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

Summary of Benefits and Coverage (SBC)

Individual Responsibility. Does this Coverage Satisfy the Individual Responsibility Requirement and Meet the Minimum Value Standard? Yes

Coverage Tiers. 3 tier (1-way)

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

Frequently Asked Questions	Network Benefit	Non-Network Benefit	Limitations and Exceptions
What is the overall deductible?	Individual: $200 Family: $600	Individual: $600 Family: $1,800	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. The family deductible is accumulative. 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. The calendar year deductible will be waived for the new calendar year for a hospital confinement spanning the end of one calendar year and the beginning of the next calendar year. Amounts used to satisfy the Deductible for Network and Non Network are separate and do not accumulate towards one another. *Eligible network preventive/wellness benefits and preferred lab benefits pay at no cost share to the covered individual.*
Are there other deductibles for specific services?	No	Facility Inpatient: Yes $100	In addition to the plan's deductible, there is also a hospital admission copay. A $100 per day copay will apply to all Non Network hospital admissions. The $100 per day copay will not exceed a maximum of $300 per admission. This copay does not apply when the admission is related to emergent/immediate care.
Is there an out-of-pocket limit on my expenses?	Individual: $600 Family:$1,800	Individual: $1,800 Family: $5,400	Once the deductibles and maximum Out of Pocket amount is satisfied per individual, the plan pays 100% of eligible charges. The family Out of Pocket is accumulative. Once the family out of pocket amount has been satisfied, the Out of Pocket, it will not apply for any other family member's charges. Amounts used to satisfy the Out of Pocket for Network and Non Network are separate and do not accumulate towards one another. .
What is not included in the out-of-pocket limit?	*See Limitations and Exceptions*	*See Limitations and Exceptions*	The following do not apply towards the Out of Pocket: Penalties for failure to follow required Notification procedures, ineligible charges, charges for treatment of morbid obesity, charges from a chiropractor, charges that exceed usual and customary, access fees, and charges which exceed the Plan's maximum benefit and prescription copays. *Ineligible charges do not accumulate toward meeting your Deductible or Out of Pocket amount.*
Is there a maximum out-of-pocket limit (MOOP) on all my expenses?	Individual: $6,600 Family: $13,200	No	The max out-of-pocket (MOOP) limit for PPO plans is defined per the Federal Government for plan years January 1, 2017 thereafter. Once the maximum out-of-pocket amount is met, the medical and prescription network services accessed within the scope of the benefit plan will be paid at 100% with no out-of-pocket copayment required. This plan does not have a maximum out of pocket for Non Network services. **The PPO MOOP amount for 2017: Individual: $6,600 • Family: $13,200. This is less than the Federal Maximum Out of Pocket for 2017.**
Is there an overall annual limit on what the plan pays?	No	No	This plan does not have an annual limit for all benefits combined. The plan does have some limits on lifetime and calendar year benefits for specific conditions and/or treatments, as indicated.
Does this plan use a network of providers?	Yes	N/A	Go to www.iebp.org or call (800) 282-5385 for a list of participating providers. Your deductible, out-of-pocket expenses, and benefit percentage will be different for Network and Non Network services.
Do I need a referral to see a specialist?	No	No	This plan does not require referrals. You have the option to choose any provider.

Frequently Asked Questions	Network Benefit	Non-Network Benefit	Limitations and Exceptions
What is my copayment?	Office Visit: $20	N/A	The Office Visit copay includes: Physician office visits, consultations, labs, x-rays, infusions and injections.
Is there a maximum out-of-pocket limit (MOOP) on all my expenses?	Individual: $6,600 Family: $13,200	No	The max out-of-pocket (MOOP) limit for PPO plans is defined per the Federal Government for plan years January 1, 2017 thereafter. Once the maximum out of pocket amount is met, the medical and prescription network services accessed within the scope of the benefit plan will be paid at 100% with no out-of-pocket copayment required. This plan does not have a maximum out of pocket for Non Network services. **The PPO MOOP amount for 2017: Individual: $6,600 • Family: $13,200. This is less than the Federal Maximum Out of Pocket for 2017.**
Is there an overall annual limit on what the plan pays?	No	No	This plan does not have an annual limit for all benefits combined. The plan does have some limits on lifetime and calendar year benefits for specific conditions and/or treatments, as indicated.
Are there services this plan does not cover?	Yes	Yes	Please refer to the General Exclusions or Limitations section and the definition of Unproven Medical Procedures/Treatment in the plan document.

