

City of San Marcos



Medical Benefits

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

Customer Care:
English: (800) 282-5385
Spanish: (800) 385-9952
Care Management: (800) 847-1213

City of San Marcos*

Medical Benefits Booklet

Plan Effective August 1, 2001 with Amendments through January 1, 2016

The City of San Marcos has designed a plan of benefits for TML MultiState IEBP (IEBP) to administer the plan as the Benefits Administrator. As the Plan Administrator, the City of San Marcos has the responsibility for compliance with state and federal laws applicable to employee benefits. However, for most state and federal laws applicable to a health plan based upon the number of employees enrolled or eligible to enroll in the health plan, the size of the health plan is determined by the number of individuals enrolled in the plan as a whole. This is a governmental plan excluded from coverage under ERISA (29 U.S.C.A. 1003(b)).

* *A Risk Pool created under and governed by the Texas Political Subdivisions Uniform Group Benefits Program (Section 172 Local Government Code). Section 172.014 provides that "A risk pool created under this Section is not insurance or an insurer under the Insurance Code or other laws of this state, and the State Board of Insurance does not have jurisdiction over a pool created under this Section." Section 172.015 provides that "The payor of employee benefits, whether a political subdivision, group of political subdivisions, pool or carrier providing reinsurance to one of these entities, shall be subrogated to the Employees' right of recovery for personal injuries caused by the tortious conduct of a third party."*

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Introduction

Your Medical Benefits Plan

The City of San Marcos, in conjunction with the TML MultiState IEBP (IEBP), has prepared this booklet to help you understand the medical benefits provided by the City of San Marcos. The City of San Marcos partially self-funds the medical and fully self-funds the dental plan. This means the City provides for the payment of claims by using contributions of the City and contributions collected from plan participants. The City has contracted with IEBP to maintain enrollment information, pay claims for benefits described in this book and provide all administrative services relating to this benefit plan.

The Medical benefits described in this booklet provide coverage for a wide range of medical care, services and supplies. Your benefits are affected by certain limitations and conditions, which require you to be an informed consumer of health services and to use only those services you need. Benefits are not provided for certain kinds of treatment or services, even if recommended by your physician.

Health Care Costs and Use of Benefits

It is important for you to understand that the cost of the plan to you, as a covered individual and the City, as an Employer, is dependent upon prudent use of plan benefits by covered individuals. Excessive or inappropriate use of the plan, such as routine care in the emergency room, increases plan costs and ultimately the rates that you pay as a participant. We urge you to familiarize yourself with the provisions of this Plan described herein in order to understand your benefits.

Preferred Provider Organization (PPO)/Preferred Provider Network (PPN)

Each time you need medical services, you have the option to select any of the hospitals, physicians, or ancillary services listed in the preferred provider organization (PPO)/preferred provider network (PPN) directory to receive the best value under the medical plan. There is no PPN/PPO provision in the dental plan. Dental benefits under this plan allow you to see the dentist of your choice. Please keep in mind that payment arrangements need to be made before utilizing services, as some dentists require payment at the time services are rendered. If this is the case, you should request an itemized claim from the dentist and file it with IEBP for reimbursement. If you have questions regarding plan benefits or requirements you are encouraged to call IEBP Customer Care at (800) 282-5385.

The medical plan currently utilizes the TML MultiState IEBP/UnitedHealthcare Choice network. This network is nationwide and offers network providers in and outside of Texas. You can access a complete list of Network providers on the Internet by visiting our website at www.iebp.org. The site is continuously updated and will provide you with the most current listing of Network providers for the City of San Marcos Medical plan. You will be prompted for your website ID number, which is **ASANMAR1**. The website ID number is also shown on your ID card.

Primary Care Provider

While the plan does not require a primary care provider, the City encourages you to be a prudent health care consumer. Network benefits provide the best value and offer a wide selection of providers. When using an in-network provider, the provider will ask you to sign an assignment of benefits form. This form will allow the provider to arrange for payment of your services. You will be responsible for the deductible, the copay and/or co-insurance portion of your bill as an out-of-pocket expense for all covered services that are eligible benefits.

Preferred Lab Program

Lab services received through a Preferred Lab Program participating provider are paid at 100%. Remember to notify your provider about using a Preferred Lab Program provider prior to services being rendered. There will be a \$30 office visit copay for specimen collection in the doctor's office. The participant will not pay any fee for specimen collection at a preferred lab site. The preferred lab must bill IEBP directly for the service to be covered under the Preferred Lab Program benefit. Lab charges billed by any other provider will be subject to deductible and co-insurance. Preferred Lab Locations can be identified on the IEBP website www.iebp.org or by contacting Member Services at (800) 282-5385.

Use of Out Of-Network Resources

You still have the option to use an out-of-network medical provider, although your out-of-pocket expenses will be higher and you will not receive the discounted service rates available through in-network providers. In addition, out-of-network physicians may charge fees exceeding usual, reasonable and customary rates that are not covered by this Plan and become additional expenses to you. A pre-determination of how charges will be paid is available upon submitting an estimate of charges to IEBP. If your physician or hospital is out-of-network and is interested in participating in the network, please call (800) 282-5385. You will need to provide the name, address and telephone number of the provider you wish to be contacted by IEBP. Out-of-network deductible and maximum out-of-pocket amounts accumulate separately from in-network amounts.

Medical Extenuating Circumstances (Out-of-Area Benefits)

If a Covered Individual requires emergent/immediate care until stabilized or if a specialist care provider is required but there is not a Network specialist care provider within a seventy-five (75) mile radius, eligible charges will be paid at the Network benefit, subject to the deductible and Network Out of Pocket, subject to usual, reasonable and customary allowable amounts.

Prescription Drug Program

Your insurance (ID) card will include information on the prescription drug program benefits and contact information. In addition, you will find information on your Prescription Drug Schedule of Benefits.

The Claims Review Process

When a claim form or bill is presented to IEBP for payment, several things happen. The coding submitted by the medical provider is entered and the claim is reviewed. Questions may arise during this review, which result in a letter to you requesting additional information. It is important for you to respond to this letter thoroughly and in a timely manner so that your claim can be processed and payment made. In some instances, IEBP will deny your claim depending on the information you provide. For example, a claim may be denied if the treatment is related to employment which should be covered by workers' compensation or an accident which is covered by automobile or other coverage. More detail is provided in this book regarding these types of subrogated claims and third party claims. When a bill is paid on your behalf by IEBP, an explanation of benefits (EOB) will be mailed to you. You are encouraged to review the EOB for accuracy of payment. If you notice something that does not seem correct to you, you can call IEBP Customer Care at (800) 282-5385.

Section 125 Flexible Spending Program

If you participate in the Section 125 Flexible Spending program, you may file a flex claim form for out-of-pocket expenses you incur. This may include copays for doctor visits, copays for prescription drugs, co-insurance amounts due or items not covered, such as prescription glasses, orthodontics, etc. The flexible spending account allows you to use pre-tax dollars to pay unreimbursable out-of-pocket medical expenses. The Section 125 Flexible Spending program is administered on behalf of the City of San Marcos by IEBP. If you have any questions regarding flexible benefits, you may call IEBP at (800) 282-5385. You may also visit their website at www.iebp.org.

Emergency Care

The City encourages you to establish a relationship with a physician for routine medical care and other visits. If you or a dependent become ill and you are not signed up as a patient, you most likely will be directed to the emergency room and charged a two-hundred and fifty dollar (\$250) access fee. In addition, if the treatment is for non-emergent/non-immediate care, charges will also be subject to the deductible and coinsurance. Initial consultations to become an established patient are covered under this plan and you are encouraged to plan this visit, rather than waiting until there is an urgent care or emergency situation.

Federal Government Maximum Out of Pocket (MOOP)

The maximum out of pocket (MOOP) limit for PPO and High Deductible H.S.A. plans are defined per the Federal Government and updated per calendar year. Eligible network, most cost effective out of pocket expenses accumulate to the Federal Government MOOP. Once the H.S.A. or PPO Federal Government defined maximum out of pocket amount is met the medical and prescription most cost effective, eligible network services accessed within the scope of the benefit plan will be paid at 100%. The City of San Marcos' medical plan has an out of pocket limit that is less than the MOOP amount set by the Federal Government.

Plan Administration Information

The City of San Marcos, hereinafter referred to as the “Employer,” hereby establishes the benefits, rights, and privileges which shall pertain to Participating Employees, hereinafter referred to as “Covered Individuals”, and the Eligible Dependents of such Covered Individuals, as herein defined, and which benefits are provided through a Fund established by the Employer and hereinafter referred to as the “Plan”. IEBP is the Benefits Administrator for the City of San Marcos’ plan.

Purpose

The purpose of the Plan Document is to set forth the provisions of the Plan, which provide for the payment or reimbursement of all or a portion of eligible medical expenses.

