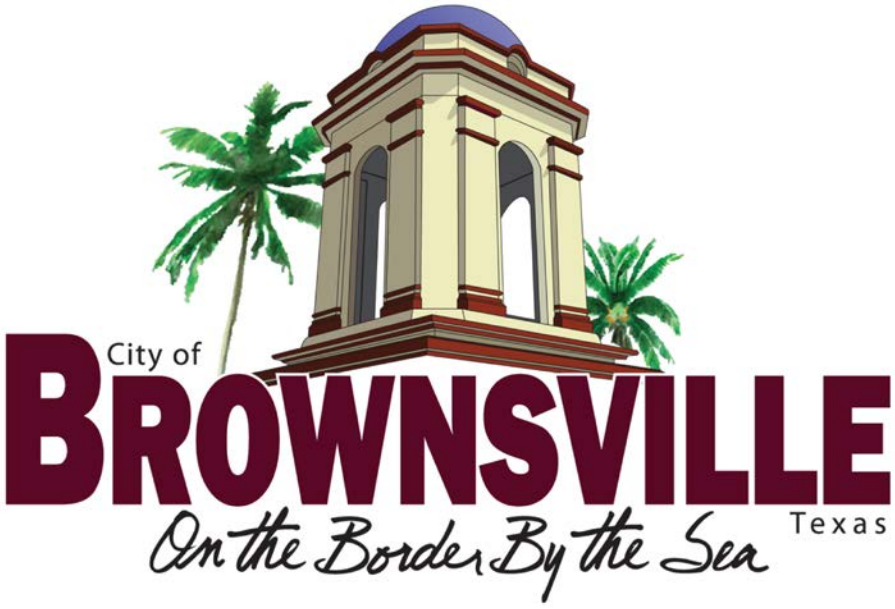

CITY OF BROWNSVILLE MEDICAL BENEFITS BOOKLET

Effective October 1, 2018

Claims Address:
TML MultiState IEBP
PO Box 149190
Austin, Texas 78714-9190

Customer Care:
English: (800) 282-5385 / Spanish: (800) 385-9952
Professional Health Coach (888) 818-2822
Medical Intelligence: (800) 847-1213

Major Medical Benefits are self-funded by the City of Brownsville. Claims are administered in accordance with an Administrative Services Agreement between the TML MultiState Intergovernmental Employee Benefits Pool (Benefits Administrator; hereafter IEBP) and the City of Brownsville (Plan Administrator) and as the Plan Administrator, has the responsibility for compliance with state and federal laws applicable to Chapter 172 employee benefits. The coverages described in this Plan Booklet are subject to the terms and conditions of this Plan Booklet. In the event of any conflict with the provisions outlined in this Booklet and those in the Summary of Benefits and Coverage, the provisions of this Plan Booklet will prevail. **Disclaimer:** This book should be used as a guideline for the explanation of your healthcare benefits. Updates and changes to this benefit book may occur during the plan year.

Resource	Contact Information	Accessible Hours
TML MultiState Intergovernmental Employee Benefits Pool (IEBP)	**1821 Rutherford Lane, Suite 300 | Austin, Texas 78754** PO Box 149190 | Austin, Texas 78714-9190	
Customer Care Helpline:	(800) 282-5385	7:00 AM -6:00 PM Central
Secured Customer Care E-mail:	Visit www.iebp.org | click on the "Login" button | click on "Online Customer Care" under the "My Tools" menu | click on "Send a Secure Email"	8:30 AM - 5:00 PM Central
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) hours
*My*IEBP Mobile Access:	iPhone–App Store, Droid–Google Play, All other Phones–www.iebp.org	Twenty-four (24) hours
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	Plans A and D: OptumRx | Toll Free: (800) 711-4555 Plan C: RxResults | Toll Free: (844) 853-9400	
Professional Health Coaches: Professional Health Coaches will answer basic health and medication questions and assist Covered Individuals with the Healthy Initiatives Incentive Program. Covered Individuals may enroll in professional health coaching.	(888) 818-2822	8:30 AM - 6:00 PM Central or Scheduled Appt.
Translation Line:	(800) 385-9952 translation_cc@iebp.org (There is an underscore between translation 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 | www.optumrx.com	
OptumRx Specialty/Biotech Pharmacy:	(855) 427-4682 | Fax: (800) 491-7997	
After Hours and/or Weekend Medical and Mental Healthcare Emergencies:	Call 911 or immediately go to the emergency department.	
Cultural Sensitive Counties: Summary of Benefits and Coverage (SBC) and benefit declinations can be requested in Spanish in the following counties. County list may be updated midyear.	Visit www.iebp.org | click on the "Login" button | click on "Online Customer Care" under the "My Tools" menu | click on "Send a Secure Email"	
Counties for 2017: 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 | Mendard | Midland | Moore | Navarro | Nueces | Ochiltree | Parmer | Pecos | Potter | Presidio | Reagan | Reeves | San Saba | Sherman | Starr | Sterling | Sutton | Terry | Titus | Travis | Upton | Uvalde | Val Verde | Ward | Webb | Willacy | Winkler | Yoakum | Zapata | Zavala		

NOTICE TO PLAN PARTICIPANTS

REGARDING THE CITY OF BROWNSVILLE ELECTION UNDER 42 U.S.C. § 300gg-21

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, such as the City of Brownsville's plan, generally must comply with the requirements listed below. 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. Federal law allows a self-funded, non-federal, governmental plan such as the City of Brownsville to exempt its plan in whole or in part from the requirements of HIPAA Title I. The City of Brownsville has elected to opt out of the following provisions:

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

Because of this election:

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

In addition to the above, on April 14, 2003, the Federal government imposed HIPAA Title II, which pertains to administrative simplification of health plans. The administrative simplification process includes: standards for electronic transactions and code sets, national identifiers (employers, health plans and healthcare providers), security standards for the protection of health information (Security Rule), standards for notification in case of breach of unsecured health information and standards for privacy of individually identifiable health information (Privacy Rule).

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

The intent of the City of Brownsville's plan is to provide coverage that is compliant with applicable State or Federal laws and regulations, including making changes mid-plan year, when mandated by law.

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HOW BENEFITS ARE PAID

The Plan relies mainly on information provided when a claim is submitted. If the Benefits Administrator finds that additional information is needed to determine if benefits are payable under the Plan, a written request for such information will be made to the Covered Person, or if necessary, the health care provider. If the information is not provided, the claim will be denied. If the claim is denied because requested information is not provided, the information may be filed as long as it is within the twelve (12) months from the date of service. Additional information may also be submitted within ninety (90) days after a decision is made by the employer's Workers' Compensation carrier or by the Workers' Compensation Division of the Texas Department of Insurance, that the medical expense sought to be claimed is due to an injury that is non-compensable, whichever is later.

To avoid a prompt pay penalty, required information must be received by IEBP not later than the prompt pay contract deadline.

Claims

Requests for Reimbursement

Requests for reimbursement for a covered benefit should be sent to the Benefits Administrator within ninety (90) days of date of service but not later than twelve (12) months, or within ninety (90) days after a decision is made by the employer's Workers' Compensation carrier or by the Workers' Compensation Division of the Texas Department of Insurance, that the medical expense sought to be claimed is due to an injury that is non-compensable, whichever is later. Requests must include:

1. the employee's name, address, unique identification number (or social security number) and group name;
2. the patient's name and relationship to the employee;
3. the health care provider's name, tax ID (or social security number) and address;
4. a description of the service rendered including charges, diagnosis code and applicable CPT codes and the date of service.

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

If you have any questions regarding your claim please call IEBP's Customer Care team at (800) 282-5385 [En Español: (800) 385-9952], or log on to *www.iebp.org* and contact Customer Care via e-mail at www.iebp.org. Login and click on "Online Customer Care" under the "My Tools" menu, then click on "Send a Secure Email".

No benefits are payable for claims submitted by the employee or a provider more than twelve (12) months after the date the expense was incurred. Benefits will not be recalculated to allow a better benefit for charges incurred at a later date.

Claim forms are not required for benefits to be payable under the Plan. The Plan may request specific information from the Covered Person or employer in order to complete processing of the claim or to verify eligibility in the Plan. The information requested may include but is not limited to:

1. verification of employment status;
2. proof of eligible dependents status;
3. information related to accidental injuries;
4. information related to work related accidents or illness; and/or
5. information regarding any other source of benefits.

Covered Persons need to keep the Plan Administrator (City of Brownsville) informed in writing of any change in address, phone number or dependents. IEBP may rely on United States Postal Service and/or the Employer demographic information for a covered individual's last known address.

As a claimant under the Plan, you must supply the Benefits Administrator with the information necessary to determine whether the charges incurred are for a covered expense. Decisions with respect to the type of information necessary to determine coverage shall be made with sole discretion of the Benefits Administrator. The Benefits Administrator reserves the right to withhold or deny payment until the requested information has been furnished.

Right to Receive and Release Necessary Information

All personnel involved in the processing of claims are advised of the need to treat all personal and medical information as confidential. However, the Benefits Administrator has the right to disclose information to or obtain information regarding a Covered Person from any organization or person if necessary to determine benefits payable under the Plan.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The City of Brownsville's Employee Health Plan ("Plan") is required by law to keep your health information private and to notify you if the Plan, or one of its business associates, breaches the privacy or security of your unsecured, identifiable health information. This notice tells you about the Plan's legal duties connected to your health information. It also tells you how the Plan protects the privacy of your health information. The Plan must use and share your health information to pay benefits to you and your healthcare providers. The Plan has physical, electronic and procedural safeguards that protect your health information from inappropriate or unnecessary use or sharing.

Is all my health information protected?

Your individually identifiable health information that the Plan transmits or maintains in writing, electronically, orally or by any other means is protected. This includes information that the Plan creates or receives and that identifies you and relates to your participation in the Plan, your physical or mental health, your receipt of healthcare services and payment for your healthcare services.

How does the Plan use and share my health information?

The Plan's most common use of health information is for its own treatment, payment and healthcare operations. The Plan also may share your health information with healthcare providers, other health plans and healthcare clearinghouses for their treatment, payment and healthcare operations. (Healthcare clearinghouses are organizations that help with electronic claims.) The Plan also may share your health information with a Plan business associate if the business associate needs the information to perform treatment, payment or healthcare operations on the Plan's behalf. For example, your health benefits include a retail and mail order pharmacy network, the Plan must share information with the pharmacy network about your eligibility for benefits. Healthcare providers, other health plans, healthcare clearinghouses and Plan business associates are all required to maintain the privacy of any health information they receive from the Plan. The Plan uses and shares the smallest amount of your health information that it needs to administer your health plan.

What are treatment, payment and healthcare operations?

Treatment is the provision, coordination or management of healthcare and related services. For example, your health information is shared for treatment when your family doctor refers you to a specialist.

Payment includes Plan activities such as billing, claims management, subrogation, plan reimbursement, reviews for appropriateness of care, utilization review and prior notification of healthcare services. For example, the Plan may tell a doctor if you are covered under the Plan and what part of the doctor's bill the Plan will pay.

Healthcare operations include quality assessment and improvement, reviewing competence or qualifications of healthcare professionals, underwriting and other activities necessary to create or renew health plans. It also includes disease management, Medical Intelligence, conducting or arranging for medical review, legal services, auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information from your claims to contact you about treatment alternatives or other health-related benefits and services that may be of interest to you. Please note that while IEBP may use and share your health information for underwriting, IEBP is prohibited from using or sharing any of your genetic information for underwriting.

How else does the Plan share my health information?

The Plan may share your health information, when allowed or required by law, as follows:

- Directly with you or your personal representative. A personal representative is a person who has legal authority to make healthcare decisions for you. In the case of a child under eighteen (18) years of age, the child's personal representative may be a parent, guardian or conservator. In the case of an adult who cannot make his own medical decisions, a personal representative may be a person who has a medical power of attorney.
- With the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Plan's compliance with federal regulations on protecting the privacy and security of health information.
- With your family member, other relative, close personal friend or other person identified by you who is involved directly in your care. The Plan will limit the information shared to what is relevant to the person's involvement in your care and, except in the case of an emergency or your incapacity, you will be given an opportunity to agree or to object to the release of your health information.
- For public health activities.
- To report suspected abuse, neglect or domestic violence to public authorities.
- To a public oversight agency.
- When required for judicial or administrative proceedings.
- When required for law enforcement purposes.
- With organ procurement organizations or other organizations to facilitate organ, eye or tissue donation or transplantation.
- With a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties required by law.
- With a funeral director when permitted by law and when necessary for the funeral director to carry out his duties with respect to the deceased person.
- To avert a serious threat to health or safety.
- For specialized government functions, as required by law.
- When otherwise required by law.
- Information that has been de-identified. This means that the Plan has removed all your identifying information and it is reasonable to believe that the organization receiving the information will not be able to identify you from the information it receives.

Can I keep the Plan from using or sharing my health information for any of these purposes?

You have the right to make a written request that the Plan not use or share your health information, unless the use or release of information is required by law. However, since the Plan uses and shares your health information only as necessary to administer your health plan, the Plan does not have to agree to your request.

Are there any other times when the Plan may use or share my health information?

The Plan may not use or share your health information for any purpose not included in this notice, unless the Plan first receives your written authorization. To be valid, your authorization must include: the name of the person or organization releasing your health information; the name of the person or organization receiving your health information; a description of your health information that may be shared; the reason for sharing your health information; and an end date or end event when the authorization will expire.

You may revoke or take back any authorization that you make. Your request to revoke your authorization must be in writing and will not apply to any information shared before IEBP receives your request.

The plan must always have your written authorization to:

- Use or share psychotherapy notes, unless the Plan is using or sharing the psychotherapy notes to defend itself in a legal action or other proceeding brought by you.
- Use or share your identifiable health information for marketing, except for: (1) a face-to-face communication from the Plan, or one of its business associates, to you; or (2) a promotional gift of nominal value given by the Plan, or one of its business associates, to you.
- Sell your identifiable health information to a third party.