Common Medical Event	Services You May Need	Network Benefit	Non-Network Benefit	Limitations, Exceptions and Exclusions
If you visit a health care provider's office or clinic	Primary care or Specialist visit to treat an injury or illness	100% after $20 copay deductible waived	60% after deductible up to U&R	The office visit copay includes charges for office visits, consultations, labs, x-rays, infusions and injections. For maternity the copay will only apply to the initial visit.
	All other Physician Services	80% after deductible	60% after deductible up to U&R	The office visit copay includes charges for office visits, consultations, infusions and injections. For maternity the copay will only apply to the initial visit
	Preventive care/screening/immunization	100% deductible waived	60% after deductible up to U&R	**Preventive/Routine Care Benefit** The following will be processed for network reimbursement at 100% of network allowable. Non Network provider eligible billings will be subject to Usual and Reasonable (U&R) charges and are subject to the Non Network deductible and benefit percentage. To be considered as an eligible preventive/routine care benefit, the provider's bill must designate or outline a routine diagnosis code. This benefit excludes coverage for virtual colonoscopies. The following preventive/routine care benefits includes but is not limited to: • Routine Physical • Well Baby and Well Child Visits • Vision Exam (excluding refractions) • PAP Test and Office Visit • Breast cancer annual chemoprevention counseling for women at high risk • Genetic Counseling for BRCA testing • BRCA testing for women with or without an history of BRCA related cancer • Routine Hearing Exams • Routine Venipuncture • General Health Panel • Mammograms • Prostate Specific Antigen (PSA) • Coronary Risk Profile (lipid panel) • Urinalysis • (TB) Tuberculosis test • Autism Screening – eighteen (18) and twenty-four (24) months of age • Developmental Screening for Children under age three (3) • Handling of specimen to/from physician's office to a laboratory • Occult Stool Test • Examination for the detection of skin cancer • Chest X-Ray (front & lateral) • ECG (electrocardiogram) • Digital Rectal Exam • Skin Cancer Counseling
If you visit an urgent care clinic	Urgent care visit to treat an injury or illness	80% after deductible	60% after deductible up to U&R	Urgent Care Services billed on a UB will be processed under Urgent Care benefit. Urgent Care Services billed on a HCFA will be processed under Hospital Benefit.
If you have a test	Diagnostic test (x-ray, blood work)	80% after deductible	60% after deductible up to U&R	Preferred Lab will pay at 100% deductible waived In Network and includes lab expenses from a Preferred Lab Provider and Preferred Lab drawing site. Eligible network preventive/routine benefits and preferred lab benefits pay at no cost share to the covered individual. If lab services are not received at a Preferred Lab drawing site, any physician professional fees billed will be payable as a "physician all other service".

Questions: Call (800) 282-5385 or visit the IEBP website at www.iebp.org. If you are not clear about any of the underlined terms used in this document, refer to the Uniform Glossary (Member Rights and Responsibilities Guide). You can view the Glossary at www.iebp.org or call (800) 282-5385 to request a copy. The SBC is available on the web.