Effective Date

The effective date of the Plan is January 1, 2016

Participation Requirements

All regular employees working at least 30 hours per week will be plan participants; and retirees as defined in this plan and City of San Marcos Employee Handbook.

Coverage Period

The coverage period is the first day of the month through the last day of the month.

Contributions under the Plan

Employees and retirees contribute for coverage.

Named Fiduciary

The named fiduciary is the Employer who shall have the authority to control and manage the operation and administration of the Plan. The Employer shall have the authority to amend the Plan, to determine its policies, to appoint and remove other Benefits Administrators, fix their compensation (if any), and exercise general administrative authority over them. The Employer has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

Compliance with Applicable Laws

It is the intent of the City, the Plan Administrator, the Claims Administrator and the Plan to comply with all applicable laws. If any provision of this Plan is in conflict with applicable State or Federal laws, the minimum requirements of such law will apply.

Plan Amendments

This document contains all the terms of the Plan and may be amended from time to time by the Employer. Any changes so made shall be binding on each Covered Individual.

Termination of Plan

The Employer reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions by the Employer shall continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or shall be used for the purpose of providing similar health benefits to Covered Individuals, until all contributions are exhausted.

Plan is not a Contract

This Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Covered Individual the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any Covered Individual.

Benefits Administrator

The Benefits Administrator of the Plan is IEBP.

Claims Administration & Care Management Services

IEBP operates under Chapter 172 of the Local Government Code. IEBP offers a multitude of services to self-funded entities. IEBP provides the Employer with Claims Administration, Care Management/Intensive Care Management, IEBP’s Provider Network, and Employee/Dependent eligibility.

Hours of Operation	8:30 A.M. to 5:00 P.M., Central Standard Time
Customer Care	(800) 282-5385
Member Services Spanish Line	(800) 385-9952
Automated Benefit Verification.....	(800) 282-6186
Care Management Services/Notification	(800) 847-1213
Alliance Work Partners (EAP)	(800) 343-3822
Clinical Prior Authorization other than Chemotherapy (prescribers should call OptumRx)	(800) 711-4555
Clinical Prior Authorization for Chemotherapy (prescribers should call IEBP)	(800) 847-1213
Step Therapy (prescribers should call OptumRx)	(800) 711-4555
Customer Service for Prescriptions	(888) 543-1369
Mail Order Prescriptions.....	(800) 788-7871
To locate an In-Network provider	(800) 282-5385
IEBP Website.....	www.iebp.org

To locate an In Network provider on the IEBP website in the state of Texas, or for an In Network provider located outside of Texas, follow the instructions provided.

NOTE: Please have the name of your Group, San Marcos, and website ID # “ASANMAR1”, and the unique identification number, or Social Security Number, of the Covered Employee when you call or access the website.

IEBP Claims Mailing Address

TML MultiState IEBP
Attn: Member Services
P.O. Box 149190
Austin, TX 78714-9190

Stop Loss

The Employer purchases Stop Loss coverage.

Notice of Privacy Practices

The Notice of Privacy Practices for San Marcos is located on page 70.

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 San Marcos'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, care management, 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 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 the Plan 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 its business associates, to you; or (2) a promotional gift of nominal value given by the Plan, or one 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 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 60 days of the date the Plan receives your written request. However, the Plan is allowed an additional 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 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 San Marcos
Attn: Director of Human Resources
630 E Hopkins
San Marcos, TX 78666-6397

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 60 days after it receives your request to respond. If the Plan is not able to respond, it is allowed one 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.

In writing:

City of San Marcos

Attn: Director of Human Resources

630 E Hopkins

San Marcos, TX 78666-6397

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 are the privacy practices described in this notice effective?

This privacy notice has an effective date of September 1, 2013, and it replaces 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. The Plan and IEBP (the Plan's Group Benefits Administrator) will maintain their current privacy notice's on IEBP's website at: www.iebp.org. If a revision is made during your plan year, IEBP will post the revised notices to the website on the date the new notice goes into effect.

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

The Plan is required to maintain your records for at least six 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 San Marcos

Attn: Director of Human Resources

630 E Hopkins

San Marcos, TX 78666-6397

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

Write to:

City of San Marcos

Attn: Director of Human Resources

630 E Hopkins

San Marcos, TX 78666-6397

Eligibility Requirements and Effective Dates for Coverage

Coverage provided under this Plan for Participants and the Dependents shall be in accordance with the Eligibility, Effective Date and Termination provisions as stated in this Plan Document, including any benefit coverage stated in the Summary of Benefits and Coverage. All participant coverage under the Plan shall commence at 12:01 A.M. Central Standard Time on the date such coverage is effective.

Participant Eligibility

A Participant eligible for coverage under the Plan shall include only employees who are employed by the City of San Marcos on a regular basis for at least thirty (30) hours per week. Once eligible, the Participant's coverage will be effective on the first day of the month following completion of the thirty (30) day waiting period. The waiting period is waived for eligible employees returning from an unpaid leave of absence.

A Participant eligible for dependent coverage shall be any participant whose dependents meet the definition in the following section of the Plan. Each Participant will become eligible for Dependent Coverage on the latest of the following:

1. The date eligible for participant coverage; or
2. The date a dependent is first acquired; or
3. The date the participant becomes eligible for dependent coverage.

If both spouses are employed by the Employer, and both are eligible for dependent coverage, either spouse, but not both, may elect dependent coverage for their eligible dependents.

Participant Effective Date

Participant coverage under the Plan shall become effective with respect to an eligible person on the first of the month following the 30th day of eligibility, provided written application for such coverage is made prior to the effective date. Eligible employees returning from an unpaid leave of absence will be reinstated on the day the employee returns to work.

In the event that application for coverage is not received prior to the effective date, the plan will no longer automatically enroll the employee for employee only medical and dental coverage. Employees will have the opportunity to opt out of health and dental coverage under the plan. Employees who opt out of coverage during their initial enrollment period, may only enroll for coverage during the plan's annual open enrollment or within thirty-one (31) days of a qualifying event.

Dependent Eligibility

A dependent will be considered eligible for coverage on the date the Participant becomes eligible for dependent coverage, subject to all limitations and requirements of this Plan, and in accordance with the following:

Spouse – The term "spouse" means the Participant's lawful spouse, whether or not such spouse is an employee. Common law marriages require a "Declaration and Registration of an Informal Marriage" certificate to be filed with the County Clerk's office before the marriage is considered legal.

Child(ren) – A child or children may be covered from birth to the last day of the month of his/her 26th birthday. Coverage may be extended in some instance as defined in the following section on extension of coverage.

A dependent that enters (or is in) the armed forces of any country as full-time member on active duty for a period that exceeds thirty (30) days is not eligible under this plan as a dependent. Subject to the limitations set forth in this plan, the term "Child" means a person who is not a covered employee under this Plan and is either:

1. Your natural, step-child or legally-adopted (or legally placed for adoption) or foster child placed by the State in the Covered Employee's care;
2. Your child or stepchild, for whom you or your spouse are required by court order to provide coverage regardless of whether the child resides with you or whether the child is eligible to be claimed as an exemption on your federal tax return;

3. Any other children living in your household and under legal guardianship; or
4. Dependent 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. The grandchild must continue to be a dependent of the employee for federal income tax purpose, who is financially dependent on the employee.

Dependents' Effective Date

Each participant who makes written request for dependent coverage hereunder, on a form approved by the Employer, shall, subject to the further provisions of this section, become covered for dependent coverage as follows:

Initial Eligibility

A Covered Individual's eligible dependents shall be covered on the date the Covered Individual begins participation in the plan, if a properly completed enrollment form is filed with the City's Human Resources Department within 31 days after the Covered Individual's effective date of coverage. Coverage of a spouse due to marriage will be effective on the first of the month following receipt of the change form in Human Resources as long as the form to add the spouse is received in Human Resources no later than 31 days following the date of marriage. Coverage added due to the qualifying event of birth, adoption or placement for adoption will be effective on the date of the birth, adoption or placement for adoption as long as the change form to add the child is received in Human Resources no later than 31 days after the birth, adoption or placement for adoption.

IMPORTANT: Refer to the section on qualifying events, which defines when changes can be made.

Extension of Coverage

Mentally or Physically Disabled Children

If a covered dependent child 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 Benefits 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 Benefits Administrator may require satisfactory proof of the continued incapacity. The Benefits Administrator may request proof of the incapacity annually. If you fail to submit proof when reasonably required then coverage for the child will terminate.

COBRA Continuation of Coverage under Federal COBRA Laws

Once you and/or any family members become covered, there are specific COBRA events called "qualifying events" that can cause you or your family to lose coverage. The maximum coverage period and the timing of the employer notice requirements are measured from the date coverage is lost due to the qualifying event.

For more information see the section titled "COBRA Continuation of Coverage (COC) Rights under COBRA".