You may revoke or take back any authorization that you make. Your request to revoke your authorization must be in writing and will not apply to any information shared before the Plan receives your request.

Can I find out if my health information has been shared with anyone?

You may make a written request to the Plan's Privacy Officer for a list of any disclosures of your health information made by the Plan during the last six (6) years. The list will not include any disclosures made for treatment, payment or healthcare operations; any disclosures made directly to you; any disclosures made based upon your written authorization; any disclosures reported on a previous list; or any disclosures reported on a previous list.

Generally, the Plan will send the list within sixty (60) days of the date the Plan receives your written request. However, the Plan is allowed an additional thirty (30) days if the Plan notifies you, in writing, of the reason for the delay and notifies you of the date by which you can expect the list.

If you request more than one list within a twelve (12)-month period, the Plan may charge you a reasonable, cost-based fee for each additional list.

Can I view my health information maintained by the Plan?

You may make a written request to inspect, at the Plan's offices, your enrollment, payment, billing, claims and case or medical management records that the Plan maintains. You also may request paper copies of your records. If you request paper copies, the Plan may charge you a reasonable, cost-based fee for the copies. Requests to view your health information should be made in writing to:

City of Brownsville
Attn: Safety & Risk Management
PO Box 911
Brownsville, TX 78522-0911

If I review my health information and find errors, how do I get my records corrected?

You may request that the Plan correct any of your health information that it creates and maintains. All requests for correction must be made to the Plan's Privacy Officer, must be in writing and must include a reason for the correction. Please be aware that the Plan can correct only the information that it creates. If your request is to correct information that the Plan did not create, the Plan will need a statement from the individual or organization that created the information explaining an error was made. For example, if you request a claim be corrected because the diagnosis is incorrect, the Plan will correct the claim if the Plan (or its business associate) made an error in the data entry of the diagnosis.

However, if your healthcare provider submitted the wrong diagnosis to the Plan, the Plan cannot correct the claim without a statement from your healthcare provider that the diagnosis is incorrect.

The Plan has sixty (60) days after it receives your request to respond. If the Plan is not able to respond, it is allowed one thirty (30)-day extension. If the Plan denies your request, either in part or in whole, the Plan will send you a written explanation of its denial. You may then submit a written statement disagreeing with the Plan's denial and have that statement included in any future disclosures of the disputed information.

I'm covered as a dependent and do not want any of my health information mailed to the covered employee's address. Will you do that?

If mailing communications to the covered employee's address would place you in danger, the Plan will accommodate your request to receive communications of health information by alternative means or at alternative locations. Your request must be reasonable, must be in writing, must specify an alternative address or other method of contact, and must include a statement that sending communications to the covered employee's address would place you in danger. Please be aware that the Plan is required to send the employee any payment for a claim that is not assigned to a healthcare provider, except under certain medical child support orders.

If I believe my privacy rights have been violated, how do I make a complaint?

If you believe your privacy rights have been violated, you may make a complaint to the Plan.

City of Brownsville
Attn: Safety & Risk Management
PO Box 911
Brownsville, TX 78522-0911

Also, you may file a complaint with the U.S. Department of Health and Human Services. The Plan will not retaliate against you for filing a complaint.

When were the privacy practices described in this notice effective?

This privacy notice was effective September 1, 2016, and it replaced any privacy notice issued by the Plan before that date.

Can the Plan change its privacy practices?

The Plan is required by law to follow the terms of its privacy notice currently in effect. The Plan reserves the right to change its privacy practices and to apply the changes to any health information the Plan received or maintained before the effective date of the change. The Plan will distribute any revised notice to covered employees, either by hand or by mail, before the effective date of the revised notice.

What happens to my health information when I leave the plan?

The Plan is required to maintain your records for at least six (6) years after you leave the Plan. However, the Plan will continue to maintain the privacy of your health information even after you leave the Plan.

How can I get a paper copy of this notice?

Write to: City of Brownsville
Attn: Safety & Risk Management
PO Box 911
Brownsville, TX 78522-0911

Who can I contact for more information on my privacy rights?

Write to: City of Brownsville
Attn: Safety & Risk Management
PO Box 911
Brownsville, TX 78522-0911

No Replacement for Workers' Compensation

The Plan does not replace Workers' Compensation or provide any benefits if any Workers' Compensation benefit was paid or could have been paid whether or not the employer is a subscriber or non-subscriber in a Workers' Compensation Program. For purposes of this booklet, work on the Covered Person's family farm or ranch is not considered an employment arrangement requiring Worker's Compensation

Assignments

The benefits provided under the Plan are payable only to the Covered Person. The Benefits Administrator may pay benefits directly to the health care provider if they are assigned by the Covered Person.

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

Legal Actions

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

Claim Appeals

The Benefits Administrator will conduct a full and fair review of your appeal. The appeal will be reviewed by appropriate individual(s) on the Benefits Administrator's staff for internal review; or a health care professional with appropriate expertise during the initial benefit determination process. The appeal filing deadlines below could be superseded by network contractual obligations.

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

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

Appeal of Urgent/Emergent Request for Benefits (Adverse Pre-Determination/Notification Request)		
Type of Request for Benefits or Appeal	**Internal/External Appeal Process**	**Hours/Calendar Days**
If the appellant appeals the adverse notification determination or declination of notification, the appellant must appeal within:	**Internal**	**Twelve (12) months** 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 incomplete pre-determination/notification information declination letter*** within:	**Internal**	**twenty-four (24) hours** of receipt of appellant's information
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**

Appeal of Urgent/Emergent Request for Benefits (Adverse Pre-Determination/Notification Request)		
Type of Request for Benefits or Appeal	**Internal/External Appeal Process**	**Hours/Calendar Days**
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) calendar 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)		
Type of Request for Benefits or Appeal	**Internal/External Appeal Process**	**Hours/Calendar Days**
The appellant must appeal the denial no later than:	**Internal**	**Twelve (12) months** 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) calendar days**
If the **request for pre-determination/notification** is ***clinical information incomplete***, IEBP will notify you within:	**Internal**	**fifteen (15) calendar days**
The appellant must then provide completed information within:	**Internal**	**forty-five (45) calendar days** after receiving an extension notice*
IEBP will notify you of the **first level appeal decision** within:	**Internal**	**fifteen (15) calendar days** after receiving the first level appeal
The appellant must appeal the first level appeal (file a second level appeal) within:	**Internal**	**sixty (60) calendar days** after receiving the first level appeal decision
IEBP will notify you of the second level appeal decision within:	**Internal**	**fifteen (15) calendar 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) calendar 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) calendar days**
* A one-time extension of no more than fifteen (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**	**Hours/Calendar Days**
The appellant must appeal the claim denial no later than:	**Internal**	**Twelve (12) months** after receiving the denial
If the appellant's claim is incomplete, IEBP will notify the appellant within:	**Internal**	**thirty (30) calendar days**
The appellant must then provide completed claim information within:	**Internal**	**forty-five (45) calendar days** after receiving an extension notice
IEBP will notify the appellant of the first level appeal decision within:	**Internal**	**thirty (30) calendar days** after receiving the first level appeal
The appellant must file the second level appeal within:	**Internal**	**sixty (60) calendar days** after receiving the first level appeal decision
The appellant will be notified of the second level appeal decision generally within:	**Internal**	**thirty (30) calendar days** after receiving the second level appeal
The appellant may request an appeal be submitted to an IRO. This request must be submitted for the review within:	**External**	**one hundred twenty (120) calendar days** of receipt of the original denial or response to your appeal

Post-Service Claims		
Type of Claim or Appeal	**Internal/External Appeal Process**	**Hours/Calendar Days**
The IRO must complete the review of a non-emergent claim or benefit appeal within:	**External**	**thirty (30) calendar 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 healthcare provider should be included with the appeal.

- For claims denied or partially denied for not being notified, the appeal must include:
- the admission history and physical;
- the discharge summary; and
- the operative and pathology reports (if applicable).

An appeal requested without proper documentation may not be considered. All written appeals should be sent to the Benefits Administrator'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 unique 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. The Benefits Administrator 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.

MEDICAL INTELLIGENCE FEATURES

This program is included to assist you in making informed health care decisions. Occasionally proposed health care or the scheduled length of stay or setting is not an eligible benefit. Please read this provision so that you understand the admission, continued stay and notification process and are not faced with a penalty for failure to provide Notification or a denial of benefits for not providing Notification. Even when Notification is provided, reimbursement is subject to the terms and conditions of the Plan including, but not limited to, all plan exclusions and limitations. Providing the required Notification does not constitute verification of eligibility for benefits. Notification is not required when this Plan is not primary.

If Medical Intelligence does not receive Notification prior to a scheduled service requiring Notification, claims for benefits for that service will not be considered unless an appeal is filed and benefits eligibility is reviewed. If the benefits are eligible under the Plan, they will be paid, but the Late Notification Penalty will apply.

How the Notification and Notification Process Works

The Twenty-Three (23) Hour Rule

Inpatient means treatment or confinement in a hospital or other medical facility for more than twenty-three (23) hours. Outpatient means treatment or confinement in a hospital or other medical facility for twenty-three (23) hours or less.

What is an admission?

When the hospital or facility sends a bill to the Benefits Administrator, they include the length of time the patient was in their facility and a designation that can be inpatient, outpatient or observation. For the Plan, the important item is the number of hours, not the classification. If it looks like the patient will stay more than twenty-three (23) hours, you must call Medical Intelligence. Medical Intelligence must be called for any inpatient expectant mother admission.

If a newborn baby requires more than routine nursery care, you must notify Medical Intelligence so that a separate Notification can be issued for the baby. Newborns must be added to the Plan within thirty-one (31) days of birth in order to be a Covered Person.

Responsibilities of the Covered Person

Between the hours of 8:30 AM - 5:00 PM Central time, call the Notification number on the ID card to provide Notification to Medical Intelligence prior to any health care service that requires Notification. After hours, Voice Mail records your notification twenty-four (24) hours a day and a Medical Intelligence Intake Staff will return your call the next business day. **Please refer to the Notification chart for a complete list.**

COMPLIANCE WITH NOTIFICATION REQUIREMENTS DOES NOT GUARANTEE PAYMENT OF ANY CLAIM RELATED TO THE TREATMENT OR SERVICE FOR WHICH NOTIFICATION WAS PROVIDED.

Responsibilities of Medical Intelligence

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

What Happens on Treatment in Excess of Twenty-Three (23) Hours?

The covered individual must provide Notification to Medical Intelligence of a scheduled admission five (5) working days prior to the date of service or one (1) business day after an emergency admission. If the notification is made after the above-referenced time frames, a late notification penalty will apply. Concurrent stay review requirements apply to all inpatient confinements. Failure to provide Notification to Medical Intelligence will result in no paid benefits for related charges.

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

Outpatient Surgery not on the Outpatient Surgery List

If Notification is provided to Medical Intelligence within forty-eight (48) hours of an outpatient surgery that exceeds the twenty-three (23) hour limit, it will be considered an admission, and a late review will be performed. If the services and the length of stay are eligible benefits, there is no penalty. If the services are determined to be non-eligible benefits, charges are not covered. If you do not provide Notification to Medical Intelligence within forty-eight (48) hours of the admission, the outpatient Late Notification Penalty will apply. Failure to provide Notification to Medical Intelligence will result in no paid benefits for related charges.

Outpatient Surgery on the Outpatient Surgery List

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

Immediate Care/Emergency (Unscheduled) Medical Admission

If Notification is provided to Medical Intelligence within one (1) business day of the admission requiring immediate care, no late notification penalty will apply.

Continued Stay Review

Medical Intelligence does not solicit Continued Stay clinical information. If the Covered Individual's treatment plan changes, the Healthcare Provider must provide Notification to Medical Intelligence at (800) 847-1213. Medical Intelligence will obtain an update on the treatment plan and will conduct a concurrent review regarding the additional length of stay.

Medical Intelligence Utilization Management/Catastrophic Care

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

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

Population Health Engagement

Population Health Engagement supports members in all stages of health. This program provides information to the covered individual regarding healthy lifestyle choices and management of chronic disease states. The program offers personalized professional coaching to support the healthy lifestyle of change and plan of action. Online tools and educational material(s) are available to the covered individual. The population health engagement team consists of an interdisciplinary team of licensed professional nurses, licensed professional counselors and registered dietitians. **To contact a Professional Health Coach, call (888) 818-2822.** Para pedir servicios o la información en español, llame por favor (800) 385-9952.

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.