Common Medical Event	Services You May Need	Network Benefit	Non-Network Benefit	Limitations, Exceptions and Exclusions
	Imaging (CT/PET scans, MRIs)	80% after deductible	60% after deductible up to U&R	Refer to Notification Requirements
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.iebp.org.	Generic drugs	$0 up to thirty (30)-day Retail $9 for a thirty-one (31)-ninety (90) day Retail $20 up to a ninety (90)-day Mail Order		To locate or confirm that a pharmacy is in the OptumRx network or to locate network retail pharmacy locations, visit www.optumrx.com. For Mail Order customer service call (800) 797-9791 or visit www.optumrx.com.
	Best Brand	$20 up to thirty (30)-day Retail $40 up to a ninety (90)-day Mail Order		
	Specialty drugs	$20 per thirty (30)-day supply		The Plan offers an injectable drug benefit called SpecialtyRx/Biotech drug program. This benefit is accessed through OptumRx. This service provides the Plan and Covered Individual a convenient and cost-effective way to order injectable drugs and supplies through OptumRx's SpecialtyRx/Biotech drug program. Contact OptumRx 866-218-5445 to access these medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	80% after deductible	60% after deductible up to U&R	In addition to the plan's deductible, there is a hospital admission copay. A $100 per day copay will apply to all Non Network hospital admissions. The $100 per day copay will not exceed a maximum of $300 per admission. This copay does not apply when the admission is related to emergent/immediate care. Review Notification Requirements.
	Physician/surgeon fees	80% after deductible	60% after deductible up to U&R	
If you need immediate medical attention	Emergency room services (Emergent/ Urgent) – facility and physician	80% after deductible	80% after deductible	All emergency Room Facility charges are subject to a $50 facility access fee. The Emergency Room Access fee is waived if admitted. The access fee also applies to emergent/immediate care. Please refer to the definitions in the plan document for what is considered emergent/immediate care. Regular Network and Non Network
	Emergency room services (Non Emergent/ Non Urgent) – facility and physician	80% after deductible	60% after deductible	
	Emergency medical transportation	80% deductible waived	80% deductible waived	Limited to a $5,000 for air and $1,500 for ground benefit per occurrence. This plan does not include benefits for transportation for non-emergency medical services.
	Urgent care	80% after deductible	60% after deductible up to U&R	
If you have a hospital stay	Facility fee (e.g., hospital room)	80% after deductible	60% after deductible up to U&R	In addition to the plan's deductible, there is a hospital admission copay. A $100 per day copay will apply to all Non Network hospital admissions. The $100 per day copay will not exceed a maximum of $300 per admission. This copay does not apply when the admission is related to emergent/immediate care. Review Notification Requirements.
	Physician/surgeon fees	80% after deductible	60% after deductible up to U&R	All emergency Room Facility charges are subject to a $50 facility access fee. The Emergency Room Access fee is waived if admitted. The access fee also applies to emergent/immediate care. Please refer to the definitions in the plan document for what is considered emergent/immediate care.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	80% after deductible	60% after deductible up to U&R	In addition to the plan's deductible, there is a hospital admission copay. A $100 per day copay will apply to all Non Network hospital admissions. The $100 per day copay will not exceed a maximum of $300 per admission. This copay does not apply when the admission is related to emergent/immediate care. Inpatient limit fifteen (15) days per calendar year. Outpatient limit to twenty-six (26) visits per calendar year. Expenses for the treatment of a Mental Health condition are paid the same as any other illness. Office Visits are covered the same as any other illness and are covered under the copay.
	Mental/Behavioral health inpatient services	80% after deductible	60% after deductible up to U&R	