During Absence from Work

An employee who meets the definition of an active employee while on employer approved leave will be eligible to continue health care for themselves and their eligible dependents. This includes employees on paid leave, approved FMLA (whether paid or unpaid) and Military Leave (whether paid or unpaid). The City of San Marcos Employee Handbook governs leave policies. Sworn Police and Fire employees are affected by requirements of the Texas Firemen's and Policemen's Civil Service Law (LGC143).

Active Duty Reservists

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

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

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

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

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

The employer must notify the Benefits Administrator by sending a Qualifying Event Notice and mark the qualifying event "Called to Active Duty" and attach a copy of the employee's written order for the call to duty.

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.

Survivors of Certain Public Safety Employees

Coverage for a dependent cannot extend beyond the date coverage for the active employee ends, unless required by Section 615.071 of Chapter 615 of the Government Code for survivors of certain employees described in Section 615.003 of the Chapter who are killed in the line of duty. Section 615.075(c) requires that the survivor must give the employer notice of election to purchase coverage within 180 days of the decedent's death.

Family and Medical Leave Act of 1993

This plan will be administered in compliance with the Family and Medical Leave Act of 1993, including the right to maintenance and restoration of health benefits of an employee who is absent under the provisions of the act. For more information, contact the City's Human Resources Department or the nearest office of the Wage and Hour Division of the Department of Labor.

Retiree Eligibility

An employee separating from active employment with the City of San Marcos who is entitled to receive retirement benefits from the Texas Municipal Retirement System may elect to purchase continued health care coverage as follows:

Retiree (and Retiree Dependent)

Retirees may enroll themselves and their eligible dependents for coverage in place on the day the employee retires with the City of San Marcos. Retirees may only cover dependents that were on the Plan at the time of the employee's retirement. Retirees are not permitted to add or change dependent coverage at the time of retirement or thereafter, including at Open Enrollment. In addition, Qualifying Events and Family Status Changes are not applicable to retired employees and their dependents.

Eligible retirees must enroll themselves and eligible dependents no later than the last day of the month in which the employee has coverage as an active employee with the City of San Marcos, or they are ineligible. The retiree must be enrolled for eligible dependents to be enrolled. Retirees are not eligible for participation in the City's plan if eligible for coverage through another employer.

After retirement, a retiree may elect to cancel coverage for themselves and/or dependents at any time. Coverage will remain effective until the last day of the month in which coverage was cancelled, if premiums have been paid. If coverage for the retiree or eligible dependents is cancelled or the retiree discontinues coverage, there is no re-enrollment right.

Retirees who elect COC/COBRA (continuation coverage) cannot later elect retiree coverage.

Retiree Coordination of Benefits with Medicare

Retirees who are entitled to coverage under Medicare will be subject to coordination of benefits. Coordination of benefits also applies to a covered spouse of a retiree who is entitled to coverage under Medicare.

Generally, Medicare is primary for a retiree/covered spouse and the City's plan will pay benefits as though the retiree/covered spouse has both Part A and Part B of Medicare coverage, even if the retiree is not enrolled in Part B of Medicare. This Coordination of Benefits provision will also apply to Medicare Part D, if the retiree is enrolled in Medicare's prescription benefit. Please see pages 32-33, "*Coordination with Medicare*" for details.

Retirees ages 65 and older are required to make enrollment for full Medicare coverage or make due claim for Medicare benefits. If the Retiree elects to not enroll in Medicare, the Benefits Administrator will calculate the benefits which would have been paid by full Medicare coverage and adjust the Plan benefits payable accordingly to the Medicare allowed amount.

Retiree Effective Date

Retiree coverage under the Plan shall become effective for eligible retirees on the first of the month following the end of active employment, provided written application for such coverage is made on or before the last day of the month in which the employee is covered as an active employee.

Retiree Payment of Contributions

Payment for retiree coverage contribution is due on the first day of the month of coverage with a thirty (30) day grace period. If payment is not received by the Benefits Administrator within the grace period, coverage will end on the last day of the month for which premiums were paid, with no reinstatement right.

Qualifying Events to Make Changes during the Plan Year

The following describes the circumstances under which you may be allowed to add or drop coverage for yourself, your eligible spouse and/or dependent children to your medical insurance under this plan, outside of the annual open enrollment period or your initial enrollment period. The individual with the qualifying event is **not** the only individual who can make a change or be enrolled as a result of a qualifying event.

You have 31 days from the date of the “qualifying” event (or 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) to make an eligible change to your medical coverage. If you make a change during the 31-day period allowed, the change to your coverage will be effective on the later of the first of the month following receipt of the change form **or** the date of the qualifying event, with the following exceptions:

1. Coverage for loss of dependent eligibility will end the last day of the month in which the dependent loses eligibility.
2. The effective date for adding a dependent child due to birth, placement for adoption or adoption will be the date of birth, placement for adoption or adoption, as long as the change form is received in Human Resources within the 31-day period allowed to make a change.
3. Coverage will be reinstated on the day an employee returns to work in an eligible position following leave as allowed under FMLA, USERRA, or unpaid leave of absence.

Evidence of the qualifying event is required. If you do not submit the form within the time period allowed, you will have to wait until the next open enrollment period to make the change, and may be required to continue payment of premiums under the Flexible Benefits Plan which are not refundable, and for which no benefit may be received under the medical plan.

Please be aware that if you have dependent children covered under your plan and acquire a new dependent child, you **MUST** enroll the new dependent in the plan within 31 days of acquiring that dependent. Coverage for the additional child is not automatic.

Qualifying Events (Change in Status)

1. A change in legal marital status (marriage, divorce, legal separation, annulment, death of spouse).
2. A change in the number of dependents (birth, adoption, placement for adoption, death). Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child’s adoption. The child’s placement for adoption with such person terminates upon the termination of such legal obligation.
3. Change in employment status for you, your spouse or dependent (termination or commencement of employment, strike or lockout, commencement or return from an unpaid leave of absence).
4. Change in dependent status (events that cause a dependent to satisfy or cease to satisfy eligibility requirements for coverage).
5. Initial or change in legal judgment, court decree or court order that requires coverage for a child who is a dependent of the employee.
6. Change in entitlement to Medicare or Medicaid.
7. Significant cost or coverage changes under another employer’s plan (Including a change made by your spouse or dependent during another employer’s open enrollment period that differs from the City of San Marcos’ open enrollment period).
8. Loss of coverage under a State’s Children’s Health Insurance Program (SCHIP) under Title XXI of the Social Security Act.
9. Special requirements relating to the Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA).
10. Special enrollment rights allowed under the Health Insurance Portability and Accountability Act of 1996.

Termination of Coverage

Employees are responsible for requesting termination of coverage for dependents that lose eligibility, within 31 days of the qualifying event. Failure to notify the Human Resources Department in a timely manner could result in payment of premiums under the Flexible Benefits Plan that are not refundable and for which no benefits may be received under the medical plan (Section 125 IRS regulations). Due to IRS regulations, we cannot process a change to the Flexible Benefit Plan that is requested more than 31 days after the event, or loss of coverage due to the event, and the next opportunity to end deductions will be at the next open enrollment period.

After termination of coverage, you will be issued a certificate of coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The certificate will show how long you were covered under the Plan and the date your coverage under the Plan ended. The plan will comply with all provisions of COBRA Continuation of Coverage (COC/COBRA). Coverage under the plan shall end at 12:00 A.M. Central Standard Time, on the last day of the month in which one of the events listed below occurs.

Participant Termination

Participant coverage shall automatically end the last day of the month in which*:

1. Participant terminates employment;
2. Participant ceases to be eligible for coverage;
3. Premiums have been paid; or
4. Termination of the benefit plan or with respect to any participant benefits of the Plan, the date of termination of such benefit.

* *Except as provided in any Extension of Benefits Provision.*

Dependent Termination

The Dependent Coverage of a Participant shall automatically end the last day of the month in which*:

1. The dependent ceases to be an eligible dependent as defined in the Plan;
2. Participant terminates employment;
3. Participant ceases to be eligible for coverage;
4. Participant fails to make any required contribution for dependent coverage by the end of the 30 days grace period;
5. Date the Plan is terminated; or with respect to any dependent's benefit of the Plan, the date of termination of such benefit; or
6. The dependent enters the armed forces of any country as full-time member if active duty is to exceed thirty (30) days.

* *Except as provided in any Extension of Benefits Provision*

Retiree Termination

If a retiree elects to continue coverage for themselves and on a subsequent date elects to discontinue such coverage, the retiree and/or dependent is no longer eligible for coverage under this plan.

Retiree Participant coverage shall automatically end the last day of the month in which*:

1. Retiree elects to discontinue such coverage;
2. Retiree participant is eligible for group health benefits coverage through another employer;
3. Participant ceases to be eligible for coverage;
4. Premiums have been paid; or
5. Termination of the benefit plan, or with respect to any participant benefits of the Plan, the date of termination of such benefit.