Notification Requirements

Notification enables clinical support and educations, such as:

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

Notification is required for the following admissions and/or procedures:

SERVICE	NOTIFICATION REQUIRED	LATE NOTIFICATION PENALTY
Inpatient Admissions		
Emergency Admissions	Facility: Twenty-four (24) hours after emergency admission or by 5:00 pm the next calendar day for weekend/holiday admissions. In an emergency, Voice Mail records and dates your notification twenty-four (24) hours-a-day.	$500* If an emergency admission notification is received seventy-two (72) hours or more after admission, the network provider and network facility reimbursement will receive the contracted reduction of a 100% of the daily contract rate for the days non-notified.
Scheduled Admissions		
Scheduled Admissions • Inpatient Admission • Acute Care Admission • Skilled Nursing • Long-Term Care Rehabilitation • Extended Care Facility • Mental Health/Substance Use Disorder Admissions • Mental Health/Substance Use Disorder Day Treatment • Mental Health/Substance Use Disorder Residential Treatment	Facility: Five (5) days prior to a non-emergency admission	$500* If a planned admission notification is received seventy-two (72) hours or more after admission, the network provider and network facility reimbursement will receive the contracted reduction of a 100% of the daily contract rate for the days non-notified.
• Newborns who remain in the hospital after mother is discharge	Notification required no later than Twenty-four (24) hours of mother's discharge.	$500* If the notification is received greater than twenty-four (24) hours after mother's discharge, the network provider and facility reimbursement will receive the contracted reduction of 100% of the daily contract rate.
• Pregnancy/Maternity (Delivery Admission) Normal vaginal delivery in excess of forty-eight (48) hours	Facility: Twenty-four (24) hours after the forty-eight (48) hours after the delivery or by 5:00 pm the next business day or weekend/holiday admission.	$500

SERVICE	NOTIFICATION REQUIRED	LATE NOTIFICATION PENALTY
• Pregnancy/Maternity (Delivery Admission) Caesarean Section delivery in excess of ninety-six (96) hours	Facility: Within ninety-six (96) hours following admission	$500
Outpatient Surgical 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 (roof of mouth surgery)	Prior to procedure	$500
• Radiation Therapy	Prior to commencement	$500
Outpatient/Office Infusion Therapy		
• Pain Management (IV) • Oncological Chemotherapy	Prior to commencement	$500
Miscellaneous		
• Hospice • Home Health Care • Physician Home Visit	Prior to commencement	$500
• Durable Medical Equipment: for charges in excess of $1,000 (including repairs) • Prosthetics and non-foot Orthotics in excess of $1,000 (including repairs) • Implantable and/or removable ocular prosthetic lens in excess of $1,000 (including repairs)	Prior to dispensing/delivery of standard durable medical equipment and prosthetic/non-foot orthotics for charges prior to purchase, lease or rental	$500
• Cardiac Rehabilitation	Prior to commencement	$500
• PET Scan (Positron Emission Tomography) • CAT Scan (Computerized Axial Tomography) • Magnetic Resonance Imaging (MRI)	Prior to procedure	$500
• Transplants	Ten (10) working days prior to initial evaluation	$500
• Surgical Treatment of Morbid Obesity (after the approved six (6) consecutive months (within the most recent twelve (12) months) physician supervised weight management treatment plan with a psychiatric evaluation	Ten (10) working days prior to initial evaluation for surgical intervention	$500
• Diabetic Self-Management Education	For charges in excess of $1,000	$500
• Dental Injury • Reconstructive Surgical Procedures • Convalescent Nursing Home for Rehabilitation Services • Dialysis for End Stage Renal Disease (ESRD) • Medically Necessary Evidence-Based BRCA testing (after diagnosis has been established)	Prior to commencement	$500

SERVICE	NOTIFICATION REQUIRED	LATE NOTIFICATION PENALTY
• Maternity sonograms/ultrasounds in excess of three (3)		

*Physicians and facilities are responsible for the notification requirements. Non-compliant providers will receive the penalty. Providers cannot balance bill a member for the lack of notification penalties and denied services (asterisked items).

Self-Audit Reimbursement

(Refer to your Summary of Benefits and Coverage insert)

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

DESCRIPTION OF PLAN BENEFITS

The following benefits are applicable to each Covered Person for covered charges subject to the terms and conditions of this Plan. The medical benefits are provided for covered charges while you or your dependent(s) are covered under this Plan. All benefits provided are subject to usual and reasonable charges as determined by the Benefits Administrator.

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

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

Deductible Requirements

(Refer to your Summary of Benefits and Coverage)

Covered charges that are used toward satisfying the deductible must be incurred during the calendar year. Covered expenses incurred during any calendar year and applied toward satisfaction of a covered family member's individual calendar year deductible will be accumulated toward the Family Limit. Once the family deductible has been satisfied, it will not apply for any other family member's charges. Other family member's charges previously applied to the deductible will not be recalculated.

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

Out of Pocket Requirements

(Refer to your Summary of Benefits and Coverage)

Covered charges that are used toward satisfying the out of pocket amount must be incurred during the calendar year. Covered expenses incurred during any calendar year and applied toward satisfaction of a covered family member's individual calendar year out of pocket will be accumulated toward the Family out of pocket Limit. Charges previously applied toward the Covered Person's out of pocket amount for other family members will not be recalculated.

Federal Government Maximum Out of Pocket (MOOP)

The maximum out of pocket (MOOP) limit for PPO plans is 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. This plan has a maximum out of pocket that is less than the Federal Government MOOP. Once the plan's defined maximum out of pocket amount is met the medical and prescription most cost effective, eligible network services accessed within the scope of the benefit plan will be paid at 100%.

Usual and Reasonable

The plan will pay up to billed/negotiated charges but not more than the Usual and Reasonable rate as determined by the Plan.

COVERED EXPENSES

Coverage for charges for active employees, dependents of active employees, continuation of coverage participants, retirees, and dependents of retirees, for the following services will be reimbursed by the Plan, subject to the conditions described in this booklet and the Summary of Benefits and Coverage.

Hospital

Inpatient hospital - more than twenty-three (23) hours

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

Inpatient Newborn Care charges by a physician, hospital, or health care provider for a newborn will be covered as charges to the mother subject to the benefit percent of the Summary of Benefits and Coverage if the mother is covered by the Plan and the newborn is discharged within two (2) days of delivery for a vaginal delivery and within four (4) days of delivery for a C-Section delivery. **Newborns must be enrolled in the Plan within thirty-one (31) days of birth.** If the mother is not covered and the newborn is enrolled within thirty-one (31) 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 C-Section delivery, any charges incurred for the newborn will not be covered as charges unless they are an eligible expense for the newborn to remain in the hospital. Such charges, if covered on the basis of being deemed eligible benefits 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 thirty-one (31) days for any charges to be considered.**

The inpatient newborn care benefit includes routine circumcision if completed prior to discharge or within thirty (30) days of discharge.

Outpatient hospital - twenty-three (23) hours or less.

Extended Care Facility room and board including necessary medical services and supplies.

Pre-Admission Testing Benefit

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

1. performed in connection with an illness or injury which results in hospital confinement;
2. ordered by the attending physician; and
3. performed in a facility accepted by the hospital in place of the same tests, which would otherwise be done while the Covered Person is hospital-confined; not duplicated when the Covered Person is in the hospital.

Facility Outpatient

Free-Standing Surgical Facility charges for surgical procedures performed by a physician including charges incurred for covered related services and supplies furnished on the day of surgery. If the office or facility does not meet the definition of a freestanding surgical facility as defined in this book, surgical facility charges will not be covered.

Physician

Physician charges for surgery or medical treatment including eligible charges for an **Assistant Surgeon** as long as the charges are deemed an eligible benefit.

Physician charges will also include the insertion and/or removal of physician inserted contraceptive devices and implants. The plan will also cover the cost of physician inserted contraceptive devices/ implants.

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

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

Second Surgical Opinion Benefit - If a Covered Person obtains and provides the Plan with a written second surgical opinion prior to a covered surgical procedure concerning the need for a surgical procedure, then the deductible will not apply to expenses incurred for the opinion and usual and reasonable charges will be paid in full if the services are incurred using a Network provider. This benefit does not include any diagnostic tests or x-rays ordered by the physician making the second opinion. Such diagnostic tests and x-rays are subject to the deductible and copayment percentage.

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

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

Prescription

Outpatient Prescription Drugs when purchased through the Prescription Drug Card Program. *See the Retail Prescription Drug Benefit Schedule of Benefits for complete details.*

SpecialtyRx/Biotech Medications under the Medical plan will be covered when provided by a Network provider. The Medical plan will not consider SpecialtyRx/biotech provided by Non Network providers. The applicable copay does not apply towards the Medical plan out of pocket and the copay will apply even when the Medical plan out of pocket has been satisfied. This benefit is limited to a thirty (30)-day supply per copay and is in addition to the benefits available under the prescription plan. Refer to the specific Prescription Schedule of Benefits for copay information that applies to this benefit.

Major Medical

Lab & X-ray charges.

Sonograms - more than three (3) per pregnancy will require Notification to determine benefit eligibility.

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

Chiropractor (DC) charges for treatment of an illness or injury by manipulation of the spine and appropriate treatments, subject to the maximum as shown on the Summary of Benefits and Coverage.

Nursing Services (Subject to any maximums as shown on the Summary of Benefits and Coverage)

1. Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) for professional nursing services.
2. Inpatient private duty nursing.
3. Advanced Nurse Practitioner (ANP) for nursing services including charges as an assistant in surgery. If assisting in surgery the assistance must meet benefit eligibility guidelines.
4. Registered Nurse First Assistant (RNFA) if assisting in surgery. The RNFA must meet benefit eligibility guidelines.

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

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

Inpatient Physical and/or Occupational Therapy services prescribed by a physician to restore or improve a previous level of body function. Inpatient therapy services must be performed or rendered at a hospital or licensed health care facility by a licensed Physical or Occupational Therapist or Physician.

Outpatient Physical and/or Occupational Therapy services by a licensed practitioner and prescribed by a physician to restore or improve a previous level of body function. Outpatient therapy services must be performed or rendered at a hospital, licensed health care facility or at home by a licensed Physical or Occupational Therapist. Charges are subject to the combined maximum as shown on the Summary of Benefits and Coverage.

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

Outpatient Speech Therapy services by a licensed practitioner and prescribed by a physician to restore or rehabilitate speech loss or impairment caused by injury or physical illness, following surgery, or congenital defect. Charges are subject to the maximum as shown on the Summary of Benefits and Coverage.

Aquatic Therapy – charges for evidence based aquatic services, when prescribed by a Physician and performed by a licensed practitioner. Must be direct, one-on-one treatment. Outpatient charges are subject to the combined maximum as shown on the Summary of Benefits and Coverage.

Licensed Professional Ambulance - services to the nearest hospital or emergency care facility equipped to treat a condition requiring immediate care. This does not include transportation for non-emergency medical services. The benefit is subject to the maximums as shown on the Summary of Benefits and Coverage.

Artificial Limbs or Prosthetic Appliances - limited to the usual and reasonable charges of standard models as determined by Medical Intelligence.

Custom Molded Foot Orthotics – One (1) pair every thirty-six (36) months, unless there is a medically documented physiological change.

Surgical Sterilization charges.

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

Blood storage - of personal blood when in connection with scheduled surgery or procedure covered under the Plan.

Eligible care provided during **Clinical Trials**.

Infertility Diagnostic services**.**

Durable Medical Equipment - standard rentals and purchases that are limited to the lesser of contractual charge, Usual and Reasonable fee schedule or cost of standard model items. Charges for the rental of Durable Medical Equipment in excess of the purchase price are not covered. Charges where purchase or rental exceeds $1,000 per piece of equipment require Notification to Medical Intelligence prior to purchase or rental. One per lifetime replacement of non-warranty equipment, prosthetic, non-foot orthotics, implantable and/or removable auditory and/or ocular prosthetics will be an eligible benefit if lost, stolen, or damaged beyond repair in an accident or a natural disaster. Proof of damage or theft will be required. If equipment is worn out, replacement of equipment will be considered if the equipment exhausts the three (3)-year equipment lifetime requirement. Physiological and/or technological medical necessity approval will be required for replacement of equipment prior to the three (3)-year lifetime replacement timeline.

Cardiac Rehabilitation - a program of clinically supervised exercise designed to strengthen the heart and improve cardiovascular functioning.

Oral Surgery - limited to the following maxillofacial surgical procedures:

1. The excision of non-dental related neoplasms, including benign tumors and cysts and situations where proper medical evidence indicates a tumor or cyst but one is not actually present, and all malignant lesions and growths;
2. The incision and drainage of facial cellulitis;
3. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses;
4. Reduction of, a dislocation of, excision of, and injection of the temporomandibular joint; and
5. Repair or alleviation of damage to sound natural teeth caused solely by accidental bodily injury, other than a chewing injury, sustained while covered under the Plan and treated within twelve (12) months of the injury.

Treatment of Temporomandibular Disorders (TMJ) - including treatment for any jaw joint disorder, TMJ disorder, craniomaxillary or craniomandibular disorder or other conditions of the joint linking the jaw bone and skull is payable for medically necessary eligible expenses limited to:

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

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

Hearing Evaluation/Test - The plan will cover hearing evaluations and tests with a non-routine diagnosis with no limit. Routine hearing tests are eligible under the Preventive Care benefit.

Charges for **Newborn Hearing Screening, Diagnosis and Treatment**- a screening test to determine hearing loss is covered for a newborn child from birth through the date the child is thirty (30) days old. Diagnosis and treatment is covered for Covered Persons from birth through the date the child is two (2) years old.

Orthomolecular medicine or **chelation therapy** - for acute metal poisoning.

Wig - for oncology treatment, subject to the maximum as shown on the Summary of Benefits and Coverage.

Breast Prosthesis/Prosthetic Bra - for oncology patients, subject to the maximum as shown on the Summary of Benefits and Coverage.

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

Treatment of sleep disorders - including but not limited to sleep apnea or narcolepsy. The plan limits sleep center evaluations to one per lifetime. Durable medical equipment and office visits are not subject to the sleep center limit.

Lenses - for initial removable contact lenses or glasses required following cataract surgery. Standard implantable ocular prosthetics to treat complex corneal diseases.

Cosmetic Surgery - for eligible benefits in connection with:

1. treatment of an accidental injury;
2. for reconstruction incidental to or following surgery resulting from an injury or illness; and
3. treatment of a congenital abnormality that results in a functional defect.

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

Treatment of Morbid Obesity - will be considered under the plan as follows, Morbid Obesity will be defined as a condition for which a Covered Person, eighteen (18) years of age or older, is 200% over ideal weight or one hundred (100) pounds overweight with a Body Mass Index (BMI) of greater than forty (40). A Notification Review is required to review the eligibility for the medically evidenced based surgical procedure. This review requires documentation of six (6) consecutive months (within the most recent twelve (12) months) of a physician-supervised weight management program that must include but is not limited to nutritional education and a physical activity program.

The covered individual, treating physician or family member must provide information for the Medical Intelligence review prior to any surgical treatment.

The covered person, treating physician or family member must provide information for the Medical Intelligence pre-determination review. Failure to do so will result in no benefit coverage for morbid obesity services.

