drugs in the specialty drug tier.

SSA: Social Security Administration

SHOP: Small Business Health Options Program

Standard Benefit Package: A set of specific health care benefits that would be offered by delivery systems. Benefit packages could include all or some of the following: preventive care services, hospital and physician services, prescription drug coverage, limited mental health and chemical dependency services and/or long-term care.

Third Party Administrator: A company that accepts responsibility for administering some or all of an employer's benefits programs.

Trending: A calculation used to predict future utilization of a group based on past utilization by applying a trend factor.

UCR (Usual, Customary, and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Unbundling: Separately packaging units that might otherwise be packaged together. For claims processing, this includes providers billing separately for health care services that should be combined according to industry standards or commonly accepting coding practices. Also refers to the practice of providing separate prices and administrative support for services such as prescription drug benefit administration, mental health/substance abuse services or utilization review services.

Uniformed Services Employment and Reemployment Rights Act: USERRA ensures that employees who leave their jobs to serve in the military will not lose benefits, including 401(k) plan contributions, when they return to work.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

USP: United States Pharmacopeia

Usual and Reasonable (U&R): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The U&R amount sometimes is used to determine the allowed amount.

Utilization Review Accreditations Commission (URAC): 1996 URAC began accrediting organizations. The accreditation process by which an impartial organization (URAC) will review a company's operations to ensure that the company is conducting business in a manner consistent with national standards. URAC's accreditation process consists of a review of policies and procedures (the desktop review and an onsite visit to the applicant organization to determine that it is, in fact, operating according to its stated polices. URAC reviews organizations such as health plans, case management and/or credentialing procedures. This accreditation is an external seal of approval.

Voluntary Employees' Beneficiary Association: A trust tax-exempt under Code Section 501c (9) that is created to fund life insurance, sick leave, accident or certain other benefits for a nondiscriminatory class of employees, their dependents or designated beneficiaries.

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How You and Your Insurer Share Costs - Example