* *Except as provided in any Extension of Benefits*

Retiree Dependent Termination

If the person elects to continue coverage for any dependent and on a subsequent date elects to discontinue such coverage, the dependent is no longer eligible for coverage under this plan.

The Dependent Coverage of a Retiree shall automatically end the last day of the month in which*:

1. The dependent ceases to be an eligible dependent as defined in the Plan;
2. Participant terminates participation in the plan;
3. Participant ceases to be eligible for coverage;
4. Participant fails to make any required contribution for dependent coverage by the end of the 30-day grace period; or
5. Date the Plan is terminated; or with respect to any dependent's benefit of the Plan, the date of termination of such benefit.

* *Except as provided in any Extension of Benefits*

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 other health coverage alternatives that may be available to you through the Health Insurance Marketplace. This notice generally explains COBRA Continuation of Coverage when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 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 booklet 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 and/or Part C); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because 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 and/or Part C);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a “dependent child.”

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

Sometimes, filing a proceeding in bankruptcy under Title 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 coverage for 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 and/or Part C), the employer must notify the Benefits Administrator 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 Benefits 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 receives notice that a qualifying event has occurred, COBRA Continuation of Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA Continuation of Coverage. Covered employees may elect COBRA Continuation of Coverage on behalf of their spouses, and parents may elect COBRA Continuation of Coverage on behalf of their children.

COBRA Continuation of Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (Part A, Part B and/or Part C), your divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA Continuation of Coverage lasts for up to a total of thirty-six (36) months. When the qualifying event is the end of the employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA Continuation of Coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA Continuation of Coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six (36) months minus eight (8) months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA Continuation of Coverage generally last for only up to a total of eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA 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, the Benefits Administrator, 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 the Benefits Administrator that an employee has been called to active duty and submit a copy of the employer member's active reservist policy to the Benefits Administrator.

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 Benefits Administrator within sixty (60) days of that determination, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA Continuation of Coverage for a total maximum of twenty-nine (29) months. The disability must start at some time before the sixtieth (60th) day of COBRA Continuation of Coverage and must last at least until the end of the eighteen (18) or twenty-four (24) month period of COBRA Continuation of Coverage. You may contact TML MultiState IEBP (the Benefits Administrator) 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) months of COBRA Continuation of Coverage, the spouse and dependent children in your family may get up to eighteen (18) additional months of COBRA 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 COBRA Continuation of Coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B and/or Part C) or gets divorced or legally separated, or 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.

Adding Dependents

If you are a COBRA Continuation of Coverage participant, you have the same rights to add dependents to your COBRA Continuation of Coverage as an active covered employee. For example, you may add dependents to your COBRA Continuation of Coverage within thirty-one (31) days of marriage or the birth, adoption or placement for adoption of a child. Also, you may add dependents to your COBRA Continuation of Coverage during your employer's open enrollment. However, these dependents who were not covered under the Plan before your qualifying event occurred are not qualified beneficiaries and do not have individual COBRA Continuation of Coverage rights, except for children added within thirty-one (31) days of birth, adoption or placement for adoption. Children added to your COBRA Continuation of Coverage within thirty-one (31) days of birth, adoption or placement for adoption are qualified beneficiaries and have their own COBRA Continuation of Coverage rights.

If you have questions

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

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

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Benefits 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 Benefits Administrator.

Benefits Administrator Contact Information

TML MultiState IEBP
1821 Rutherford Lane, Suite 300
Austin, Texas 78754

Phone:	(512) 719-6500
Customer Care:	(800) 282-5385
Care Management:	(800) 847-1213
Spanish Line:	(800) 385-9952

How Benefits are Paid (Claims)

The Benefits Administrator may request specific information to complete processing of the claim or to verify eligibility in the Plan. As a covered individual and claimant under the Plan, you are responsible to supply the Benefits Administrator with information necessary to determine if charges incurred are for a covered expense. The Benefits Administrator reserves the right to withhold payment or deny a claim until the requested information has been furnished. Covered Individuals need to update their personal information, including address, in a timely manner through the City's Human Resources Department.

If required information is not provided, the claim will be denied. The claim may be re-filed as long as it is within the later of 12 months of the date of service or within ninety (90) days after a non-compensable claim decision is made by Workers' Compensation. Claims or information submitted later than 12 months from the date of service (or within ninety (90) days after a non-compensable claim decision is made by Workers' Compensation) will not be paid. To avoid a prompt pay penalty, required information must be received by IEBP not later than the prompt pay contract deadline.

Deductible and co-insurance (out-of-pocket amount) accumulate on a calendar year basis. Out-of-area benefits are subject to the in-network deductible and maximum out-of-pocket amounts. Out-of-network deductible and maximum out-of-pocket amounts accumulate separately from in-network or out-of-area amount.

Benefits will not be paid to providers who negotiate benefit settlements with patients, i.e., agree to accept whatever payment the Plan makes or providers who waive deductibles or copays.

Requests for Reimbursement

All requests for reimbursement, or proof that services for a covered benefit have been incurred, must include:

1. the employee's name, address, 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 (National Provider Identification/NPI number or social security number) and address; and
4. a description of the service rendered including charges, diagnosis code and applicable procedure codes and the date of service.

The request for reimbursement must be legible. If a claim is not legible, it may be returned with a request to submit a legible copy. Claims submitted electronically must meet the Standard for Electronic Transactions and Code Sets set forth by appropriate regulatory bodies.

A Clean Claim must be submitted by a network provider no later than the filing deadline. If the provider fails to submit a clean claim within the filing deadline, the provider forfeits the right to payment unless the failure is a result of a catastrophic event that substantially interferes with the normal business operations of the network provider.

Claims may be mailed to:

TML MultiState IEBP | PO Box 149190 | Austin, Texas 78714-9190

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

Claims or information submitted after twelve (12) months of the date of service or not within 90 days after a non-compensable claim decision by Workers' Compensation (the later of) will not be paid.

Assignments

The benefits provided under the Plan are payable to the covered individual. However, the Benefits Administrator will pay benefits directly to the health care provider if they are assigned by the Covered Individual.

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 or obtain information regarding a Covered Individual from any organization or person if necessary to determine benefits payable under the Plan.

As a Covered Individual under the Plan, you must supply the Benefits Administrator with the information necessary to determine benefits payable. The Benefits Administrator reserves the right to withhold payments until the requested information has been furnished.

No Replacement for Workers' Compensation

The Plan does not cover 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.

Self-Audit Reimbursement

Once IEBP has audited and made payment on a bill, a covered individual who 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 individual will be reimbursed 30% of the amount of savings generated. The reimbursement may not exceed \$500 per calendar year.

Subrogation

This Plan may withhold payment of benefits when a party other than the Covered Individual or the Plan may be liable for expenses until such liability is legally determined.

In the event of any payment for services under the Plan, the Employer shall, to the extent of such payment, be subrogated to all the rights of recovery of the Covered Individual arising out of any claim or cause of action which may accrue because of the alleged negligent conduct of a third party. Any such Covered Individual hereby agrees to reimburse the Plan, for any benefits so paid hereunder, out of any monies recovered from such third party as the result of judgment, settlement or otherwise; and such Covered Individual hereby agrees to take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Plan Administrator may require to facilitate the enforcement of their rights.

Conformity with Law

If any provision of this Plan is contradictory to any law to which it is subject, such provision is hereby amended to conform thereto.

Legal Actions

No legal action (including arbitration) may be brought against the Employer and/or the Benefits Administrator prior to the expiration of sixty (60) days after written proof of services incurred has been furnished in accordance with the requirements of the Plan and all appeal rights pursuant to the Plan have been exhausted. No such action may be brought after the expiration of two years from the date services were incurred. This paragraph shall be applicable where a medical provider makes a complaint that a prompt payment contract was not followed.

The Employer and/or the Benefits Administrator reserves the right to take any legal action available against a Covered Individual to recover expenses incurred by the Employer and/or the Benefit Administrator to defend frivolous lawsuits or actions brought before all appeal rights have been exhausted. 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.

