

Guidance document appear at 77Fed Reg. 8668 and 8706 respectively (02-14-12). | 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 (4-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, coinsurance/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: \$1,000 Family: \$2,000	Individual: \$2,000 Family: \$4,000	The Network and Non-Network deductible are separate and do not accumulate toward one another. 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 toward 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 satisfying the next calendar year deductible for charges during confinement. All other charges are subject to the new calendar year deductible amount. <i>Eligible network preventive/wellness benefits and preferred lab benefits pay at no cost share to the covered individual.</i>
Are there other deductibles for specific services?	Facility Inpatient: No	Facility Inpatient: No	
Is there a plan maximum out-of-pocket limit on my expenses?	Individual: \$3,000 Family: \$6,000	Individual: \$4,500 Family: \$9,000	The Network and Non Network plan maximum out of pocket amounts are separate and do not accumulate. The family out of pocket limit is accumulative. Once covered family members satisfy their family out of pocket during the calendar year, no other family member will be subject to remaining out of pocket for the rest of the year. The out of pocket limit includes the medical plan deductible and medical plan Network copays. Once the out of pocket has been satisfied, medical plan copays will no longer apply. <i>This plan has a separate plan maximum for prescription expenses.</i>
What is not included in the medical plan out-of-pocket limit?	See Limitations and Exceptions	See Limitations and Exceptions	The following do not apply towards the medical plan Out of Pocket: Penalties for failure to follow required Notification procedures, charges that exceed usual and reasonable, Non Network copays, emergency room access fees, charges from non-OptumHealth/ Centers of Excellence Designated Transplant Centers, non-covered charges, charges which exceed the Plan's maximum benefit and prescription plan deductibles and prescription plan copays. <i>Ineligible charges do not accumulate toward meeting your Deductible or Out of Pocket.</i>
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. <i>Note: Network and Non Network benefits may vary.</i>
What is my copayment?	\$30 Primary Care \$50 Specialist	N/A	The Office Visit copay applies to charges for and includes: Physician office visits, consultations, allergy testing, allergy treatment, allergy injections, infusions and non-allergy injections.

Frequently Asked Questions	Network Benefit	Non-Network Benefit	Limitations and Exceptions
	\$15 Teladoc		Teladoc services are subject to a \$15 copay. Teladoc can be reached at 1 (800) Teladoc or (800) 835-2362. \$50 copay for Specialist Physicians: Include all physicians <i>other than</i> Family or General Practice (M.D. or D.O.), OB/GYN, Internist and Pediatricians The Office Visit copay includes: office visits, consultations and all services provided in the doctor's office <i>except</i> labs, x-rays, major imaging, physical, occupational, aquatic and speech therapy, and SpecialtyRx/Biotech medications.
Is there a plan <u>maximum out-of-pocket limit</u> on my prescription expenses?	Individual: \$3,000 Family: \$6,000	N/A	The Family plan maximum out of pocket limit for prescription expenses is accumulative. Once covered family members satisfy their family out of pocket during the calendar year, no other family member will be subject to remaining out of pocket for the rest of the calendar year. The out of pocket limit includes Retail, Mail Order and SpecialtyRx/Biotech Drug copays and amounts applied to the \$100 prescription deductible for plan eligible prescriptions. Once the prescription out of pocket limit has been satisfied, prescription plan copays will no longer apply for plan eligible prescriptions.
What is not included in the prescription <u>out-of-pocket limit</u>?	See Limitations and Exceptions	See Limitations and Exceptions	<i>The following do not apply towards the prescription out of pocket:</i> Expenses for prescriptions listed as "drugs not covered under this benefit", ineligible prescription charge mailing or shipping costs and Medical plan expenses, including SpecialtyRx/Biotech medications that are accessed under the Medical plan.
Is there an overall <u>annual limit</u> 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 exclusion list and unproven/experimental definition 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 visit to treat an injury or illness	100% after \$30 copay; Deductible waived	50% after deductible	\$30 copay for Primary Care Physicians: Family or General Practice (MD or DO), OB/GYN, Internist and Pediatricians. \$50 copay for Specialist Physicians: Include all physicians other than Family or General Practice (MD or DO), OB/GYN, Internist and Pediatricians. The Office Visit copay applies to charges for and includes: Physician office visits, consultations, allergy testing, allergy treatment, allergy injections, infusions and non-allergy injections. The copay will apply regardless of whether or not an office visit code is billed.
	Specialist visit	100% after \$50 copay; Deductible waived	50% after deductible	
	Allergy Injections (not given by a physician)	100% Deductible waived	50% after deductible	
	Telehealth: Teladoc (800) 835-2362 www.teladoc.com	100%* after a \$15 copay	N/A	Teladoc services are subject to a \$15 copay. Teladoc can be reached at 1-(800) Teladoc or (800) 835-2362. The deductible is waived for Network services.