Common Medical Event	Services You May Need	Network Benefit	Non-Network Benefit	Limitations, Exceptions and Exclusions
	Substance use disorder outpatient services	80% after deductible	60% after deductible up to U&R	In addition to the plan's deductible, there is a hospital admission copay. A $100 per day copay will apply to all Non Network hospital admissions. The $100 per day copay will not exceed a maximum of $300 per admission. This copay does not apply when the admission is related to emergent/immediate care. Limit of three (3) Treatment Series per lifetime. Expenses for the treatment of Substance Use Disorder are paid the same as any other illness. Office Visits are covered the same as any other illness and are covered under the copay.
	Substance use disorder inpatient services	80% after deductible	60% after deductible up to U&R	
If you are pregnant	Prenatal and postnatal care	80% after deductible	60% after deductible up to U&R	A copay will apply to the initial office visit charge for network services. The remainder of the physician charges will be subject to the deductible and covered at the appropriate benefit percentage.
	Delivery and all inpatient services	80% after deductible	60% after deductible up to U&R	
If you need help recovering or have other special health needs	Home Health Care	80% after deductible	60% after deductible up to U&R	Limited to one hundred (100) visits per calendar year
	Rehabilitation/Habilitation services (Outpatient)	80% after deductible	60% after deductible up to U&R	Outpatient physical therapy, occupational therapy and aquatic therapy services are limited to a combined calendar year limit of twenty-four (24) visits. Services billed by a chiropractor are limited to ten (10) visits per calendar year for non-surgical treatments only. Chiropractic services never pay at 100% and out of pocket expenses do not apply towards any out of pocket maximums. Outpatient speech services are limited twelve (12) visits per calendar year.
	Rehabilitation/Habilitation services (Inpatient)	80% after deductible	60% after deductible up to U&R	Limited to thirty (30) days per calendar year
	Cardiac Rehabilitation (Outpatient)	80% after deductible	60% after deductible up to U&R	
	Skilled nursing care	80% after deductible	60% after deductible up to U&R	Limited one hundred (100) days per calendar year
	Durable medical equipment	80% after deductible	60% after deductible up to U&R	Notification is required for charges in excess of $1,000 per durable medical equipment prior to purchase, lease or rental; limited to the Usual and Reasonable (U&R) charges of standard models as determined by Medical Care Management.
	Hospice services	80% after deductible	60% after deductible up to U&R	Does ***not*** include Respite Care or Bereavement Counseling.
If your child needs dental or eye care *(attained age of 19)*	Eye exam			Vision Acuity Screenings-paid as Preventive under Medical Plan-100% allowed Usual and Reasonable (U&R). Vision screening services [for the detection of eye disease and refractive disorders and well-child visits that include visual acuity testing stereoacuity, cover-uncover tests, Hirschberg light 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.
	Glasses	Ineligible under Medical Plan		
	Dental check-up			Dental Screenings-paid as Preventive under Medical Plan-100% allowed Usual and Reasonable (U&R). Pediatric oral [application of fluoride varnish to the primary teeth of all infants starting at the age of primary tooth eruption; recommended at six (6), nine (9), twelve (12), eighteen (18), twenty-four (24), thirty (30) months, three (3) and six (6) years].

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

Unproven Medical Procedures/Treatment. Experimental/Investigational/Unproven Services: medical, surgical, diagnostic, mental health, substance use disorder, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time IEBP makes a determination regarding coverage in a particular case, are determined to be any of the following: • Any drug not approved by the U.S. Food and Drug Administration (FDA) for marketing; any drug that is classified as IND (Investigational New Drug) by the FDA; • Determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials; • Not consistent with the standards of good medical practice in the United States as evidenced by endorsement by national guidelines; • Exceeds (in scope, duration, or intensity) that level of care which is needed • Given primarily for the personal comfort or convenience of the patient, family member(s) or the provider; • Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered Experimental or Investigational.); or • The subject of an ongoing clinical trial that meets the definition of a Phase 1 or 2 clinical trial, or is the experimental arm of a Phase 3 or 4 clinical trial as set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Medically Justified. A service that falls under the Plan definition of UNPROVEN MEDICAL PROCEDURES/THERAPY, but that can be justified for an individual patient due to: • A rare/orphan disease (a rare/orphan disease is one that affects fewer than 200,000 people, according to the U.S. Rare Disease Act of 2002). • A unique co-morbidity, or complication that precludes treatment with a proven medical procedure or therapy. > No other treatment available due to co-morbidities > Co-morbid Disease State Risk • Continuation and/or repeat of a previously approved successful treatment plan. • Concern for Complications due to treatment area. • Repeat of prior successful treatment intervention and disease state; disease state put in remission. • Treatment dose should be in compliance for best outcome. • Severity of illness defined as ongoing intensity and complication of disease state with lab value concerns.