Claims 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 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 for Urgent Care 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) days after receiving the denial based on a completed review process
If the appellant's request for emergent benefits is incomplete IEBP will send the <u>urgent care incomplete pre-determination/notification information declination letter</u> 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 <u>urgent care pre-determination/notification denial letter</u> 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) hrs
If the appellant's request an Independent Review Organization, (IRO) , the external review appeal request must be submitted for the review within:	External	one hundred twenty (120) days of receipt of the original denial or response to your appeal
The IRO will complete the review and IEBP will submit the response of <u>an expedited urgent care pre-determination/notification</u> of a benefit appeal within:	External	seventy-two (72) hours

Appeal of Non-Urgent Care 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) days 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) days
If the request for pre-determination/notification is <u>clinical information incomplete</u> , IEBP will notify you within:	Internal	fifteen (15) days
The appellant must then provide completed information within:	Internal	forty-five (45) days after receiving an extension notice*
IEBP will notify you of the first level appeal decision within:	Internal	fifteen (15) days after receiving the first level appeal
The appellant must appeal the first level appeal (file a second level appeal) within:	Internal	sixty (60) days after receiving the first level appeal decision
IEBP will notify you of the second level appeal decision within:	Internal	fifteen (15) days after receiving the second level appeal*
The appellant may request the appeal be submitted to an Independent Review Organization, (IRO). The External Review Request must be submitted within:	External	one hundred twenty (120) days of receipt of the original denial or response to your appeal
The IRO must complete the review of a <u>non urgent care claim or benefit appeal</u> within:	External	thirty (30) days

* A one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control

Post Service Claims Appeal		
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) days after receiving the denial
If the appellant's claim is incomplete, IEBP will notify the appellant within:	Internal	thirty (30) days
The appellant must then provide completed claim information within:	Internal	forty-five (45) days after receiving an extension notice
IEBP will notify the appellant of the first level appeal decision within:	Internal	thirty (30) days after receiving the first level appeal
The appellant must file the second level appeal within:	Internal	sixty (60) days after receiving the first level appeal decision
The appellant will be notified of the second level appeal decision generally within:	Internal	thirty (30) days after receiving the second level appeal
The appellant may request an appeal be submitted to an Independent Review Organization, (IRO). This request must be submitted for the review within:	External	one hundred twenty (120) days of receipt of the original denial or response to your appeal
The IRO must complete the review of a non emergent claim or benefit appeal within:	External	thirty (30) days
The IRO must complete a requested expedited review of an emergent claim or benefit appeal within:	External	seventy-two (72) hours

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

If a claim for benefits is wholly or partially denied, an Explanation of Benefits (EOB) will be furnished to the covered individual and the provider of services. This EOB will give the reason(s) the claim was denied. If the covered individual or provider of services does not agree with the claim decision or alleges that a contractual prompt payment requirement was not followed in the administration of a claim, he or she may submit an appeal within the 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.

Coordination of Benefits

Once a claim or potential claim for benefits has been submitted, if 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.

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 duplicate payment of medical expenses for the same illness or injury and to manage the high cost of medical coverage by seeking reimbursement from other sources.

Coordination of Benefits

The Coordination of Benefits (COB) provision applies when a Covered Individual may receive benefits for medical expenses from more than one source. The benefits payable under this plan will not exceed 100% of what the plan would pay in the absence of other coverage. 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

Custodial Parent means the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Plan means any of the following arrangements which provides medical benefits or services:

1. Insurance or any arrangement of benefits for individuals or groups;
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. Prepayment coverage or any other coverage toward the cost of which any Employer makes contributions;
4. A labor-managed trustee plan, union welfare plan, Employer organization plan or employee organization plan;
5. Any governmental program or coverage required to be provided by statute;
6. Coverage for students sponsored by, or provided through a school or other educational institution; or
7. 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.

Employer Plan means the medical expense benefits provided by the City of San Marcos and administered by IEBP.

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

Secondary means a plan that coordinates their payments so that the total of the payments from all plans shall not exceed 100% of maximum allowable eligible expenses.

Application

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 allowable expenses. In addition, the City's payment as secondary will not exceed what the City would have paid if it were the primary plan. Only the reduced amount will be credited to Covered Individuals plan deductible and out-of-pocket maximum.

In order to obtain all benefits available, a Covered Individual should file a claim under each plan. The first claim should be filed with the primary plan and an explanation of benefits from this claim **must be** provided 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. a retiree) is primary to a plan that covers that person as a dependent.
2. When a dependent child is covered under separate plans of each parent, the plan covering the parent whose birthday (month and day) falls earlier in the year is primary to the plan of the parent whose birthday falls later in the year.
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. Non-custodial step-parent.

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 plan covering the person as an employee, or retiree, or as a dependent of an employee or retiree will pay first before the plan providing Continuation of Coverage (e.g. COBRA).
5. 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.
6. 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.

Other Party Liability

This section applies if you:

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

Contractual Right of Reimbursement

If a Covered Individual:

1. is injured in an accident, regardless of who is at fault; or
2. becomes ill through the act or omission of another person, the Plan shall provide benefits on the condition that the Covered Individual cooperates with IEBP, its agents, subcontractors and attorneys by:
 - a. providing notification of any accidental injury or illness which may involve another individual, business or insurance company;
 - b. providing any information requested that is associated with the injury or illness; and
 - c. filing any claim documentation with an insurance carrier or third party as requested by IEBP.

In addition, the Covered Individual specifically delegates to IEBP the right to make a claim or assert a cause of action on the Covered Individual's behalf against any source of recoveries, and assigns to IEBP the right to any proceeds from the claim or cause of action.

"Source of recovery" shall include, but not be limited to:

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

By enrolling in this Plan, the Covered Individual agrees to abide by the provisions in one (1) through eleven (11) following this paragraph. IEBP may suspend payment of claims for the injury or illness based on the amount of the claim, indication of other insurance, indication there may be another source to pay for the medical services required as a result of the injury or illness, or evidence that the claim may not be covered because it is work-related.

As an additional assurance, payment of the claim(s), and future claims relating to the injury or illness will **only** resume if the Covered Individual:

1. provides any and all information requested by IEBP; and
2. agrees in writing not to settle damages whether by legal action, settlement or otherwise and only after consulting with IEBP to determine the full and potential medical charges; and
3. agrees that should the Covered Individual settle for damages as a result of an injury/illness with a third party or insurer, prior to securing such written permission, IEBP and the employer's health benefits plan is relieved of any liability for medical benefits resulting from the injury/illness; and
4. agrees that IEBP may provide any medical bills or payment information related to the injury/illness to the Covered Individual's attorney, any insurer or any other person who will be reimbursing IEBP for medical benefits; and
5. agrees in writing to reimburse IEBP immediately upon collection of damages whether by legal action, settlement or otherwise including, but not limited to, first party and third party motor vehicle insurance; and
6. agrees in writing to provide IEBP with a first lien on all proceeds recovered for this injury to the extent of benefits provided by the Plan; and
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 Individual 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 IEBP, the Covered Individual must reimburse IEBP the amount paid to the Covered Individual or any provider for services or treatment for the injury or illness. If the Covered Individual does not reimburse IEBP, the amount not reimbursed may be withheld from future benefits.

Automobile/Homeowners Liability and/or Medical Payments Insurance Benefits

Benefits payable under this Plan may be adjusted by IEBP for any first party or third party insurance benefits available for medical benefits, including no-fault medical payments uninsured motorist coverage which are paid or payable by a non-immediate family member whether or not any party has admitted liability.

Right of Recovery

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

1. the Covered Individual;
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 Individual specifically delegates to IEBP the right to make a claim or assert a cause of action on the Covered Individual's behalf against any source of recovery, and assigns to IEBP the right to any proceeds from the claim or cause of action.

A third party may be liable or legally responsible for expenses incurred by a Covered Individual for an illness, sickness or bodily injury. Subrogation rights may take precedence over a Covered Individual's right to receive payment of the benefits from the third party. 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.

Overpayment Provisions

Right of Offset

If IEBP makes any payment on behalf of a Covered Individual exceeding the amount needed to satisfy its obligation under the terms of this Plan, then IEBP reserves the right to offset the overpayment against future benefits otherwise payable to a Covered Individual or provider.

Facility of Payment

When another plan makes a payment which should have been made under the Plan, IEBP reserves the right to decide:

1. whether or not to reimburse the organization making the payment; and
2. the amount to be paid in order to satisfy the intent of this provision.

Any such payment made by IEBP will fulfill IEBP's responsibility in the amount paid.

Fraudulent or Erroneous Billing

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

Coordination with Medicare

Medicare is a federal health insurance program for people age sixty-five (65) or older and certain disabled individuals provided by Title XVIII of the Social Security Act, as amended.

Full Medicare Coverage is coverage under both Part "A" (Hospital Insurance) and Part "B" (Medical Insurance). If a person is eligible for premium free Part "A", that person will be deemed to have full Medicare coverage, even if they have not enrolled in Part "B". No benefits are payable if the person is enrolled in Part "C" (Medicare + Choice).

Who will pay first or primary usually depends on work status and the size of the Employer.

Status	Age	Primary Plan
Active	65+	Employer
Spouse of Active EE	65+	Employer
Retiree	65+	Medicare
Spouse of Retiree	65+	Medicare
Spouse	<65	Employer

There are special rules for people with permanent kidney failure and persons under sixty-five (65) who have Medicare because of a disability.

If the Plan is primary, the normal benefits payable under the Plan will be paid without regard to Medicare. If Medicare is primary, the combined total payable by full Medicare coverage and the Plan will not exceed the normal benefit payable by the Plan.

If Medicare coverage is due to End Stage Renal Disease (ESRD), the order of payment shall be determined by applicable federal regulations.

The Benefits Administrator will determine which plan is primary. The determination is based on the status of the covered individual on the date expenses are incurred.