Common Medical Event	Services You May Need	Network Benefit	Non-Network Benefit	Limitations, Exceptions and Exclusions
Preventive Care/Wellness	Preventive care/Wellness Benefit	100% Deductible waived	50% after deductible	<p>Preventive Care/Wellness Benefit The following will be processed for network reimbursement at 100% of network allowable. Non-Network provider eligible billings will be subject to U&R charges and are subject to the Non-Network deductible and benefit percentage. To be considered as an eligible preventive/routine care benefit, the provider's bill must designate or outline a routine diagnosis code. The Wellness Benefit does not include virtual colonoscopies. The following preventive care/wellness routine care benefit includes (see plan document for a complete list): • Immunizations/Inoculations • Routine Physical • Well Woman • Baby and Well Child Exams • Routine Hearing Exams • Routine Venipuncture • General Health Panel • Prostate Specific Antigen test (PSA) • Coronary Risk Profile (lipid panel) • (TB) Tuberculosis test • Osteoporosis Screening • Autism Screening - eighteen (18) and twenty-four (24) months of age • 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) • EKG (electrocardiogram) • Digital Rectal Exam</p> <p>Colon-Rectal 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 Colon-Rectal Examination benefit will also apply for the first non-routine colon-rectal exam claim received during the 5/10 year time period. <i>See plan document for more information.</i></p>
	Colorectal Cancer Screenings	100% Deductible Waived	Not Covered	
Routine Mammograms	Women's Health	100% Deductible waived	Not Covered	Routine Mammograms
Routine Vision Exams	Vision Exams	100% Deductible waived	100% Deductible waived	This benefit includes charges for the refraction regardless of diagnosis.
If you visit an <u>urgent care clinic</u>	Urgent care visit to treat an injury or illness	100%* after \$50 copay; Deductible waived	50% after deductible	Facility charges, labs, x-rays, infusions, injections, and allergy serum, injection and/or testing charges
If you have a test	Diagnostic test (x-ray, blood work)	80% after deductible	50% after deductible	
	Imaging (CT/PET scans, MRIs)	80% after deductible	50% after deductible	
If you need drugs to treat your illness or condition Refer to Retail and Mail Order Prescription Drug Schedule of Benefits for more information.	Over the Counter/Behind the Counter	\$0 Retail <i>Not available through Mail Order</i>		<p>Prescribed Over the Counter/Behind the Counter Alternates: This Plan covers these non-prescription drugs for a \$0.00 copay, when purchased at the pharmacy counter with a physician's prescription: Non-Sedating Antihistamines (ie: Claritin®, Claritin-D®, Alavert®, Allegra®, Allegra-D®, Zyrtec®, Zyrtec-D®); Smoking Deterrents (ie: Nicorette Gum, Nicotine Patch, or Lozenges) limit 3 per calendar year; Stomach and Ulcer (ie: Prilosec®, Prevacid®, Zegerid®); Aspirin; Folic Acid; Iron Deficiency Supplements; Fluoride Chemoprevention Supplements; and Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at an increased risk for falls. This also includes store brand and generic versions of these products.</p>