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

General Exclusions or Limitations - No benefits shall be payable under any part of the Plan with respect to any charges. Refer to the Medical Plan Book for a complete list of Exclusions and Limitations: Login: www.iebp.org • Select: My Tools • Select: MyBenefits on Demand • Select: Benefits • Select: Medical • Medical Plan Book

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, reasonable and customary for services and supplies;

This is not a complete list. Refer to the Medical Plan Book for a complete list of Exclusions and Limitations: Login: www.iebp.org • Select: My Tools • Select: MyBenefits on Demand • Select: Benefits • Select: Medical • Medical Plan Book

Other Covered Services. This is not a complete list. Check your plan document for other covered services and your costs for these services.
The Plan Document covers eligible medical expenses that include: Ambulatory Surgical Center (ASC); Anesthesia; Artificial Limbs or Prosthetic Appliances; Autism Screenings; Blood Storage; Breast Oncology; Breast Reduction; Cardiac Rehabilitation; Cataract Surgery.

Your Rights to Continue Coverage. Federal and State laws may provide protections that allow you to continue health coverage after it would otherwise end. For more information about your rights and obligations under the plan and under federal law, you should review the plan booklet or contact TML MultiState IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out of pocket costs. Additionally, you may qualify for a thirty (30)-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

COBRA Continuation of Coverage (COC). The right to COBRA Continuation of Coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation of Coverage can become available to you and other members of your family when your group health coverage would otherwise end.

What is COBRA Continuation of Coverage? COBRA Continuation of Coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA Continuation of Coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Continuation of Coverage may be required to pay for coverage depending on the policy of your Employer.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". Yes, this plan provides minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). Yes, this plan's coverage meets the minimum value standard.

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

Your Grievance and Appeals Rights. 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 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. The appeal filing deadlines below could be superseded by network contractual obligations.

Appeal of Urgent/Emergent Request for Benefits (Adverse Pre-Determination/Notification Request)		
Type of Request for Benefits or Appeal	**Internal/External 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**
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 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**

Appeal of Non-Emergent Request for Benefits (Adverse Pre-Determination/Notification Request)		
Type of Request for Benefits or Appeal	Internal/External Process	Hours/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 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) calendardays** 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
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.

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

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

Having a Baby (normal delivery)	
•Amount owed to Providers: $13,170.65 • Plan pays: $10,635.65 • Covered Individual/Patient pays: $2,535.00	
Sample Care Costs	
Hospital charges (mother)	$6,252.00
Routine obstetric care	$2,619.52
Hospital charges (baby)	$1,464.09
Anesthesia	$1,706.72
Laboratory tests	$184.03
Prescriptions	$464.80
Radiology	$479.49
Total	**$13,170.65**
Covered Individual/Patient Pays	
Deductible	$500.00
Copayments: Medical/Rx	$35.00/$0.00
Plan/Max Plan OOP	$2,000.00/$2,500.00
Federal Maximum OOP	$2,535.00
Limits or Exclusions	$0.00
Total	**$2,535.00**

Managing Type 2 Diabetes (routine maintenance of a well-controlled condition)	
• Amount owed to Providers: $6,942.43 • Plan pays: $5,770.80 • Covered Individual/Patient pays: $1,171.63	
Sample Care Costs	
Prescriptions	$5,693.70
Medical Equipment and Supplies	$208.32
Office Visits and Procedures	$642.53
Education	$200.89
Laboratory tests	$58.42
Vaccines, other preventive	$138.57
Total	**$6,942.43**
Covered Individual/Patient Pays	
Deductible	$467.63
Copayments: Medical/Rx	$210.00/$494.00
Plan/Max Plan OOP	$0.00/$467.63
Federal Maximum OOP	$1,171.63
Limits or Exclusions	$0.00
Total	**$1,171.63**

Simple Fracture (with emergency room visit)	
• Amount owed to Providers: $2,053.50 • Plan pays: $1,146.81 • Covered Individual/Patient pays: $906.69	
Sample Care Costs	
Emergency Services	$1,459.00
Medical Equipment and Supplies	$122.00
Office Visits and Procedures	$350.05
Physical Therapy	$92.40
Laboratory tests	$0.00
Prescriptions	$30.05
Total	**$2,053.50**
Covered Individual/Patient Pays	
Deductible	$500.00
Copayments: Medical/Rx	$175.00/$0.00
Plan/Max Plan OOP	$231.69/$731.69
Federal Maximum OOP	$906.69
Limits or Exclusions	$0.00
Total	**$906.69**