Even if a person does not enroll for full Medicare coverage or make due claim for Medicare benefits, the Benefits Administrator will calculate the benefits which would have been paid by full Medicare coverage (see chart above) and adjust the Plan benefits payable accordingly to the Medicare allowed amount.

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

Electronic eligibility information will be submitted to Medicare per the Medicare secondary payor regulations.

Major Medical Expense Benefits

Benefit Percentage and Deductible

Upon receipt of a claim, the plan will pay the percentage shown in the Summary of Benefits and Coverage for eligible expenses incurred in each calendar year, unless otherwise stated in the Plan, which are in excess of any deductible per Covered Individual. The amount payable in no event shall exceed any Maximum Benefit stated in the Summary of Benefits and Coverage.

The deductible applies to the eligible charges of each calendar year but it applies only once for each Covered Individual within a calendar year, regardless of the number of illnesses. The family deductible for a family of three or more is met when the total for all covered family members equals the equivalent of three individual deductibles during the same calendar year. Any deductible accumulated for service dates occurring during the last three months of the calendar year will be applied toward the next calendar year's deductible requirement.

Allocation and Apportionment of Benefits

The Employer reserves the right to allocate the deductible amount to any eligible charges and to apportion the benefits to the Covered Individual and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Individual and all assignees.

Ancillary Services

All ancillary services, including radiology, anesthesiology, pathology, and ER physician provided at an In-Network facility will be covered as In-Network.

Covered Expenses

In order to be eligible for benefits under this provision, expenses actually incurred by a Covered Individual must meet all of the following requirements:

1. They are administered or ordered by a physician;
2. They are eligible benefits for the diagnosis and treatment of an illness or injury unless otherwise specifically included as a Covered Expense; and
3. They are not excluded under any provision of this Plan.

Covered expenses include, but are not limited to, the following:

1. Charges made by a **hospital** for:
 - Daily room and board and general nursing services, or confinement in an Intensive Care Unit, not to exceed the applicable maximum limits shown in the Summary of Benefits and Coverage.
 - Inpatient hospital – more than twenty-three (23) hours –Semi-private room and board up to the semi-private rate. If the hospital has only private rooms, the private room rate will be considered as the semi-private rate.
 - Necessary services and supplies other than room and board furnished by the hospital, including inpatient miscellaneous service and supplies, outpatient hospital treatments for chronic conditions, and emergency room use, physical therapy treatments, hemodialysis, and x-ray and linear therapy.
2. Charges made by a **Convalescent Nursing Facility** for the following services and supplies furnished by the facility during the first sixty (60) days of convalescent confinement in any one convalescent period. Only charges incurred in connection with convalescence from the illness or injury for which the Covered Individual is confined will be eligible for benefits. These expenses include:
 - Room and board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. Semi-private room and board up to the semi-private rate. If the facility has only private rooms, the private room rate will be considered as the semi-private rate.
 - Medical services customarily provided by the convalescent facility, with the exception of private duty or special nursing services and physicians' fees.

Drugs, biologicals, solutions, dressings, and casts furnished for use during the convalescent period, but no other supplies.

3. Charges made by a **hospice** for:

The usual, reasonable and customary charges for hospice care services provided in accordance with a hospice care program to terminally ill covered individuals. Care Management must receive Notification prior to hospice care commencement.

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

Hospice care charges are paid per the Summary of Benefits and Coverage. These benefits are eligible under the plan if the hospice stay or services meet all of the following:

- a. provided while the terminally ill person is a covered individual;
- b. ordered by the supervising Physician as part of the hospice care program;
- c. charged for by the hospice care program;
- d. the terminally ill person's Physician has estimated life expectancy to be six (6) months or less; and
- e. Care Management Notification.

4. The services of a **physician** for medical care and/or surgical treatments including office, home visits, hospital inpatient care, hospital outpatient care, hospital outpatient visits/exams, clinic care, and surgical opinion consultations.

5. **Breast Oncology** – 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 prosthetics due to complications. Reconstructive surgery includes tissue expanders, breast implants, nipple reconstruction, and nipple tattooing.

6. **Oophorectomy** – evidence-based genetic testing for ovaries with positive results will be required before a prophylactic oophorectomy will be considered as an eligible benefit.

7. **Cosmetic Procedures/Reconstructive Surgery** – cosmetic surgery for eligible benefits in connection with medically necessary treatment of an accidental injury.

Cosmetic procedures/reconstructive surgery only if:

- ▶ for the repair of an accidental injury;
- ▶ for reconstruction incidental to or following surgery resulting from an injury or illness; or
- ▶ for correction of congenital anomalies.

8. **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.

9. Charges for **contraceptives and contraceptive devices** for the insertion and removal of contraceptive devices including, but not limited to IUD and Norplant. The benefits under the Medical plan will also include charges for contraceptive counseling and for the cost of diaphragms. The benefit does not include charges for the cost and administration of injectable contraceptives, which are eligible under the prescription plan. Eligible charges under the Contraceptive Management benefit will be covered at 100% with no cost share, when using an In Network provider.

10. Charges for **chiropractic care** from a chiropractor (DC) for treatment of an illness or injury by manipulation of the spine and appropriate treatments. Charges are subject to the maximum as shown on the Summary of Benefits and Coverage. The maximum under chiropractic care does not apply to Airrosti providers.

11. Fees of registered nurses (RN) or licensed practical nurses (LPN) for **private duty nursing** will need to be approved by Care Management Services.

12. Fees of a legally qualified physician or qualified speech therapist for restoratory or rehabilitative **speech therapy** for speech loss or impairment due to surgery performed as a result of an illness or injury, or due to an illness or injury other than a functional nervous disorder. If the speech loss is due to a congenital anomaly,

surgery to correct the anomaly must have been performed prior to the therapy. Charges for outpatient speech therapy are subject to the combined maximum as shown on the Summary of Benefits and Coverage

13. Charges for professional **ambulance services** to the nearest facility where emergency care or treatment is rendered. Charges are subject to the plan's per occurrence maximum as shown on the Summary of Benefits and Coverage.
14. Charges for **x-rays**, microscopic tests, **laboratory tests** and initial diagnostic assessment of infertility.
15. Charges for **radiation therapy** or treatment.
16. Charges for the **processing and administration of blood or blood components**, but not for the cost of the actual blood or blood components if replaced.
17. Charges for **blood storage** when in connection with a covered scheduled surgery or procedure.
18. Charges for the administration of **oxygen and other gases**.
19. Charges for the following: **electrocardiograms, electroencephalograms, pneumoencephalograms**, basal metabolism tests, or similar well established diagnostic tests generally approved by physicians throughout the United States.
20. Charges for the cost and administration of **anesthesia**.
21. Charges for **dressings, sutures, casts, splints, trusses, crutches, braces, orthotic devices** (The plan does not cover orthotics for the feet) or other necessary medical supplies, with the exception of dental braces or corrective shoes.
22. Charges for **diabetic related therapeutic footwear/shoes** for the prevention of complications associated with Diabetes. Limited to two (2) pairs of therapeutic footwear/shoes per calendar year.
23. Charges for the rental of **Durable Medical Equipment** (or purchase if the Benefits Administrator determines that the course of purchase is less than anticipated total rental charges). All rental and/or purchases are limited to the lesser of contractual charge, usual, reasonable and customary fee schedule or cost reasonable rental/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 with Care Management.

If Care Management does not receive notification prior to a rental or purchase of Durable Medical Equipment that exceeds \$1,000 per piece of equipment, claims for benefits for that equipment 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.
24. Charges for **artificial limbs, prosthetic appliances, eyes or larynx**, limited to the reasonable cost of standard models as determined by Care Management, but not the replacement thereof.
25. Charges made for the professional services of a licensed physical therapist (LPT) or a physical therapy assistant when specifically prescribed by a physician as to type and duration but only to the extent that the **physical therapy** is directed at improving impaired muscle strength, range of motion, or physical endurance. Charges for outpatient physical therapy are subject to the combined maximum as shown on the Summary of Benefits and Coverage.
26. Charges for evidence based **aquatic therapy** services, when prescribed by a Physician. Must be direct, one-on-one treatment; by a licensed Physical Therapist. Charges for outpatient aquatic therapy are subject to the combined maximum as shown on the Summary of Benefits and Coverage.
27. Charges for voluntary **sterilization**.
28. Charges for **circumcision**.
29. Charges made by a free-standing **surgical facility** for surgical procedures performed by a physician including charges incurred for eligible related services and supplies furnished on the day of surgery. If the office or facility does not meet the definition of a free-standing surgical facility as defined in the book, surgical facility charges will not be covered.
30. Charges made by a **skilled nursing facility** for room and board including medical services and supplies.