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 will not be paid if the procedure is an Unproven Medical Procedure as defined in this booklet.

Eligible Morbid Obesity expenses incurred will be covered subject to Medical Intelligence approval and Plan limitations. Under this provision, the Morbid Obesity benefit includes the pre-treatment evaluation, medical and surgical treatment for 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 have been accredited. The Centers and physicians must also participate in the UnitedHealthcare Choice Plus Network for IEBP Plan to consider them as a designated provider.

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

Cornea transplant charges.

Infusion Therapy charges.

Charges for **Diabetes Equipment, Orthopedic Shoes** which are required due to diabetic condition, **and Diabetes Self-Management Education** for Covered Persons who have been diagnosed with:

1. Insulin dependent or non-insulin dependent diabetes.
2. Elevated blood glucose levels induced by pregnancy.
3. Another medical condition associated with elevated glucose levels.

Genetic Testing - for medically necessary evidence based testing to direct treatment (after diagnosis has been established) for amniocentesis and evidence based BRCA test.

Contraceptive devices - which are physician inserted, including but not limited to IUDs, implantable contraceptive devices (e.g., Norplant), and injectable contraceptives (e.g., Depo Provera). Coverage includes the cost of the injection, device, and/or drug, at no cost share to the covered member.

Women's Preventive Health Services – The following will be processed for Network Reimbursement at 100% of Network allowable (unless otherwise specified). The provider's bill must designate or outline a routine diagnosis code. Non-Network provider eligible billings will be subject to Usual and Reasonable charges and Non-Network deductible and benefit percentage.

Benefit	Retail Rx Medical Plan	Prescription Plan	
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 and Hysterosalpinography services related to the fitting *(no cost share)*	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 *(no cost share)*		X	
Over-The-Counter (OTC) Contraceptives (e.g., contraceptive films, foams, gels, etc.)		X	
Contraceptive Management *(no cost share)*	X		
Female Condoms *(no cost share)*		X	
Female Surgical Sterilization *(no cost share)*	X		
Medications for risk reduction of breast cancer in women (age thirty-five (35) and older) 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.			

Preventive/Routine Care Benefit

Routine checkups for the purpose of monitoring health, tests and procedures are listed below. The routine procedures will be reimbursed per the Summary of Benefits and Coverage, subject to usual and reasonable charges. The provider administration cost of immunization is also covered. To be considered under this benefit, the provider's bill **must** designate a routine diagnosis code. **This routine list is a guideline but is not an all-inclusive list.**

This benefit excludes coverage for virtual colonoscopies and genetic testing (unless listed otherwise).

Tests/Procedures

- Routine Physical
- Routine Venipuncture
- Routine Hearing Exam
- Routine Vision Exam *(refractions are not covered)*
- Breast cancer annual chemoprevention counseling for women at high risk
- Genetic Counseling for BRCA testing
- BRCA testing for women with or without any history of BRCA related cancer
- General Health Panel
- Coronary Risk Profile (lipid panel)
- Urinalysis
- (TB) Tuberculosis test
- Handling of specimen to/from physician's office to a laboratory
- Occult Stool Test
- Chest X-Ray (front & lateral)
- ECG (electrocardiogram)
- Digital Rectal Exam
- Bone Density Screening
- Skin Cancer Counseling
- Autism Screening – eighteen (18) and twenty-four (24) months of age
- Developmental Screening for Children under three (3) years of age
- Mammogram
- PSA (Prostate Specific Antigen test)

Colorectal Examination - Coverage for the medically recognized screening examination for the detection of colorectal cancer for covered individuals at any age who have a personal or family history of polyps (or colon cancer), or who are at normal risk for developing colon cancer. This benefit includes expenses incurred while conducting a medically-recognized screening examination for the detection of colorectal cancer. In addition, the Colorectal Examination benefit will also apply for the first non-routine colorectal exam claim received during the five/ten (5/10) year time period as noted below.

This includes annual fecal occult blood tests and a flexible sigmoidoscopy performed every five (5) years with a family or personal history of polyps (or colon cancer) or a colonoscopy performed every ten (10) years. This benefit excludes coverage for virtual colonoscopies.

This plan will also cover more frequent colonoscopies, sigmoidoscopies and fecal occult blood tests for all covered individuals at any age, with no limits at regular plan benefits, including when they are billed with a non-routine diagnosis. This includes when they are billed with a diagnosis of personal or family history of polyps (or colon cancer).

Immunizations

The following Network eligible immunizations and administrative fees are reimbursable at 100% of the allowable. Non-Network eligible billings are subject to Usual and Reasonable charges and the Non-Network deductible and benefit percentage. Allergy injections and expenses related to routine newborn care are not considered as part of this benefit. This list is a guideline.

Immunizations/Inoculations

- DT (Diphtheria and Tetanus Toxoids)
- Td (Tetanus) booster
- MMR (Measles, Mumps, Rubella)
- MMR booster
- Poliomyelitis Vaccine
- Oral Polio
- Varicella Vaccine (Chicken Pox)
- Influenza
- Hepatitis B
- Pneumococcal
- Pneumovax (Pneumonia)
- Pediarix (Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Hepatitis B (Recombinant) and Inactivated Poliovirus Vaccine Combined)
- HIB (Haemophilus influenza B)
- Small Pox immunizations
- Shingles Vaccine (Shingrix)
- Rotavirus
- Human Papillomavirus (HPV) vaccinations

Hospice Care Benefit

(Please see Notification requirements)

The Plan will pay for the usual and reasonable charges for hospice care services provided in accordance with a hospice care program to a terminally ill Covered Person and members of the immediate family. Medical Intelligence must receive Notification prior to hospice care commencement.

A hospice program must be established, approved, and reviewed in writing by the attending physician and certified by the attending physician that proper treatment of the disability would otherwise require confinement as an inpatient in a hospital or extended care facility in the absence of the services and supplies provided by the hospice care program.

Hospice care expenses are paid per the Summary of Benefits and Coverage. These benefits are subject to the deductible if the hospice stay or services meet all of the following:

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

Expenses related to Hospice care are subject to the maximums as shown on the Summary of Benefits and Coverage.

Home Health Care Benefit

(Please see Notification requirements)

To be a covered benefit, a home health care plan must be in writing and ordered by the attending physician and certified by Medical Intelligence that proper treatment of the disability would otherwise require confinement as an inpatient in a hospital, extended care facility, or rehabilitative hospital in the absence of the services and supplies provided as part of the home health care plan. Home Health care expenses are paid per the Summary of Benefits and Coverage and are limited to one hundred (100) visits per Calendar Year. Charges from Non Network providers are also subject to a daily maximum as shown the Summary of Benefits and Coverage. Multiple professional visits in a single day may be arranged by Medical Intelligence.

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

1. skilled nursing care under the supervision of a physician or registered nurse (RN);
2. certified home health aide services for other than custodial care;
3. rehabilitative therapy, and respiratory therapy provided by the home health care agency;
4. nutrition counseling provided by or under the supervision of a registered dietitian;
5. social worker to assess and identify community resources; and
6. physician services if the patient is homebound and physician homebound intervention is medically necessary.

Supplies, nutritional counseling (provided by or under the supervision of a registered dietitian), durable medical equipment, physical therapy, occupational therapy and speech therapy are not included in the one hundred (100) visit calendar year home health care maximum, are not subject to any other calendar year limits when they are provided through Home Health Care. If prescription medication is part of the Home Health Care Plan, please refer to the Prescription Drug Schedule of Benefits for coverage information.

TRANSPLANT BENEFIT

Transplant benefits provided at an OptumHealth/Centers of Excellence/Designated Transplant Center differ from those provided at a Non-Designated Transplant Center. At least ten (10) working days prior to any pre-transplant evaluation, the covered individual or a family member must provide Notification to Medical Intelligence; failure to do so will result in a late notification penalty of $500.

If the organ transplant is performed at a Non-Designated Transplant Center or Medical Intelligence is refused, the pre-transplant, transplant and post-transplant care will not be covered.

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

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

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

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

Transplant Center

The transplant must be performed at a hospital or facility designated by the Plan as an OptumHealth/Centers of Excellence/Designated Transplant Center. A list of such hospitals may be obtained from Medical Intelligence.

This benefit will cover charges resulting from organ transplantation at a Plan-Designated Transplant Center plus charges for:

1. travel (if more than one hundred (100) miles one way to hospital or facility from the covered person's home address);
2. organ transportation;
3. donor medical expenses not covered under the donor's plan of benefits;
4. locating and preserving the tissue for the transplant procedure;
5. fees for maintenance on an organ transplant waiting list; and
6. lodging (if more than one hundred (100) miles one way from hospital or facility from the covered person's home address).

Reimbursement

Reimbursement requests for travel and lodging shall be submitted on an Expense Activity Report to Medical Intelligence. Reimbursement for food will be calculated and dispersed by the Benefits Administrator based on travel and lodging information as submitted on the Expense Activity Report. All benefits under this provision, not directly billed to the Benefits Administrator, will be paid to the Employee. The maximum travel, food and lodging benefit for the covered individual is $10,000 and $5,000 for an eligible companion. Eligible companion is a person of the covered individual's choice.

Travel

Eligible travel expenses (ground, air transportation, lodging and food) will only be reimbursed for the covered individual or eligible companion if they live more than one hundred (100) miles from the hospital or facility designated by the Plan as an OptumHealth/Centers of Excellence/Designated Transplant Center. Private vehicle use will be reimbursed at the maximum allowable amount determined by the Internal Revenue Service and reimbursement is limited to travel between home and the OptumHealth/Centers of Excellence/Designated Transplant Center. Airfare will be reimbursed at cost. The purchase of commercial airline tickets may be arranged by Medical Intelligence.

The Plan provides for ground or air transportation of the covered individual to and from the pre-transplant evaluation, organ transplantation and any other Eligible Benefit or follow-up appointment.

The Plan provides for ground or air transportation of each eligible companion to and from the pre-transplant evaluation, organ transplantation and any other eligible provider services or follow-up appointment.

Lodging

The Plan will pay for the covered individual's lodging when not hospital confined and the eligible companion's lodging when the patient is confined to an OptumHealth/Centers of Excellence/Designated Transplant Center. Receipts will be required for reimbursement.

Food

The Plan will pay for the covered individual and eligible companion's food during transplant-related outpatient treatment that is an Eligible Benefit and the eligible companion's food during transplant-related inpatient treatment that is an Eligible Benefit at an OptumHealth/Centers of Excellence/Designated Transplant Center up to a maximum rate of $35 each per day (not to exceed a maximum of $3,500).

Non-Plan Designated Transplant Center

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

Mental Health Conditions

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

Outpatient Benefit

The Plan will reimburse up to twenty-six (26) individual or group therapy sessions (outpatient visits per calendar year) for the eligible treatment of a mental nervous condition.

Intensive Outpatient Therapy Program

The Intensive Outpatient Therapy individual or group sessions will accumulate to the mental health visit benefit calendar year maximum of twenty-six (26) visits. The program must treat the Covered Person sixteen (16) hours per week or a three (3) hour daily session.

Inpatient Benefit

An inpatient confinement requires Notification by Medical Intelligence. Please see the Notification requirements in the Cost Containment section. The Plan will reimburse up to fifteen (15) inpatient days each calendar year for the benefit eligible treatment of a mental nervous condition.

Alternative Settings Benefit

Residential Treatment is considered an inpatient confinement and requires Notification by Medical Intelligence. Please see the Notification requirements in the Cost Containment section. The Plan will reimburse up to fifteen (15) inpatient days each calendar year for the benefit eligible treatment of a mental nervous condition while confined in a residential treatment center and are subject to the following restrictions:

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

Day Treatment

The Plan will reimburse up to fifteen (15) inpatient days each calendar year for the benefit eligible treatment. Day treatment is counted 2:1 towards the inpatient day limit. The facility must treat a Covered Person 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 certify that such treatment is in lieu of hospitalization. **Notification by Medical Intelligence is required. Please see the Cost Containment section.**

Serious Mental Health

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

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

Substance Use Disorder Benefit

The plan provides benefits for the treatment of Substance Use Disorders. The Substance Use Disorder benefit is limited to a maximum of three (3) lifetime treatment series that may include: inpatient detoxification, inpatient rehabilitation or treatment, partial hospitalization, intensive outpatient, outpatient, 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.

DATES OF ELIGIBILITY AND COVERAGE

Enrollment Requirements

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

Qualifying Events/Open Enrollment

During the plan year, certain qualifying events will permit an employee to enroll themselves and/or add a dependent(s) other than during Open Enrollment. Documentation must be submitted when requested. Qualifying Events are applicable only if the Covered Person had prior health care coverage, except for birth and adoption of a child. These qualifying events are as follows:

1. marriage;
2. within thirty-one (31) days of the birth or adoption of a child;
3. loss of coverage, due to loss of eligibility, under Medicaid or SCHIP;
4. becoming eligible for Medicaid or SCHIP assistance with payment for coverage under this Plan;
5. loss of coverage due to termination of a spouse's employment;
6. loss of coverage because your spouse changes from full-time to part-time employment;
7. loss of coverage because your spouse takes an unpaid leave of absence;
8. loss of coverage because a dependent no longer meets the Patient Protection and Affordability Act's definition of a full time equivalent employee: thirty (30) hours a week, one hundred thirty (130) hours a month and/or one hundred twenty (120) seasonal days a year for employers with fifty (50) or more employees; or
9. significant change in the cost or coverage of your spouse's health plan.*

   **** Significant change means the cost of the spouse's health coverage increases by at least 10%.***

Employees must enroll the eligible dependent(s) within thirty-one (31) days of the qualifying event (sixty (60) days if the qualifying event is the loss of coverage under Medicaid or SCHIP or becoming eligible for payment assistance under Medicaid or SCHIP) or wait until the next open enrollment period. The dependent with the qualifying event is **not** the only individual who can be enrolled as a result of a qualifying event other than at open enrollment.