Common Medical Event	Services You May Need	Network Benefit	Non-Network Benefit	Limitations, Exceptions and Exclusions
	* <i>The prescription copay listed below for Tier 2 and 3 medications and SpecialtyRx/Biotech will apply after the covered person has met their \$100 prescription plan deductible. Copays will apply once this \$100 per calendar year prescription plan deductible is satisfied. This prescription plan deductible will apply to all Tier 2 and 3 medications and SpecialtyRx/Biotech medications, Retail and Mail Order combined.</i>			
	Tier 1 medications	\$0 up to a 34 day supply at Retail \$9 for a 35-90 day supply at Retail \$25 up to a 90 day supply through 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 care call (800) 797-9791 or visit www.optumrx.com
	Tier 2 medications	\$30* up to a 34 day supply at Retail \$75* for up to a 90 day through 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 care call (800) 797-9791 or visit www.optumrx.com
	Tier 3 medications	\$75* up to a 34 day supply at Retail \$187.50* for up to a 90 day through 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 care call (800) 797-9791 or visit www.optumrx.com
	Biotech/SpecialtyRx Prescriptions	\$100 copay per 34 day supply through OptumRx		Prior Authorization contact OptumRx at (800) 711-4555 (Doctor/Prescription Prescribers Only). Once Prior Authorization has been established, the covered individual can contact OptumRx Specialty Pharmacy at (866) 218-5445 to access these medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	80% after deductible	50% after deductible	
	Physician/surgeon fees	80% after deductible	50% after deductible	
If you need immediate medical attention	Emergency room services	100% after \$250 access fee; Deductible waived	100% after \$250 access fee; Deductible waived	All Emergency Room Facility charges are subject to a \$250 facility access fee. The Emergency Room access fee is waived if admitted. The ER access fee also applies to emergent/immediate care.
	Emergency medical transportation	80% Deductible waived	80% Deductible waived	Limited to a maximum benefit payable of \$1,250 ground and \$7,500 air per occurrence. This plan does not include benefits for transportation for non-emergency medical services.
	Urgent care	100% after \$50 copay	50% after deductible	Facility charges, labs, x-rays, infusions, injections, and allergy serum, injection and/or testing charges
If you have a hospital stay	Facility fee (e.g., hospital room)	80% after deductible	50% after deductible	
	Physician/surgeon fees	80% after deductible	50% after deductible	
If you have mental health, behavioral health, or substance abuse needs	Physician Office Visit	100% after \$30/\$50 copay, deductible waived	50% after deductible	\$30 copay for Primary Care Physicians: Family or General Practice (MD or DO), OB/GYN, Internist and Pediatricians. \$50 copay for Specialist Physicians: Includes all physicians <i>other than</i> Family or General Practice (MD or DO), OB/GYN, Internist and Pediatricians.
	Inpatient Facility	80% after deductible	50% after deductible	Limited to forty-five (45) days per calendar year.
	Outpatient Facility	80% after deductible	50% after deductible	
	Inpatient & Outpatient Physician	80% after deductible	50% after deductible	Outpatient individual or group therapy visits are limited to sixty (60) visits per calendar year.
If you are pregnant	Prenatal and postnatal care	80% after deductible	50% after deductible	A copay will apply to the initial visit. After initial visit to a Network physician for Maternity services, charges will be subject to the deductible and coinsurance.
	Delivery and all inpatient services	80% after deductible	50% after deductible	
	Home Health Care	80% after deductible	50% after deductible	

Common Medical Event	Services You May Need	Network Benefit	Non-Network Benefit	Limitations, Exceptions and Exclusions
If you need help recovering or have other special health needs	Rehabilitation/Habilitation services	80% after deductible	50% after deductible	PT, OT, ST and AT services are limited to forty-five (45) outpatient days per calendar year for all services combined. The maximum cal. yr benefit is for Network and Non Network combined.
	Skilled nursing care	80% after deductible	50% after deductible	
	Durable medical equipment and Related Supplies	80% after deductible	50% after deductible	Notification is required for charges in excess of \$1,000 per durable medical equipment prior to purchase, lease or rental; limited to the U&R charges of standard models as determined by Medical Intelligence.
	Hospice services	100% Deductible waived	50% after deductible	
If your child needs dental or eye care (attained age of 19)	Eye exam	Ineligible under Medical Plan		Vision Acuity Screenings-paid as Preventive under the Medical Plan-100% allowed U&R
	Glasses	Ineligible under Medical Plan		
	Dental check-up	Ineligible under Medical Plan		Dental Screenings-paid as Preventive under Medical Plan-100% allowed U&R