31. Charges for **occupational therapy** services including related office visits and tests, when such services are prescribed by a Physician and performed by a Licensed Professional Physiotherapist or Licensed Professional Occupational Therapist. Charges for outpatient occupational therapy are subject to the combined maximum as shown on the Summary of Benefits and Coverage.
32. The necessary care and treatment of medically diagnosed congenital defects and **abnormalities, sickness or injury**.
33. **Genetic Testing** – medically necessary evidence-based testing to direct treatment (after diagnosis has been established) and/or maternity related amniocentesis to direct treatment.
34. Charges made by a hospital for the routine nursery care of a healthy **newborn child, including physician and ancillary services**, that are incurred up to and including the seventh (7th) day of age are payable as part of the mother's pregnancy charges if the mother is a Covered Individual. Physician services and newborn medical complication services for eligible treatments will be charged to the enrolled newborn from the date of birth, subject to the calendar year deductible and coinsurance requirement of this plan. The healthy newborn child's hospital nursery, physician and ancillary charges will not be considered part of the mother's charges for the purpose of determining the benefits payable to the covered mother. This provision shall not apply nor in any way affect the normal maternity provisions applicable to the mother.
35. **Newborn screening test to determine hearing loss** from birth through the date the child is 30 days old and necessary diagnostic follow-up care related to the screening test from birth to through the date the child is 24 months of age. The deductible is waived for this benefit.
36. Charges for the purchase and/or repair of **hearing aids and/or hearing appliances**, subject to the maximum as shown on the Summary of Benefits and Coverage. This benefit does not include charges for batteries.
37. **Telemedicine Services**
 - a. Medical information that is communicated in real-time with the use of interactive audio and video communications equipment, and is between the treating physician and/or a distant physician or health care specialist with the patient present during the communication.
 - b. The plan's contracted telemedicine services via the convenience of phone or online, video consultation, diagnostic and/or medication management services for many conditions including allergies, cold and flu symptoms, ear infection, and other minor medical conditions. Teladoc services are subject to a \$15 copay. Teladoc can be reached at 1 (800) Teladoc or (800) 835-2362.
38. The **Wellness Benefit** is payable at 100% with no deductible when services are received In-Network (and Non Network for Routine Eye Exams). For Out-of-Network, refer to the Summary of Benefits and Coverage. The Routine procedures will be reimbursed subject to usual, reasonable and customary charges. To be considered under this benefit, the provider's bill must designate a routine diagnosis code (except for refractions). The Wellness Benefit does not include virtual colonoscopies.

Tests/Procedures

- Routine Physical
- Breast cancer annual chemoprevention counseling for women at high risk
- Genetic Counseling for BRCA testing
- BRCA testing for women without any history of BRCA related cancer
- Well Baby/Child Exams
- Well Woman Exam
- Routine Mammogram
- Routine Eye Exams (including refractions, regardless of the diagnosis) – charges for contact lens fitting are not covered and will be denied.
- Routine Hearing Exams
- Routine Labs and X-rays
- Routine Venipuncture
- General Health Panel
- Coronary Risk Profile (lipid panel)
- Urinalysis
- Prostate Specific Antigen (PSA)

- (TB) Tuberculosis test
- Handling of specimen to/from physician's office to a laboratory
- Occult Stool Test
- Examination for the detection of skin cancer
- Autism Screenings for 18 (eighteen) and twenty-four (24) months of age

Recommended at and after age 40 (this is a recommendation not a requirement)

- Chest X-Ray (front & lateral)
- EKG (electrocardiogram)
- Digital Rectal Exam
- Osteoporosis Screening

Immunizations/Inoculations

Charges for immunizations and administrative fees are covered under the plan, subject to usual, reasonable and customary limits. Allergy injections and expenses related to routine newborn care are not considered as part of this benefit.

This benefit included state-mandated and non state-mandated immunizations and is available to all covered persons under the plan, with no age limitations. To be considered under this benefit, the provider's bill must designate a routine diagnosis code. This list is a guideline, not an inclusive list.

- DT (Diphtheria and Tetanus Toxoids)
- DtaP Diphtheria, Tetanus Toxoids and Pertussis
- Td (Tetanus) booster
- MMR (Measles, Mumps, Rubella)
- MMR booster
- Poliomyelitis Vaccine
- Oral Polio
- Varicella Vaccine (Chicken Pox)
- Influenza
- Hepatitis A
- Hepatitis B
- Pneumococcal (Pneumonia)
- Pediarix (Diphtheria and Tetanus Toxoids and Acellular Pertussis Absorbed, Hepatitis B (Recombinant) and Inactivated Poliovirus Vaccine Combined)
- HIB (Hemophilus Influenza B)
- HPV (Genital Human Papillomavirus)
- Rotovirus
- Zosatavax (Shingles Vaccine)

Colon-Rectal screening –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 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 routine or non-routine diagnosis. This includes when they are billed with a diagnosis of personal or family history of polyps (or colon cancer).

39. **Sleep Disorders** – The plan covers the treatment of sleep disorders, including but not to limited sleep apnea or narcolepsy. This benefit includes sleep studies.
40. **Dental expenses** incurred as the result of a non-occupational injury to natural sound teeth which occurred while the injured person was covered under the Plan or dental expenses incurred due to impacted wisdom teeth including anesthesia and postoperative care.
41. **TMJ** and related care to include the initial diagnostic visit, x-rays of the joint, injections into the joint and surgical repair of the temporomandibular joint on the same basis as any other illness, to exclude dental and orthodontic services.
42. Charges for **Orthognathic surgery** to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
- The deformity or disfigurement is accompanied by a documented clinically significant functional impairment and there is reasonable expectation that the procedure will result in meaningful functional improvement;
 - The orthognathic surgery is the result of tumor, trauma, disease; or
 - The orthognathic surgery is performed prior to age nineteen (19) and is required as a result of severe congenital facial deformity or congenital condition.
- Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by Care Management. *Please note that this plan does not provide benefits for orthodontic procedures.*
43. Charges from a **Certified Nurse Midwife (CNM)/Certified Professional Midwife (CPM)** in connection with normal pregnancy and delivery care.
44. Charges for **Diabetic Self-Management Education** to include education provided after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetic equipment and diabetic supplies; Additional education authorized on the diagnosis of a Healthcare Provider of a significant change in the covered individual's symptoms or condition of diabetes that requires changes in the covered individual's self-management regime; and Periodic or episodic continuing education when prescribed by an appropriate Healthcare Provider as warranted by the development of new techniques and treatment for diabetes.

Care Management Features

The Care Management program is included to assist you in making informed health care decisions. Occasionally proposed health care is not an eligible benefit, or the scheduled length of stay or setting is inappropriate. 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. Although medical services are certified, reimbursement is subject to the terms and conditions of the Plan. All procedures requiring Notification must meet the criteria established by the Plan's Care Management Services Staff. Notification is not required for Coordination of Benefits when this Plan is not primary. Care Management personnel do not verify eligibility for benefits. Approval or denial of a service that requires Notification is typically not immediate.

If Care Management does not receive Notification prior to a scheduled service requiring Notification, claims for benefits for that service will not be considered eligible unless an appeal is filed for review by Care Management. If the benefits are eligible under the Plan, they will be reviewed for eligible payment, but the Notification Penalty will apply.

Remember that notification for inpatient, residential and day treatment for mental health, serious mental illness, and substance use disorders **must be provided to IEBP**.

IEBP Care Management Toll Free Phone Number (800) 847-1213 (Notification)

How the Notification Process Works

The 23 Hour Rule

Inpatient means treatment or confinement to a hospital for more than twenty-three (23) consecutive hours. Outpatient means treatment or confinement to medical facility for twenty-three (23) or fewer hours.

What is an Admission?

When the hospital or facility sends a claim 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, please call Care Management.

For a newborn, routine nursery care during the first seven (7) days is provided to the newborn under the covered mother's Plan. **If a newborn is covered under the City's Plan and requires more than routine care, call Care Management for a separate notification within 48 hours.**

Responsibilities of the Covered Individual

Call (800) 847-1213 to notify Care Management prior to any health care service that requires notification. Business hours for Care Management Services are 8:30 a.m. to 5:00 p.m., Central Time. After hours, confidential Voice Mail at (800) 847-1213 records your notification twenty-four (24) hours a day and Care Management In-take Staff will return your call the next business day.

Responsibilities of Care Management Services

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

The Benefits Administrator shall retain final authority for interpretation of plan language and administration, when such exceptions are recommended by Care Management and industry consultants as reasonable and prudent for the patient and plan's financial viability.

What Happens on Inpatient Treatment?

The covered individual must notify the Care Management prior to a scheduled service that requires Notification.

If Care Management is not notified at all and a claim for benefits is filed, no benefits will be paid for any charges related to the non-certified service, and the process described in the Claims Appeal section must be initiated by **any parties who receive a copy of the explanation of benefits or information regarding the denial**. Continued stay review requirements apply to all inpatient confinements. If the benefits are eligible under the Plan, they will be paid, but the Notification Penalty will apply.

What happens if Outpatient Services go over the 23-Hour Limit?