In addition Section 125 of the Internal Revenue Code significantly restricts the circumstances under which you may add, change, or even drop coverage once coverage for you and your Dependent(s) has become effective. Once your coverage has become effective, you may not add, change, or even drop your coverage unless it is a qualifying event as defined by the Internal Revenue Service.

Other Issues Affecting Eligibility and Coverage

Changes Requiring Notification

The following events may affect dependent coverage and require you to notify the Plan Administrator in these events:

1. marriage;
2. within thirty-one (31) days of the birth or adoption of a child;
3. divorce of the Covered Employee;
4. death of the Covered Employee;
5. dependent no longer meets the Plan's definition of Dependent; or
6. dependent reaches age twenty-six (26). Coverage for these dependents will be terminated at end of the month.

You must notify your employer if you wish to voluntarily drop dependent coverage. Forms for reporting these changes are available from your employer.

Mentally or Physically Handicapped Children

If a child of a Covered Person reaches twenty-six (26) years of age, at which time coverage would normally terminate, but the child is mentally or physically incapable of supporting themselves and primarily dependent upon you for support, coverage may be continued. You must submit satisfactory proof of the child's incapacity to the Plan Administrator within thirty-one (31) days of the date the child reaches age twenty-six (26). Coverage may continue for such child as long as the incapacity continues, subject to payment of the required contribution and all other terms of the Plan.

The Plan Administrator may require satisfactory proof of the continued incapacity. The Plan Administrator or Benefits Administrator may have a physician examine the child or may request proof to confirm the incapacity, but not more often than once a year. If you fail to submit proof when reasonably required or refuse to allow the Plan Administrator or Benefits to examine the child, then coverage for the child will terminate.

EMPLOYEE ELIGIBILITY

For Active Employees

Eligible Employees

Active Employees are eligible for coverage under the Plan, if they have completed ninety (90) days of continuous active employment with the City of Brownsville.

To receive coverage, you must enroll within thirty-one (31) days of the commencement of your employment, unless you elect to waive coverage. Coverage will become effective on the ninety-first (91st) following the ninety (90) day Waiting Period. Coverage is not effective on the date of hire.

Example:
Samantha starts work at the City on March 9th as an Active Employee. Her ninety (90) day Waiting Period is over on June 7th, and her coverage will become effective on June 8th.

Covered Employees are eligible as long as:

1. the Covered Employee an Active Employee (as defined by this plan) of the City of Brownsville;
2. the Covered Employee is and continues to be actively employed by the City of Brownsville; and
3. the Covered Employee receives compensation for the work performed for the City of Brownsville.

A person who is eligible for coverage under the plan as an employee may elect to be covered under their spouse's plan as a dependent if their spouse also works for the City of Brownsville and is covered under the plan if this election is made:

- During the employee's initial enrollment period following the ninety (90) day Waiting Period;
- During Annual/Open Enrollment; or
- Due to a Qualifying Event as defined by the Internal Revenue Service.

In addition, at the time of the employee's first enrollment period, a person who is eligible for coverage under the plan as an employee may elect to be covered under their parent's plan as a dependent providing they have not yet attained age twenty-six (26), if their parent also works for the City of Brownsville and is covered under the plan.

Please note that when an employee elects to be covered as a dependent, they will no longer be viewed as an Active Employee's under the plan, and will instead be considered a dependent under the plan.

The First Enrollment Period

If the Plan Administrator receives your signed written request to enroll on, before or within thirty-one (31) days from the day you become eligible, you will become covered on the later of:

1. the day you become eligible; or
2. the day the Plan Administrator receives your request;

provided you are actively at work on that day. If you are not actively at work on that day, your coverage will begin on the day you return to active work.

Subsequent Enrollment Periods

Annual open enrollment periods will be allowed in which you may elect or change benefits.

The annual open enrollment period is designated by the Plan Administrator and in no event is more than thirty-one (31) calendar days.

Confinement Rule

If you are:

1. hospital confined;
2. confined in any institution/facility other than a hospital due to
3. confined at home and under the supervision of a physician;
4. coverage will begin on the day after such confinement ends.

If you are:

1. not confined; and
2. not available for work because of injury or sickness;
3. coverage will begin on the day you return to active work.

Exceptions

1. If, on the day your coverage is to begin:
   a. you are on a regular paid day of vacation; or
   b. such day is a regular non-working day;

   you will still be considered actively at work if you were available for work on the last preceding regular work day.
2. If, on the day your coverage is to begin you do not report to work, you will be considered actively at work if you are available for work on that day.
3. If your customary place of employment is at your home you will be considered actively at work if you are not confined on that day (as described in the Confinement Rule below).

When Coverage Ends

Your coverage will end at midnight on the earliest of:

1. the day the Plan ends;
2. the day any contribution for your coverage is due and unpaid;
3. the day you are terminated for gross misconduct; or
4. the last day of the Plan month in which you are no longer eligible under the Plan (other than for gross misconduct). You will no longer be eligible when:
   a. you are no longer in an eligible class; or
   b. you do not satisfy:
      - the requirements for hours worked (are not an Active Employee); or
      - any other eligibility condition in the Plan.

RETIRED EMPLOYEE ELIGIBILITY

For Retired Employees

Retired Employees may only cover dependents that were on the Plan at the time the Covered Person's Retirement. Retirees are not permitted to add or change dependent coverage at the time of retirement or thereafter. Qualifying Events and Family Status Changes are not applicable to Retired Employee's and their dependents.

Eligible Employees

Persons who retiree on or after Oct 1, 2013 will need to have at least twenty (20) years of service with the City of Brownsville.

When Your Coverage Begins

If the Plan Administrator receives the signed written request on, before or within thirty-one (31) days from the day the Retired Employee becomes eligible, the Retired Employee will become covered on the later of:

1. the day the Retired Employee becomes eligible; or
2. the day the Plan Administrator receives the request.

Changes in Classification or in the Amount of Coverage

Any changes in the Retired Employee's classification or coverage will take effect on the day of the change.

When Coverage Ends

Your coverage will end at midnight on the earliest of:

1. the day the Plan ends;
2. the day any premium for the coverage is due and unpaid;
3. the day the Retired Employee is no longer eligible under the Plan;
4. the end of the month that the Retired Employee attains age sixty-five (65) (regardless of Medicare eligibility); or
5. the day that the Retiree becomes eligible for primary group health coverage through another employer.

In addition, the Retired Employee will no longer be eligible when they do not satisfy any other eligibility condition in the Plan.

ACTIVE DUTY RESERVISTS

Active duty reservists or guard members and their covered Dependents can maintain eligibility on the Plan for up to twenty-four (24) months as prescribed by and subject to the terms and conditions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). The date on which the person's absence begins is the qualifying event for COBRA Continuation of Coverage to be offered to the reservist or guard member.

If a fire fighter or police officer is called to active duty for any period, the employing municipality must continue to maintain any health, dental or life coverage received on the date the fire fighter or police officer was called to active military duty until the municipality receives written instructions from the fire fighter or police officer to change or discontinue the coverage. Such instruction shall be provided no later than sixty (60) days following the Qualifying Event. If no such instruction is given, then coverage will terminate on the sixty-first (61st) day, which shall then become the Qualifying Event for COBRA Continuation of Coverage purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

In administering this coverage, IEBP will follow the time guidelines of Continuation of Coverage under 42 U.S.C.A. 300bb-1 *et seq*. To qualify for this coverage, the Employee must give written notice to the Employer within sixty (60) days of the qualifying event. The Employer must notify IEBP that an Employee has been called to active duty and submit a copy of the Member's Active Reservist Policy.

Under 38 USCA § 4316, an employee who is called for military leave may have rights to COBRA Continuation of Coverage for up to twenty-four (24) months and a right to reemployment once he/she is discharged from active military service.

If the Employee will be on active duty for thirty-one (31) days or less, the Employer will keep the Employee on the plan with no change in coverage. If the Employee will be on active duty for more than thirty-one (31) days, the Employer will notify IEBP of the qualifying event and attach a copy of the employee's written order for the call to duty.

The Employer must notify IEBP by sending a Qualifying Event Notice (and copy of the order) and mark the qualifying event "Called to Active Duty."

Section 143.072, Texas Local Government Code may require an employer to "continue to maintain" coverage on a police officer or fire fighter while he/she is on military leave if the employer has adopted civil service requirements and the leave has been approved by the Fire Fighters' and Police Officers' Civil Service Commission. This section only applies if the employer meets the requirements of Chapter 143 of that Code, including having a population of 10,000 or more and voted to adopt the applicable provisions of the law.

For the Employee nineteen (19) years of age or older to return to the Employer's plan and continue their benefits with no waiting period. The Employee must return to work within the time period required by state and federal law for such return.

The additional 2% of contribution is not charged for an Employee called to active duty.

DEPENDENTS ELIGIBILITY

Health Coverage - Dependents of Active Employees and Retired Employees

Retired Employees may only cover dependents that were on the Plan at the time the Covered Person's Retirement. Retirees are not permitted to add or change dependent coverage at the time of retirement or thereafter. Qualifying Events and Family Status Changes are not applicable to Retired Employee's and their dependents.

Eligible Dependents

Only the following are eligible for dependents coverage:

1. the Employee's lawful spouse;
2. the Employee's natural-born or legally adopted child;
3. the Employee's stepchild who is living in the Employee's home and is chiefly dependent on you for support;
4. a foster child; and
5. a grandchild.

A foster child is:

1. a child you are raising as your own;
2. a child who lives in your home;
3. a child who is chiefly dependent on you for support; and
4. a child for whom you have taken full parental responsibility and control.

A foster child is not:

1. a child temporarily living in your home;
2. a child placed with you in your home by a social service agency which retains control of the child; or
3. a child whose natural parent is in a position to exercise or share parental responsibility and control.

Adopted Child is:

A minor child, under the age of eighteen (18), placed with you for the purpose of legal adoption will be covered from the moment the child is placed in your custody.

Coverage for such child will not continue beyond thirty-one (31) days of placement unless any required premium has been paid to us before that thirty-first (31st) day.

The child's coverage will continue subject to any required premium until the earlier of:

1. the day the child is removed from your custody prior to legal adoption; or
2. the day coverage would otherwise end in accordance with the Plan provisions.

Placed for adoption means assumption and retention by the covered person of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

This provision is in addition to any other Adopted Child provision contained in the Plan.

When the parents of a child are covered under the Plan as employees or members, the child can be covered only as a dependent of one (1) parent.

Dependents Not Eligible

The following are not eligible for dependent coverage:

1. Your divorced spouse;
2. A child who has been legally adopted by another person shall not be considered an eligible dependent, (Coverage ends on the date custody is assumed by the adoptive parents);
3. A child who has attained age twenty-six (26). Coverage for these dependents will be terminated at end of the month; or
4. A person who no longer meets the definition of a Dependent.

The First Enrollment Period

If you want to cover your eligible dependents, you must make a written request for dependents coverage. If the Plan Administrator receives the signed written request to enroll your dependents on, before or within thirty-one (31) days from the day you become eligible, your dependents coverage will begin the same day your coverage begins.

At the time of the employee's First Enrollment Period, a person who is eligible for coverage under the plan as an employee may elect to be covered under their spouse's plan as a dependent if their spouse also works for the City of Brownsville and is covered under the plan. In addition, at the time of the employee's first enrollment period, a person who is eligible for coverage under the plan as an employee may elect to be covered under their parent's plan as a dependent providing they have not yet attained age twenty-six (26), if their parent also works for the City of Brownsville and is covered under the plan. Please note that when an employee elects to be covered as a dependent, they will no longer be viewed as an Active Employee's under the plan, and will instead be considered a dependent under the plan.

Newborn Children

If you acquire a newborn child, an enrollment form for the newborn for dependent coverage **must be completed and sent to the Plan Administrator within thirty-one (31) days of the birth**. Coverage for the newborn will be effective on the date of the birth. **The fact that you have other dependent children or a spouse covered does not automatically extend coverage to a newborn.**

Medical Child Support Order

If your eligible child is not covered because you did not enroll your child for dependents coverage, such child may be enrolled after the Plan Administrator: (a) receives a final medical child support order which requires enrollment and (b) determines that the order is qualified.

Our Procedures for Determining if a Medical Child Support Order is Qualified

When the Plan Administrator receives a proposed or final medical child support order, the Plan Administrator will notify you and each child named in the order, at the addresses shown in the order, that they have received it. The Plan Administrator will then review the order to decide if it meets the definition of a "qualified medical child support order". Within thirty (30) days after they receive the order (or within a reasonable time thereafter), you will be given a written notice of the decision to you and each child named in the order.

The Definition of "Qualified Medical Child Support Order"

A "qualified medical child support order" is defined by Section 609 of ERISA. In general, a **"Qualified Medical Child Support Order" means** any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

1. either:
   a. relates to medical benefits under the Plan and provides for your child's support or health benefit coverage pursuant to a state domestic relations law (including a community property law); or
   b. enforces a law relating to medical child support described in Section 1908 of the Social Security Act;
2. creates or recognizes the existence of your child's right to be enrolled and receive medical benefits under the Plan;
3. states the name and last known mailing address (if any) of you and each child covered by the order;
4. reasonably describes the type of medical coverage to be provided by the Plan to each child, or the manner in which this type of coverage is to be determined;
5. states the period to which the order applies;
6. states each Plan to which the order applies; and
7. does not require the Plan to provide any type or form of benefit or any option not otherwise provided by the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act for medical child support orders.

When Dependents Coverage Ends

A dependent's coverage will end at midnight on the earliest of:

1. the last day of the Plan month the dependent is no longer eligible;
2. the day any dependent premium is due and unpaid;
3. the day the Plan ends;
4. the day dependents coverage under the Plan ends because of lack of participation; or
5. the day the Employee's coverage ends.