Excluded Services and Other Covered Services (This is not a complete list. Check your plan document for other excluded and unproven or experimental 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 Plan Exclusions or Limitations: This is not a complete list. Check your plan document for other excluded and unproven or experimental services. Login: www.iebp.org • Select: My Tools • Select: MyBenefits on Demand • Select: Benefits • Select: Medical • Medical Plan Book

- The following exclusions and limitations apply to expenses incurred by all Covered Individuals:**
1. **Charges incurred prior to the effective date of coverage** under the Plan, or after coverage for eligible participants is terminated.
 2. Charges incurred as a **result of riot, revolt, war or any act of war**, whether declared or undeclared, or caused during service in the armed forces of any country.
 3. Charges **arising out of the course and scope of any occupation** for wage or profit, or for which the Covered Individual is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law.
 4. Charges incurred **while confined to a hospital owned or operated by the United States Government or any Agency thereof**, or charges for services or treatments or supplies furnished by the United States Government or any Agency thereof for any illness or injury related to military services.

5. Charges incurred for which the **Covered Individual is not, in the absence of this coverage, legally obligated to pay**, or for which a charge would not ordinarily be made in the absence of this coverage.
6. Charges resulting from or occurring (a) during the **commission of a crime** by the Covered Individual, or (b) while engaged in an illegal act, illegal occupation or felonious act or aggravated assault.
7. Charges incurred initially or as a result of complications for a **service that is excluded** under the plan, whether medically indicated or not.
8. Charges incurred for **nutritional supplements**.
9. Charges incurred for services or supplies, which constitute **personal comfort or beautification** items in connection with custodial care, education or training, 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, including manual or electronic lifts; elevators; escalators; and ramps) or expenses actually incurred by other persons.

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, Certified Nurse Midwife/Certified Professional Midwife, Chiropractor, Circumcision, Cosmetic Procedures/Reconstructive Surgery, Co Surgeon, Diabetes Self-Management Education, Durable Medical Equipment, Genetic Testing, Infertility Diagnostic, Infusion Therapy, Injectable, Biotech, and Biosimilar prescriptions, Inpatient Hospital, Inpatient Newborn Care, Inpatient Physical, Occupational, and/or Aquatic Therapy, Inpatient Speech Therapy, Lab & X-ray, Lactation Support, Licensed Professional Ambulance, Treatment of Temporomandibular Disorders (TMJ), Nursing Services, Nutritional Counseling, Oophorectomy, Oral Surgery, Orthomolecular Medicine or Chelation Therapy, Outpatient Hospital, Outpatient Physical, Occupational, and/or Aquatic Therapy, Outpatient Speech Therapy, Physician, Pre-Admission Testing Benefit, Pulmonary Rehabilitation, Registered Respiratory Therapist, Second Surgical Opinion Benefit, Skilled Nursing Facility, Surgical Sterilization, Telemedicine Services, Transplant, and Ultrasound and/or Sonograms for Pregnancy.

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

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

What is COBRA Continuation of Coverage? COBRA Continuation of Coverage is a continuation of Plan coverage when 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.

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 appellant may request an independent review from an independent state licensed external review organization that is credentialed under URAC. The external review will be conducted by a random URAC selected reviewer who was not consulted initially during the external clinical excellence review. Once the review is complete, if the denial is maintained, the appellant will receive a written explanation of the reasons and facts relating to the denial.