NOTE: Your covered spouse and/or any covered dependent child may also elect to continue health coverage when eligibility ends. See the COBRA Continuation of Coverage (COC) provision found later on in this Booklet. In the event more than one (1) continuation provision applies, the periods of continued coverage will run concurrently.

COBRA CONTINUATION OF COVERAGE (COC) RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA Continuation of Coverage (COC), which is a temporary extension of coverage under the Plan, as well as information about other health coverage alternatives that may be available to your through the Health Insurance Marketplace. This notice generally explains Continuation of Coverage when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to Continuation of Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Continuation of Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan book or contact TML MultiState IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800)282-5385.

What is COBRA Continuation of Coverage?

COBRA Continuation of Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 depending on the policy of your employer.

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

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

If you are the spouse of the employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

Any decision of whether an Employee was terminated because of gross misconduct will be made by the Employer. The Employer may not change its decision on whether or not a termination was for gross misconduct later than the forty-fifth (45th) day after the date employment terminated or the date a COBRA Continuation of Coverage election notice was mailed to the employee, whichever is earlier. Any determination of gross misconduct shall be based on events that occurred prior to the termination of employment.

Sometimes, filing a proceeding in bankruptcy under Title II of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer and the bankruptcy results in the loss of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see that your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA Continuation of Coverage does not limit your eligibility for coverage for a tax credit through the marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request your enrollment within thirty (30) days.

When is COBRA Continuation of Coverage available?

The Plan will offer COBRA Continuation of Coverage to qualified beneficiaries only after the Benefits Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the employer must notify the Benefits Administrator (IEBP) of the qualifying event.

You must give notice of some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within sixty (60) days after the qualifying event occurs. Notice must be provided to: TML MultiState IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385.

How is COBRA Continuation of Coverage provided?

Once the Benefits Administrator (IEBP) receives notice that a qualifying event has occurred, COBRA Continuation of Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect Continuation of Coverage. Covered employees may elect Continuation of Coverage on behalf of their spouses, and parents may elect Continuation of Coverage on behalf of their children.

Continuation of Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (Part A, Part B or both), your divorce or legal separation or a dependent child's losing eligibility as a dependent child, Continuation of Coverage lasts for up to a total of thirty-six (36) months. When the qualifying event is the end of the employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, Continuation of Coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, Continuation of Coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six (36) months minus eight (8) months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, Continuation of Coverage generally last for only up to a total of eighteen (18) months. There are three (3) ways in which this eighteen (18) month period of Continuation of Coverage can be extended.

Active Duty Reservists

If covered by the plan as an employee at the time of call to active duty, active duty reservists or guard members and their covered dependents can maintain eligibility on the Plan for up to twenty-four (24) months as prescribed by and subject to the terms and conditions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). The date on which the person's absence begins is the qualifying event for COBRA Continuation of Coverage (COC) to be offered to the reservist or guard member.

If a fire fighter or police officer is called to active duty for any period, the employer must continue to maintain any health, dental, or life coverage received on the date the fire fighter or police officer was called to active military duty until the employer receives written instructions from the fire fighter or police officer to change or discontinue the coverage. Such instruction shall be provided no later than sixty (60) days following the Qualifying Event. If no such instruction is given, then coverage will terminate on the sixty-first (61st) day, which shall then become the Qualifying Event for COBRA Continuation of Coverage purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

In administering this coverage, IEBP will follow the time guidelines of COBRA Continuation of Coverage under 42 U.S.C.A.300bb-1 *et seq*. To qualify for this coverage, the employee must give written notice to the employer within sixty (60) days of the qualifying event. The employer member must notify IEBP that an employee has been called to active duty and submit a copy of the employer member's active reservist policy to IEBP.

Disability extension of COBRA Continuation of Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator (the City) in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of Continuation of Coverage for a total maximum of twenty-nine (29) months. The disability must start at some time before the sixtieth (60th) day of Continuation of Coverage and must last at least until the end of the eighteen (18) or twenty-four (24) month period of Continuation of Coverage. You may contact IEBP about a disability determination at 1820 Rutherford Lane, Suite #300, Austin, Texas 78754 or by telephone (800) 282-5385.

Second Qualifying Event extension of COBRA Continuation of Coverage

If your family experiences another qualifying event while receiving eighteen (18) or twenty-four (24) months of Continuation of Coverage, The spouse and dependent children in your family may get up to eighteen (18) additional months of Continuation of Coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving Continuation of Coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B or both) or gets divorced or legally separated, of if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions

Questions concerning your Plan or your Continuation of Coverage rights should be addressed to the contact or contacts identified below. State and local government employees seeking more information about their rights under COBRA Continuation of Coverage, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, can contact the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services at:

- https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_fact_sheet.html; or
- https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html#COBRA

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Sponsor.

Plan Sponsor Contact Information

City of Brownsville **|** 1001 E. Elizabeth St. **|** Brownsville, Texas 78520

GENERAL EXCLUSIONS AND LIMITATIONS

Exclusions and limitations listed in this provision apply to provisions throughout the Plan, the Booklet and any Plan Changes. Exclusions and limitations that are used in other provisions may be found in those provisions.

No Benefits shall be payable under any part of this Plan with respect to any charges:

1. For which a Covered Person is not financially responsible or are submitted only because medical coverage exists or for discounts for which the Covered Person 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 Person is not under the regular care of a physician or does not follow the attending physician's treatment plan;
4. For expenses applied under this Plan toward satisfaction of any deductibles, copayments, benefit percentage or access charge;
5. In excess of usual and reasonable for services and supplies;
6. For treatment of any injury, illness, or disability, resulting from or sustained as a result of being engaged in a felonious act as defined by Texas law regardless of whether arrested, indicted or convicted. This exclusion will apply when the felonious act is proven by a preponderance of the evidence;
7. For treatment of any injury, illness or disability resulting from or sustained as a result of war or act of war, declared or undeclared;
8. For treatment of injuries resulting from Covered Person's participation in a riot or insurrection;
9. For treatment of any illness, injury, or disability reimbursement for which could have been available if pursued under benefits for Workers' Compensation whether or not the employer is a subscriber or non-subscriber in a Workers' Compensation Program. In applying this exclusion, work on the Covered Person's family farm or ranch is not considered an employment arrangement;
10. For eye examinations (in excess of the Calendar Year allowable) for the purpose of prescribing corrective lenses or determining visual acuity or for treatment of refractive errors, eye glasses or contact lenses (including the fitting thereof), orthoptics, vision therapy, or other special vision procedures including but not limited to Radial Keratotomy (RK) and Laser Assisted Intrastromal Keratomileusis (LASIK);
11. Incurred in connection with remedying a condition by means of cosmetic surgery or non-mastectomy reconstructive surgery, or a non-lumpectomy reconstructive surgery, or in connection with a prophylactic mastectomy without a cancer diagnosis, or in connection with a primary prophylactic oophorectomy without an appropriate bilateral diagnosis. This exclusion will not apply when evidence based BRCA testing is positive;
12. For vocational evaluation, rehabilitation or retraining;
13. For custodial care or maintenance care;
14. For any services furnished by any institution providing primarily convalescent or custodial care;
15. For repair and maintenance or replacement of durable medical equipment unless identified as an eligible benefit;
16. For home health care expenses that are for:
    a. custodial care;
    b. transportation services; or
    c. any period during which the Covered Person is not under the continuing care of physician;
17. For sex therapy, outpatient group family therapy, marriage counseling, or any other social services unless otherwise specified;
18. Connected with the treatment of infertility;
19. For elective abortions for Covered Persons except in the case of incest, rape, or situations which are life threatening to the mother;

20. For services related to intersex surgery (transsexual operations or gender reassignment) and any resulting complications;
21. For surgical procedures to reverse sterilization;
22. For personal comfort, convenience or safety items; including but not limited to, the purchase or rental of telephones; televisions; guest meals or cots; orthopedic mattresses; allergy-free pillows, blankets and/or mattress covers; non-hospital adjustable beds; waterbeds; structural changes to a house including tub rails and portable or fixed shower benches; purchase, rental or modification of motorized transportation equipment, manual or electronic lifts; elevators; escalators; or ramps;
23. For air purification, humidifying, cooling or heating equipment;
24. For exercising equipment, vibratory equipment, swimming or therapy pools, health club memberships, massage therapy, or hippotherapy;
25. Incurred in connection with acupuncture or acupressure;
26. For educational testing, educational therapy, hypnosis, biofeedback, recreational therapy or any behavior modification therapy;
27. For spinography or thermography;
28. For treatment of nicotine addiction or for any treatment, service or supply incurred or any therapy or training designed to curb or alleviate a personal habit;. This exclusion does not apply to benefits that may be available under the prescription plan;
29. For any surgical treatment of the temporomandibular (jaw) joint or jaw-related neuromuscular conditions not listed as a covered expense;
30. For care or treatment to the teeth, alveolar processes, gingival tissue, or for malocclusion and/or dental implants;
31. For any Orthognathic surgery, including any appliance, medical or surgical treatment for correction of malocclusion, or protrusion or recession of the mandible or maxilla or maxillary or mandibular hypoplasia or hyperplasia not listed as a covered expense;
32. For any drug therapy or health procedures meeting the definition of unproven as defined in this booklet;
33. For cosmetic hair loss treatment. This exclusion does not apply to the wig benefit for oncology related hair loss;
34. For drugs labeled: "Caution - limited by Federal law to investigational use" or unproven drugs;
35. For drugs and medicines lawfully obtainable without a physician's prescription (even if prescribed by a physician) including but not limited to vitamins, cosmetics, dietary supplements, supplies used for excluded benefits, nutritional formulas used as food replacement and over the counter home tests. This exclusion does not apply to benefits that may be available under the prescription plan;
36. For prescription drugs dispensed on an outpatient basis which are covered under a fixed copayment prescription drug card program (including copayments and any required payment differentials between generic and brand name drugs). This includes testosterone (all forms). This exclusion does not apply to SpecialtyRx/Biotech medications, which are eligible under the Medical plan;
37. For services rendered by any of the following relatives:
    a. spouse;
    b. parent(s), step-parent(s), or parent(s) in law;
    c. child (ren); or child(ren) in law;
    d. brother(s) or brother(s) in law;
    e. sister(s) or sister(s) in law;
    f. grandparent(s) or grandparent(s) in law;
    g. grandchild(ren) or grandchild(ren)-in-law;
    h. aunt(s) or uncle(s) or aunt(s) or uncle(s) in law;
38. For whole blood that is replaced and/or donated by or for the patient (does not exclude blood);
39. For claims or information submitted more than twelve (12) months after the date incurred;

40. For repair of hearing aids;
41. For cryotherapy machine to deliver cold therapy for home use;
42. For expenses for procedures incurred initially and as a result of complications due to a non-covered benefit under the Plan;
43. For non-custom molded foot orthotics;
44. For medications purchased in a foreign country if purchased for non-immediate services;
45. For penile prosthetic implants and devices (including external);
46. For employer-mandated immunizations, medical services or medical testing;
47. For expenses that exceed (in scope, duration or intensity) that level of care which is needed;
48. for services, medications, devices and supplies that are utilized solely for the accreditation of the facility;
49. For charges for internet medical management services and/or telemedicine, unless medical information is communicated in real-time with the use of interactive audio and video communications equipment, and is between the performing physician and a distant physician or health care specialist with the patient present during the communication;
50. For treatment or services provided outside the United States or its territories unless required for immediate care; and
51. For services or treatments that are excluded under any part of this Plan.

COORDINATION OF BENEFITS

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

The Coordination of Benefits (COB) provision applies when a Covered Person has health care coverage under more than one (1) plan. When you and/or your dependents are covered under more than one (1) plan, the combined benefits payable under all plans will not exceed 100% of the eligible expenses. Covered Persons under this Plan will periodically be required to complete a Coordination of Benefits Questionnaire. Failure to complete and return this information to the Benefits Administrator, when requested, may result in a delay or denial of the Covered Person's claims. For Medicare information, please refer to the section entitled "Coordination with Medicare."

For example:

- Charge = $100 (deductible already satisfied)
- The Plan's Allowable Amount = $100
- Primary Carrier Payment = $75
- The Plan's Payment = $25

Definitions

Plan means any arrangement which provides medical benefits or services (except school accident coverage) by means of:

1. any group coverage, including but not limited to:
    a. insurance or any arrangement of benefits for groups;
    b. prepayment coverage or any coverage toward the cost of which any employer makes contributions;
    c. a labor-management trusteed plan, union welfare plan, employer organization plan or employee organization plan;
    d. any governmental program or coverage required by statute;
    e. coverage for students sponsored by, or provided through a school or other educational institution; or
    f. non-motor vehicle coverage for expenses due to accidental bodily injury or disease to the extent to which payment as a settlement, judgment or otherwise is made by any person or their insurers without regard to whether or not liability is admitted.
2. individual plans that offer medical and hospitalization coverage that qualifies as minimum essential coverage under 26 USC 5000A(f)(1). This would exclude limited reimbursement policies such as supplemental policies under 26 USC 5000A(f)(3);
3. governmental programs other than Medicare, *(see "Coordination with Medicare")*

Employer Plan means the medical expense benefits provided by the City of Brownsville.

Primary means a plan which pays eligible expenses without regard to the existence of any other Plans.

Secondary means any plan which is not considered the primary plan when there are two (2) or more Plans covering the same person.

Applications

The Benefits Administrator will determine which plan is primary and which plan is secondary. The other plan will always be primary if that plan has no COB provision. When the Employer Plan is primary it will pay benefits as if it were the only plan. When the Employer Plan is secondary, it will pay a reduced benefit, which when added to the benefits paid by all other plans, will not exceed 100% of the total eligible expense covered by the Employer Plan.

In order to obtain all benefits available, a Covered Person should file a claim under each plan. The first claim should be filed with the primary plan and the explanation of benefits statement from this claim should be filed along with the claim to the secondary plan.

Special Rules

If both plans have a COB provision, the primary and the secondary plan will be determined according to the following rules:

1. The plan that covers a person as an employee or non-dependent (e.g. retiree) is primary to a plan that covers that person as a dependent.
2. The benefits of a plan which covers a child as a dependent of a parent whose birthday falls earlier in the year are determined before those of a Plan of the parent whose birthday falls later in the year. A person's year of birth is not relevant in applying this rule. If the other plan does not have this rule but instead has a rule based on the gender of a parent, and as a result the plans do not agree on he/she order of benefits, then the Benefits Administrator will determine the order of benefits.
3. The benefits of a plan covering a child of divorced or separated parents are determined in the following order:
    a. custodial parent;
    b. custodial step-parent;
    c. non-custodial parent.
    d. However, if there is a **court decree** which establishes financial responsibility for the health care expenses of a child, then the benefits of the plan which covers the parent with financial responsibility are determined before any other plan. In the case of divorce, a copy of the applicable portions of the divorce decree must be provided before benefits are payable.
4. The benefits of a plan for a covered employee (or a covered dependent) who is not laid off or retired are determined before the benefits of a Plan which covers such person (or dependent of such person) as a laid off or retired employee. If the other plan does not have this rule and as a result the plans do not agree on the order of benefit, this rule does not apply.
5. The plan covering the person as an employee or dependent of an employee will pay first before the plan providing Continuation of Coverage (e.g. COC).
6. When a dependent has coverage as both the dependent of an active employee and the dependent of a retiree, the plan of the active employee pays first.
7. If none of the above rules determine the order of benefits then the plan which has covered the person for the longest period of time pays first.

COORDINATION WITH MEDICARE

Definitions

Medicare - the health insurance provided by Title XVIII of the Social Security Act as amended.

Full Medicare Coverage – coverage under both:

1. Part "A" Hospital Insurance; and
2. Part "B" Medical Insurance.
3. Part "C" Choice provided by Medicare. If a person is eligible for either Part, he/she will be deemed to have Full Medical Coverage, even if he/she/she does not enroll for such coverage.

Coordination

If a Covered Person incurs covered expenses for which benefits are payable under this Plan, the Plan will determine if such coverage is primary or secondary to coverage provided by Medicare.

The Plan does not coordinate with Medicare Part C.

Primary means that the benefits payable under the Employer's Plan will be determined and paid without regard to Medicare.

Secondary means Medicare is primary and the Benefits Administrator will reduce its payment so that the total payable by full Medicare coverage and the Benefits Administrator will not exceed 100% of the actual Covered Expense.

Coverage under the City of Brownsville Plan of a Medicare eligible Covered Person will be primary only if:

1. the Covered Person is an active employee;
2. the Covered Person is a spouse of an active employee; or
3. the Covered Person is entitled to benefits under Medicare because of renal dialysis or kidney transplant. In this case, coverage under this booklet will be primary only during the first thirty (30) months of the period such person is so entitled.

The Benefits Administrator (IEBP) will determine which plan is primary. The Benefit Administrator's determination will be based on the status of the Covered Person on the date such covered expenses are incurred.

If a person does not:

1. enroll for Full Medicare Coverage; or
2. make due for Medicare benefits,

The Benefits Administrator will calculate the benefits that would have been paid by Full Medicare Coverage even if the Covered Person has not made application for Full Medicare Coverage.

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

THIRD PARTY REIMBURSEMENT AND/OR SUBROGATION

Other Party Liability

If you are injured (1) in an accident, regardless of who is at fault or (2) become ill, through the act or omission of another person, company or business and recover money from any source, you must reimburse the Plan for the benefits provided by the Plan whether or not the third party has admitted liability. For injuries from accidents on or after January 1, 2014, the plan shall be subject to Chapter 140 of the Texas Civil Practices & Remedies Code.

Contractual Right of Reimbursement

If a Covered Person is injured (1) in an accident, regardless of who is at fault or (2) become ill through the act or omission of another person, the Plan shall provide the benefits on the condition that the Covered Person cooperates with the Plan, its agents, subcontractors and attorneys by (a) providing notification of any accidental injury or illness which may involve another individual, business or insurance company; and (b) providing any information requested that is associated with the injury or illness.

In addition, the Covered Person specifically delegates to the Benefits Administrator the right to make a claim or assert a cause of action on the Covered Person's behalf against any source of recovery, and assigns to the Plan Administrator the right to any proceeds from the claim or cause of action.

"Source of recovery" shall include, but be limited to:

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

The Plan, based on the amount of the claim, indication of other insurance, or indication there may be another source to pay for the medical services required as a result of the injury or illness, may suspend payment of claims for the injury or illness. Payment of the claim(s), and future claims relating to the injury or illness will **only** resume if the Covered Person:

1. provides the information requested by the Plan;
2. agrees in writing not to settle damages whether by legal action, settlement or otherwise without first consulting with the Plan to determine the full and potential medical charges;
3. agrees in writing to reimburse the Plan immediately upon collection of damages whether by legal action, settlement or otherwise including, but not limited to, motor vehicle insurance;
4. agrees in writing to provide the Plan with a first lien on all proceeds recovered for this injury to the extent of benefits provided by the Plan;
5. agrees in writing to provide the Plan with a copy of any settlement agreement relating to this injury/illness if requested; and
6. agrees to cooperate fully with the Plan in asserting its right to subrogate. This means the Covered Person must supply the plan with all information and sign and return all documents reasonably necessary to carry out the Plan's right to recover from the third party any benefits paid under the Plan which are subject to this provision;
7. Agrees in writing that venue for all subrogation disputes shall be in Travis County, Texas; and
8. agrees in writing to provide IEBP with a copy of any settlement agreement relating to this injury/illness if requested; and
9. agrees to cooperate fully with IEBP in asserting its right to subrogate. This means the Covered Individual must supply IEBP with all information and sign and return all documents reasonably necessary to carry out IEBP's right to recover from the third party any benefits paid under the Plan which are subject to this provision; and
10. agrees to all provisions of the benefit Plan.

If the Covered Person accepts reimbursement or assigns benefits for an injury or illness for which money or benefits were received or paid by another source, and payment has also been made by the Plan, the Covered Person must reimburse the Plan the amount paid to the Covered Person or any provider for services or treatment for the injury or illness.

If the Covered Person does not reimburse the Plan, the amount not reimbursed may be withheld from future benefits.

Automobile Homeowners/Liability/Medical Payments Insurance Benefits

Benefits payable under this Plan may be adjusted by the Benefits Administrator for insurance benefits available for medical benefits, including no-fault medical payments uninsured motorist coverage if the coverage for such medical benefits is in the name of, paid for, or payable by a non-immediate family member whether or not any party has admitted liability.

Right of Recovery

The Benefits Administrator has the right to seek reimbursement on any overpayment from one or more of the following:

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

In addition, the Covered Person specifically delegates to the Benefits Administrator the right to make a claim or assert a cause of action on the Covered Person's behalf against any source of recovery, and assigns to the Group Administrator the right to any proceeds from the claim or cause of action.

Overpayment Provisions

Right of Offset

If the Benefits Administrator makes any payment on behalf of a Covered Person which is more than the amount needed to satisfy its obligation under the terms of this Plan, then the Benefits Administrator reserves the right to offset the overpayment against future benefits otherwise payable to a Covered Person or provider.

Fraud

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

DEFINITIONS

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

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

Active Employee - Means an employee who works and is paid by the employer for at least thirty (30) hours per week or is accessing vacation, sick, personal, paid time off, or paid/unpaid Family Medical Leave Act of 1993 (FMLA) and is receiving the same benefits as all other employees. Persons who are receiving long or short term disability payments or workers' compensation income benefits are not otherwise on the payroll of the employer are not active employees, nor do those benefits accrue toward the thirty (30) hour requirement.

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

An employee will be considered actively at work on any day when using sick leave, vacation/annual leave, personal leave, FMLA, up to one hundred and eighty (180) calendar days of compensable Workers' Compensation injury leave, and/or on approved leave without pay. Paid/unpaid leave per the Employer's policy may exceed a period of twelve (12) or more consecutive months. However, unpaid leave may not exceed a period of six (6) months.

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

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

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

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

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

Benefit - The amount applied to the deductible or payable by the Plan for a covered service or supply.

Benefit Percentage - The percentage of eligible expenses payable by the Plan.

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

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

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

Clean Claim - A claim for covered services that is received from a network provider that reflects the standard claim format, and accurately contains the following information: patient name, patient's date of birth, unique identification number, provider's name, address and tax ID number, national provider identification number, date(s) of service, diagnosis narrative or ICD code, procedure narrative or CPT codes, services and supplies provided, physician name and license number, provider charges and an itemized bill if the bill is in excess of $15,000 outpatient and $20,000 inpatient. Such itemized bill will be required to adjudicate the claim. Claim must be submitted by provider no later than the filing deadline. If the provider fails to submit the claim within compliance of the filing deadline and the clean claim definition the provider forfeits the right to payment unless the failure to submit the claim in compliance is a result of a catastrophic event that substantially interferes with the normal business operations of the network provider. A "Clean Claim" does not include a claim where integration/coordination of benefits is actively pursued, medical claims review is necessary, subrogation is pursued or where a work related condition may exist.

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

1. Phase I Trials – Medical researchers test the drug with a small group of people to discover its metabolic and pharmacologic actions in humans, as well as its safety, dosage and side effects. They also test the impact of increasing doses and early evidence of effectiveness. This trial may include healthy participants or patients.
2. Phase II Trials – This stage is a controlled clinical study that evaluates the effectiveness of the drug for a particular indication or indications in patients with the condition under study. During this stage, researchers test the new drug with a slightly larger group of people (one hundred (100) to three hundred (300)) to collect more information about its common short-term side effects, efficacy and risks.
3. Phase III Trials – The third stage expands controlled and uncontrolled trials after preliminary evidence suggests the effectiveness of the drug has been determined. Its purpose is to gather more information to evaluate the overall risk – benefit of the drug and provide a satisfactory basis for physician labeling. Researchers give the drug to an even bigger group (between one thousand (1000) to three thousand (3000) people) monitor its use, compare it to other treatments and further ensure its safety.
4. Phase IV Trials – Post marketing studies to identify additional uses for an FDA approved medication. The studies also identify the drug's risks, benefits and optimal use.
5. Well Conducted Clinical Trials – Trials in which two (2) or more treatments are compared to each other, and the patient or provider is not allowed to choose which treatment is received.

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

Controlled Substance - A toxic inhalant or a substance designated as a controlled substance.

Copayment - A specified amount not payable by the Plan that is the Covered Person's responsibility to pay to a medical provider. Copays are usually connected with specific benefits and may be in addition to or instead of the Plan deductible.

Cosmetic Procedure - A procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

Covered Expense - *See* ***Eligible Expense***.

Covered Person - A Covered Employee or Covered Dependent who is eligible and has enrolled in the Plan. Retirees who meet the City's definition of Retiree are also considered to be Covered Persons.

Cryotherapy - A technique that uses an extremely cold liquid or instrument to freeze and destroy abnormal skin cells.

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

Day Treatment Facility - A mental health facility that:

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

Deductible - The amount withheld from eligible expenses before benefits become payable by this plan.

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

Dependent/Dependent Child - means any one or more of the following persons:

1. An Employee's or Retiree's lawful Spouse (Proof of common law marriage may be supplied to the Plan Administrator as a prerequisite to eligibility) provided that the spouse is a resident of the same country in which the employee resides.
2. A natural Child(ren), legally adopted child(ren), child(ren) legally placed with the Employee for adoption, foster child(ren), step-child(ren), and any other child(ren) who has been placed in the legal guardianship of the Employee who is less than twenty-six (26) years of age, provided that the child(ren) is a resident of the same country in which the Employee resides.
3. An eligible grandchild who is a dependent of the covered employee for federal income tax purposes at the time application for coverage of the child is made. Grandchildren who are not financially dependent upon the covered employee upon time of enrollment, regardless of age, will not be eligible under the plan.
4. Any natural child(ren) including a dependent grandchild(ren) of the Employee who is principally dependent upon the Employee for support and maintenance and who is incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age twenty-six (26) and such child(ren) were covered under a group medical plan of the Employer prior to attainment of such age and continuously thereafter. The Employee will be required to furnish periodic proof of such child(ren)'s incapacity and dependence as may reasonably be required.
5. A dependent child(ren) who live with a divorced spouse of the Employee when a Qualified Medical Child Support Order states that the Employee must provide health coverage. Proof of the Court's ruling must be provided to the Plan Administrator.

No one may be considered as a Dependent of more than one (1) Employee. When both spouses are covered as Employees under this Plan, only one may cover dependent child(ren).

Those situations specifically excluded from the definition of Dependent are:

1. Excluded as dependents are:
    a. Any person(s) legally separated or divorced from a Covered Person: or
    b. any person(s) on active Military duty for any country, except to the extent required by applicable law; or
    c. any person(s) who fails to meet any of the eligibility criteria.

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

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

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

Diabetes Equipment means:

1. Blood glucose monitors, including monitors designed to be used by blind individuals.
2. Insulin pumps and associated appurtenances.
3. Insulin infusion devices.
4. Podiatric appliances for the prevention of complications associated with diabetes.

Diabetes Self-Management Training/Education means:

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

Disability - Any of the following conditions:

1. illness;
2. bodily malfunction;
3. accidental injury;
4. pregnancy;
5. mental health conditions; or
6. substance use disorder.

All expenses incurred as a result of the same cause or related cause are considered to be incurred for one (1) disability.

Durable Medical Equipment - Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment will not be covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription. Standard model items refer to the base model without added options and/or accessories.