Appeal of Urgent/Emergent Request for Benefits (Adverse Pre-Determination/Notification Request)

Type of Request for Benefits or Appeal	Internal/External Process	Business Hours/Days
If the appellant appeals the adverse notification determination or declination of notification, the appellant must appeal within:	Internal	one hundred eighty (180) dys after receiving the denial based on a completed review process
If the appellant's request for emergent benefits is incomplete IEBP will send the urgent/emergent incomplete pre-determination/notification information declination letter within:	Internal	twenty-four (24) hrs of receipt of appellant's information
The appellant must provide a completed information request within:	Internal	forty-eight (48) hrs after receiving the IEBP declination due to incomplete information
If the request for urgent/emergent benefits is complete and not approved, IEBP will send an urgent/emergent pre-determination/notification denial letter within:	Internal	seventy-two (72) hrs

Appeal of Non-Emergent Request for Benefits (Adverse Pre-Determination/Notification Request)

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

* A one-time extension of no more than fifteen (15) days only if more time is needed due to circumstances beyond the appellant's control.

Appeal of Urgent/Emergent Request for Benefits (Adverse Pre-Determination/Notification Request)

Type of Request for Benefits or Appeal	Internal/External Process	Business Hours/Days
If the request for concurrent review is complete and not approved, IEBP will send a concurrent review denial:	Internal	twenty-four (24) hrs
If the appellant requests an Independent Review Organization (IRO), the external review appeal request must be submitted for the review within:	External	one hundred twenty (120) dys of receipt of the original denial or response to your appeal
The IRO will complete the review and IEBP will submit the response of <u>an expedited urgent/emergent pre-determination/notification</u> of a benefit appeal within:	External	seventy-two (72) hrs

Post-Service Claims

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

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

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

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

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

Having a Baby (normal delivery)		Managing Type 2 Diabetes (routine maintenance of a well-controlled condition)		Simple Fracture (with emergency room visit)	
• Cost of Care: \$13,170.65 • Plan pays: \$10,635.65 • Covered Individual pays: \$2,535.00		• Cost of Care: \$6,942.43 • Plan pays: \$5,770.80 • Covered Individual pays: \$1,171.63		• Cost of Care: \$2,053.50 • Plan pays: \$1,146.81 • Covered Individual pays: \$906.69	
Sample Care Costs		Sample Care Costs		Sample Care Costs	
Hospital charges (mother)	\$6,252.00	Prescriptions	\$5,693.70	Emergency Services	\$1,459.00
Routine obstetric care	\$2,619.52	Medical Equipment and Supplies	\$208.32	Medical Equipment and Supplies	\$122.00
Hospital charges (baby)	\$1,464.09	Office Visits and Procedures	\$642.53	Office Visits and Procedures	\$350.05
Anesthesia	\$1,706.72	Education	\$200.89	Physical Therapy	\$92.40
Laboratory tests	\$184.03	Laboratory tests	\$58.42	Laboratory tests	\$0.00
Prescriptions	\$464.80	Vaccines, other preventive	\$138.57	Prescriptions	\$30.05
Radiology	\$479.49	Total	\$6,942.43	Total	\$2,053.50
Total	\$13,170.65	Covered Individual Pays		Covered Individual Pays	
Covered Individual Pays		Deductible	\$467.63	Deductible	\$500.00
Deductible	\$500.00	Copayments: Medical/Rx	\$210.00/\$494.00	Copayments: Medical/Rx	\$175.00/\$0.00
Copayments: Medical/Rx	\$35.00/\$0.00	Plan/Max Plan OOP	\$0.00/\$467.63	Plan/Max Plan OOP	\$231.69/\$731.69
Plan/Max Plan OOP	\$2,000.00/\$2,500.00	Federal Maximum OOP	\$1,171.63	Federal Maximum OOP	\$906.69
Federal Maximum OOP	\$2,535.00	Limits or Exclusions	\$0.00	Limits or Exclusions	\$0.00
Limits or Exclusions	\$0.00	Total	\$1,171.63	Total	\$906.69
Total	\$2,535.00				