Eligible Expenses - The fees and prices usually and reasonably charged for medical services and supplies covered by this Plan and that are generally furnished for cases of comparable nature and severity in the particular geographical area concerned. Any agreement as to fees or charges made between the individual and the doctor shall not bind the Plan in determining its liability with respect to expenses incurred. Expenses are incurred on the date which the service or supply is rendered or obtained. The Covered Person must have a contractual obligation to pay the expense.

Emergency Services - *See* ***Emergent/Immediate Care***.

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

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

Employer - The City of Brownsville.

Enroll - To make written application for coverage on the prescribed forms. Enrollment is not completed until such forms are received by the Employer.

Essential Health Benefits (EHB) - The Patient Protection Affordable Care Act defines essential benefits to include items and services within the following ten (10) benefit categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including mental health treatment, prescription drugs (plan must offer one (1) drug for each United States Preventive Service Task Force (USPTF) category and class or the number of drugs in the EHB benchmark Plan), rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric oral [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 to age five (5) years]; and 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 reflect test, Hirschberg light reflex test, autorefraction and photoscreening may be done starting age three (3) to attained age of five (5) years] as required by law.

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

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

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

1. is primarily engaged in providing for inpatient skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation service for the rehabilitation of injured or sick persons;
2. has policies which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical care or other services provided;
3. has a physician, a registered nurse (RN), and a medical staff responsible for the execution of such policies;
4. has a requirement that the health care of every patient must be under the supervision of a physician, and provides for having a physician available to furnish necessary medical care in case of emergency;

5. maintains clinical records on all patients;
6. if required, provides twenty-four (24)-hour nursing care under the supervision of a registered nurse (RN);
7. provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
8. has in place a utilization review plan which provides for the review of admissions to the institution, the duration of stays, and the professional services furnished with respect to eligible benefits;
9. is licensed by the appropriate state or local agency; and
10. is Medicare or Medicaid eligible.

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

Filing Deadline - The latest date a claim may be received by the Benefits Administrator in order to be considered eligible for payment. All requested additional information relating to the claim must also be received with the same time frame unless the information is required for contractual prompt pay compliance. This plan's filing deadline is twelve (12) months from date claim is incurred 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.

Free-Standing Surgical Facility - An ambulatory/free-standing surgical center or hospital outpatient surgical department that is JCAHO-Accredited (Joint Commission on Accreditation of Healthcare Organizations) and/or Medicare approved.

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

Grandchild - A grandchild(ren) of the Employee who is less than twenty-six (26) years of age and a dependent of the Employee for federal income tax purposes, provided that the child(ren) is a legal resident of the same country in which the Employee resides. Proof that a grandchild(ren) has been claimed as a dependent on the employees federal income taxes must be submitted at the time application for coverage of the grandchild(ren) is made and may be required annually by the Plan Administrator thereafter. Failure to provide such proof may result in the Employee being financially responsible for all health care costs provided to the grandchild(ren). A great-grandchild does not meet this definition.

Habilitation Services - Habilitative services means skilled, medically necessary, health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is medically necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding bathing or transferring from a bed to a chair.
- It is not Custodial Care.

IEBP will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or condition in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Limitations and Exclusions

- Coverage is excluded for services that are solely educational or vocational in nature or otherwise paid under state or federal law for purely educational services. A service that does not help the Covered Person to meet or maintain functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

- Coverage is excluded when the patient does not meet criteria for coverage as indicated in the indications for Coverage section above and enrollee specific benefit document.
- Coverage is excluded if the service is considered by IEBP to be Unproven, Investigational or Experimental.
- Coverage is excluded for Custodial care, respite care, day care, therapeutic recreation vocational training and residential treatment.
- In the absence of a disabling condition, services to improve general physical condition are excluded from coverage.
- Coverage is excluded once the treatment plan goals are met.
- Coverage is excluded for physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. An example includes, but not limited to, the same day combined use of hot packs, ultrasound and iontophoresis in the treatment of strain.
- Coverage is excluded for programs that do not require the supervision of Physician and/or a licensed therapy provider.
- Coverage is excluded for work hardening.
- Coverage is excluded for confinement, treatment, services or supplies that are required: a) only by a court of law, or b) only for insurance, travel, employment, and school or camp purposes.
- Coverage is excluded for services beyond any visit limits specified in the enrollee specific benefit document.
- Coverage is excluded for gym and fitness club memberships and fees, health club fees, exercise equipment or supplies.
- Biofeedback services are excluded.

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

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

HIPAA

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. This Plan has opted out of and is exempt from these provisions. However, this 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 Standards for the protection of health information (Security Rule), standards for notification in case of breach of unsecured health information and Standards for Privacy of Individually Identifiable Health Information (Privacy Rule);
- A self-funded, non-federal, governmental health plan cannot exempt itself from the Title II requirements.

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

Home Health Care Agency - A public or private agency or organization:

1. licensed by the state in which it is located to provide skilled nursing services and other therapeutic services under the supervision of a physician or registered nurse;
2. accredited by the Joint Commission for the Accreditation of Healthcare Organizations or the National League for Nursing;
3. American Public Health Association; and
4. approved by Medicare.

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

1. established, approved and reviewed in writing at thirty (30) day intervals by the attending physician, and
2. certified by the attending physician that the proper treatment of the disability would require confinement as an inpatient in a hospital, rehabilitative hospital or extended care facility in the absence of the services and supplies provided as part of the home health care plan.

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

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

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

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

The term hospital **does not include** an institution or any part of one which is used primarily as:

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

The term hospital **does not include** an institution or any part of one which is used primarily as:

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

Illness - Sickness or disease which requires treatment by a licensed health care provider.

Incapacity - *See* ***Disability***.

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

Injury - *See* ***Accidental Injury.***

Inpatient - Treatment or confinement to a medical facility for more than twenty-three (23) consecutive hours.

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

Intensive Outpatient Therapy – Sixteen (16) hours per week or a three (3) hour daily session.

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

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

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

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

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

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

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

Medicare - Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended by Social Security Amendment of 1965 or as later amended.

Mental Health Conditions - Those conditions or illnesses that are classified by either a DSM (Diagnostic & Statistical Manual of Mental Disorders, Third Edition Revised) diagnostic code or an ICDCM (International Classification of Disease) code for Mental Disorders.

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

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

Morbid Obesity - 200% over ideal weight or one hundred (100) pounds overweight with a Body Mass Index (BMI) of greater than forty (40).

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

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

Nurse Midwife (CNM)/Certified Professional Midwife (CPM) - A licensed registered nurse (RN) who is certified as a nurse midwife by the American College of Nurse-Midwives and is authorized to practice as a nurse midwife under state regulations. This does not include midwives who are not also licensed registered nurses (RN).

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

Orthotics - Orthopedic or corrective shoes and supportive appliances for the feet.

Out Of Pocket Amount - The portion of eligible expenses for which a covered person is responsible.

Outpatient - Treatment or confinement to a medical facility for less than twenty-three (23) consecutive hours.

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

Plan Administrator - The City of Brownsville.

Plan Sponsor - The City of Brownsville.

Practitioner/Health Care Provider - A physician, nurse, hospital or specialized facility as those terms are specifically defined in this section.

Pre-Admission Testing - Benefit eligible laboratory tests and x-rays performed by a hospital or facility from whom a hospital will accept the test results that are rendered to the Covered Person on an outpatient basis. The tests must be performed within ten (10) days of a scheduled inpatient hospital confinement. Charges that meet this definition must be clearly identified as such on the bill for services. Major diagnostic tests, i.e. Brain Mapping, CT Scan, EMG, MRI and NCS are not covered under this benefit.

Preferred Provider Network (PPN) - A group of medical providers (physicians, practitioners and/or hospitals) who, as a group or individually, agree to specified fee schedules, Medical review, and cost containment procedures for the delivery of health care and have contracted for such with the Benefits Administrator.

Pregnancy - Under the terms of this Plan, pregnancy includes:

1. childbirth;
2. miscarriage;
3. any complications arising wholly from pregnancy, childbirth or miscarriage; and
4. any pregnancy complications arising from any trauma.

Extra-uterine pregnancies are considered to be genitourinary conditions.

Prior Group Plan - means the group plan providing similar benefits (whether insured or self-insured including HMO's and other prepayment plans provided by the Employer) in effect immediately prior to the effective date of this Plan.

Protected Health Information - A Federal regulation, called the "Privacy Rule," requires The City of Brownsville to protect the privacy of each covered person's identifiable health information. Under the Privacy Rule, the Plan may use and disclose a covered person's identifiable health information only for certain permitted purposes, such as the payment of claims under the health plan. If the Plan needs to use or disclose a covered person's health information for a purpose not permitted under the Privacy Rule, The Plan must first obtain a written authorization signed by the covered person.

In addition to restrictions on how the Plan may use and disclose a covered person's identifiable health information, the Privacy Rule gives each covered person certain rights. These include the right of a covered person 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.

The City of Brownsville's Notice of Privacy Practices explains fully how IEBP and the Plan may use and disclose a covered person's identifiable health information and a covered person's rights under the Privacy Rule. The City of Brownsville's Notice of Privacy Practices is included with each covered employee's enrollment information.

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

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

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

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

Retiree - An employee who has ceased full-time, active employment with the City of Brownsville and meets the City's guidelines to qualify as a retiree.

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

Serious Mental Health Illness - Means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

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

Skilled Nursing Facility - A facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care that is of a lessor intensity than that received in an acute care setting. This EXCLUDES custodial and/or maintenance care. The facility must be licensed by state or local law or accredited by the Joint Commission for the Accreditation of Healthcare Organizations.

Sound Natural Teeth - Teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

Substance Abuse - *See* ***Substance Use Disorder***.

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

Substance Use Disorder or Substance Abuse Treatment Facility - A facility which provides a program for the treatment of Substance Use Disorder pursuant to a written treatment plan approved and monitored by a physician and which facility meets (a) all of the requirements under 1 or (b) the requirements under 2 below:

1.
   a. affiliated with a hospital under a contractual agreement with an established system for patient referral;
   b. accredited as such a facility by the Joint Commission for Accreditation of Healthcare Organizations; and
   c. licensed as a Substance Use Disorder treatment program by the Texas Commission on Alcohol and Drug Abuse; or

2.
   a. licensed, certified, or approved as a Substance Use Disorder treatment program or center by any other state agency having legal authority to so license, certify, or approve and is also an Approved Health Care Facility.

Telemedicine - Medical information that is communicated in real-time with the use of interactive audio and video communications equipment, and is between the performing physician and a distant physician or health care specialist with the patient present during the communication.

Total Disability - The inability to perform all the duties of the covered person's occupation as a result of a non-occupational illness or injury. For an unemployed covered person, total disability means the inability to perform the normal duties of a person of the same age and sex.

Toxic Inhalant - A volatile chemical under Chapter 484, Health and Safety Code or abusable glue or aerosol paint under Section 485.001, Health and Safety Code.

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

Transplant Center - a hospital or facility selected by the benefits administrator to be a preferred provider of a particular organ transplant procedure. The hospital or facility selected must meet all of the following requirements:

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

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

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

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

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

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

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

Usual, Reasonable and Customary - A usual and reasonable charge is based on the geographical area in which services were provided. The geographical area is a county or greater area as necessary to establish a representative cross-section of persons or other entities regularly furnishing the services.

1. A charge is usual when it is the most consistent charge by a physician or provider of service to patients for a given service.

2. A charge is reasonable when it meets the usual and customary criteria as determined by the Plan; or it may be reasonable, if upon review, it merits special consideration based on the nature and extent of treatment of the particular case.
3. A charge is usual and reasonable when it is within the range of usual charges for a given service billed by most physicians or providers of service with similar training and experience.
4. A usual and reasonable charge for a surgical procedure includes the total amount allowable as an eligible expense under the Plan for the surgery, hospital visits and postoperative visits following the surgical procedure by the doctor performing the surgery and/or any associates, partners, or affiliated physicians.

Waiting Period - A period of continuous active, full-time employment, required by the employer, that must be completed before an employee or his eligible dependents can be effective for coverage under this Plan.

Well-Baby Care - Medical treatment, services or supplies rendered to a child or newborn solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

Work Hardening **-** Work hardening is an interdisciplinary program consisting of physical therapy, occupational therapy and counseling professionals for injured workers or other adults whose injuries or disease processes interfere with their ability to work. It provides structured treatment designed to progressively improve physical function as a transition between acute care and return to work.

HELPFUL INFORMATION

Telephone Numbers

8:30 a.m. to 5:00 p.m. Central Time

Customer Care	**(800) 282-5385**
Customer Care, En Español	**(800) 385-9952**
For Notification, contact Medical Intelligence	**(800) 847-1213**

Please have the name of the Group and the Unique ID (or SSN) of the Covered Person when you call.

Mailing Address

Claims and Appeals

Attn: Claims
TML MultiState Intergovernmental Employee Benefits Pool
PO Box 149190
Austin, Texas 78714-9190

Medical Intelligence

Attn: Medical Intelligence
TML MultiState Intergovernmental Employee Benefits Pool
PO Box 141039
Austin, Texas 78714-1039

Website Address

www.iebp.org

Group Number

ABROWNS0

GENERAL INFORMATION

Name and Address of Plan Sponsor & Plan Administrator

City of Brownsville
1001 E. Elizabeth St.
Brownsville, Texas 78520

Name and Address of Benefits Administrator

TML MultiState Intergovernmental Employee Benefits Pool
1821 Rutherford Lane, Suite 300
Austin, Texas 78754

(512) 719-6500
(800) 348-7879
www.iebp.org

SIGNATURE PAGE

The effective date of the City of Brownsville Group Medical Benefit Plan is October 1, 2003 as amended through September 30, 2018.

It is hereby agreed by the City of Brownsville that the provisions of this document are correct and will be the basis for the administration of the City of Brownsville's Group Medical Benefit Plan at renewal on October 1, 2018.

Dated this 16th day of August, 2018

By _____
Fernando Arellano

Title Asst. H.R. Director/Safety Coordinator

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