Outpatient Surgery not on the Outpatient Surgery List

If Notification is provided to Care Management 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 Care Management, the Notification Penalty will apply.

Failure to provide Notification to Care Management will result in no paid benefits for related charges. *See list of outpatient services requiring notification on pages 41-42.*

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. **If the notification is not provided, a notification penalty of \$400.00 will apply** even if the benefits are eligible under the Plan.

Immediate Care (Emergency) Medical Admission

If Notification is provided to Care Management within one (1) business day of the admission requiring immediate care, no late notification penalty will apply. **If the notification is not provided, a notification penalty of \$400.00 will apply** even if the benefits are eligible under the Plan.

Continued Stay Review

Care Management does not solicit Continued Stay clinical information. At the time of notification, the Nurse will inform the facility/provider representative of the assigned Length of Stay based on the diagnosis provided. If a longer length of stay is required, the facility/provider representative must call Care Management at (800) 847-1213 to provide notification.

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 the responsibility of the Covered Individual. Notification is required for the following admissions and/or procedures:

Inpatient	Notification Required	Penalty
Emergency Admissions	Within forty-eight (48) hours or first business day following an emergency admission or as soon as reasonably possible. In an emergency, Voice Mail records and dates your notification twenty-four (24) hours-a-day. Care Management Intake Staff will return your call the next business day.	\$400

Inpatient	Notification Required	Penalty
<ul style="list-style-type: none"> • Scheduled Admissions • Acute Care Admissions • Rehabilitation Facility Admissions • Convalescent Nursing Home for Non-custodial rehabilitation services • Skilled Nursing Facility Admissions • Inpatient facility admissions, day and residential treatment for Mental Health, Serious Mental Health and/or Substance Use Disorder 	Prior to admission for non-emergency admissions	\$400
Pregnancy/Maternity (Delivery admission) Normal Vaginal Birth	Within forty-eight (48) hours or first business day	\$400
Pregnancy/Maternity (Delivery Admission) Cesarean Section delivery	Within ninety-six (96) hours or first business day.	\$400
Transplant Services	No later than prior to services being rendered	\$400
Newborns (if newborn requires more than routine care)	Within 48 hours of admission if the newborn requires more than routine care	\$400
Hospice	Prior to admission	\$400

For all medical procedures requiring hospitalization for more than twenty-three (23) hours, call IEBP Care Management at (800) 847-1213.

Outpatient	Notification Required	Penalty
Home Health Care ~ All Services	No later than prior to services being rendered	\$400
Skilled Nursing ~ All Services	No later than prior to services being rendered	\$400
Hospice ~ All Services	No later than prior to services being rendered	\$400
Oncological Chemotherapy	No later than prior to services being rendered	\$400
Durable Medical Equipment ~ Rental/Purchase of equipment over \$1,000	Prior to purchase or rental that exceeds \$1,000	\$400
Dialysis for End Stage Renal Disease (ESRD)	No later than prior to services being rendered	\$400
Treatment of a Dental Injury	No later than prior to services being rendered	\$400
Reconstructive Surgical Procedures	No later than prior to services being rendered	\$400
Medically Necessary Evidence-Based Genetic Testing to Direct Treatment (after diagnosis has been established)	No later than prior to services being rendered	\$400

Medical Utilization/Catastrophic Care Management

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.

Home Health Care

To be an Eligible Benefit, a Home Health Care plan must be in writing, ordered by the attending Physician. Care Management must receive Notification prior to home health care commencement. Home health care services will be reviewed as an Eligible Benefit if the attending Physician states that proper treatment of the disability would otherwise require confinement as an inpatient in a hospital, Skilled Nursing Facility or rehabilitative hospital in the absence of the services and supplies provided as part of the home health care plan. Home health care charges are paid per the Schedule of Medical Benefits. Custodial care is excluded. Multiple professional visits in a single day may be arranged by Care Management.

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. rehabilitative therapy and respiratory therapy provided by the home health care agency;
3. social worker to assess and identify community resources; and
4. Physician services if the covered individual is homebound and Physician homebound intervention is appropriate.

Benefits will be provided at 100% (In Network) and not subject to the plan year deductible. Any durable medical equipment (DME) exceeding \$1,000, including DME obtained in conjunction with Home Health Services will require pre-authorization from Care Management. In addition, physical therapy, occupational therapy, speech therapy and/or aquatic therapy provided in conjunction with Home Health Services will apply towards the Plan's combined maximum for these services.

Second Opinions

When surgery or treatment is advised, a Covered Individual may get a second (or third) opinion on an optional basis, to confirm that surgery or treatment is needed.

The physician who provides the second opinion must be one who:

1. Treats the type of condition for which surgery is advised;
2. Is not scheduled to do the surgery; and
3. Has no business or financial relationship with the physician recommending or performing the surgery.

If the second physician disagrees with the first physician, benefits will be payable for the cost of a third opinion, subject to the conditions listed above.

Emergency Room Benefit

Treatment in an Emergency Room of a hospital is subject to a \$250 access fee. In addition, if the treatment is for non-emergent/non-immediate care, charges will also be subject to the deductible and coinsurance. The access fee is waived if the emergency room visit precedes admission into a hospital. The access fee does not apply toward the satisfaction of the deductible or out of pocket maximums.

Transplant Benefit

Transplant Benefits provided at an OptumHealth/Centers of Excellence Designated Transplant Center differ from those provided at a Non-OptumHealth/Centers of Excellence Designated Transplant Center. At least ten (10) working days prior to any pre-transplant evaluation, the Covered Individual or a family member must contact Care Management to provide notification; failure to do so will result in a late notification penalty of \$400. Intensive care management by Care Management is required and notification and continued stay review procedures will apply.

If the donor is covered under the Plan and the recipient is not, the donor's charges and the recipient's charges are not covered.

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

Designated 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 by contacting IEBP Care Management at (800) 847-1213.

Non-Designated Transplant Center

If the organ transplant is not pre-authorized or not performed at an OptumHealth/Centers of Excellence Designated Transplant Center or intensive care management is refused, the transplant and post-transplant care will be covered subject to normal Plan provisions and will pay at the benefit percentage shown in the Summary of Benefits and Coverage, with the following exceptions. It will not, at any time, pay at 100% under the maximum out-of-pocket provision of the Plan. Charges for travel, lodging, food, organ transportation, the donor, locating and preserving the tissue for the transplant procedure, fees for maintenance on an organ transplant waiting list, and follow up care are not covered unless the transplant is performed at an OptumHealth/Centers of Excellence Designated Transplant Center. In addition, all normal plan inpatient notification requirements apply as described in the Care Management section of this book.

Eligible Transplant Expenses

Eligible Transplant Expenses incurred in connection with any organ or tissue transplant will be covered subject to Care Management approval and Plan limitations.

Under this provision, the term Transplant includes the pre-transplant evaluation, procurement, the transplant itself, and one year of post-transplant follow-up care, excluding prescription drugs covered elsewhere under the Plan. Eligible Transplant Expenses incurred for the recipient and the donor will be considered eligible benefits under the plan.

Transplant benefits are paid at the benefit percentage on the Summary of Benefits and Coverage as long as services are provided at a designated Transplant Center and approved by Care Management.

Transplant Ancillary Charge

All charges will require approval by the Benefits Administrator and are subject to verification and limitations as herein specified. Travel, lodging, and food are not covered unless a Plan Designated Transplant Center for organ transplants is utilized. These ancillary charges accumulate towards the recipient's benefit maximums.

Travel

Eligible travel expenses are subject to coordination and approval by Care Management. Private vehicle use will be reimbursed at the current IRS rate and reimbursement is limited to travel between home and the Transplant Center. Airfare will be reimbursed at cost. Care Management may arrange the purchase of commercial airline tickets. Eligible travel expenses (ground or air transportation) will only be reimbursed for the patient and companion if they live more than one hundred (100) miles one way from the hospital or facility designated by the plan as an OptumHealth/Centers of Excellence Designated Transplant Center.

The Plan provides for ground or air transportation (if more than one hundred (100) miles one way from hospital or facility) of the **patient** to and from the pre-transplant evaluation, organ transplantation and any other necessary treatment or follow-up appointment to a benefit maximum of \$10,000.

The Plan provides for ground or air transportation of each **eligible** companion to and from the pre-transplant evaluation, organ transplantation, and any other benefit eligible treatment or follow-up appointment to a maximum of \$5,000.

Lodging

The Plan will pay for the patient's lodging when not hospital confined and the eligible companion's lodging (if more than one hundred (100) miles one way from hospital or facility) as arranged by Care Management Services up to a combined maximum of \$10,000.

Food

The Plan will pay for the patient's food at a rate of (\$35) per day only during approved transplant-related outpatient treatment at the OptumHealth/Centers of Excellence Designated Transplant Center.

The Plan will pay for the eligible companion's food at a rate of (\$35) per day to maximum benefit of \$3,500 during the patient's approved transplant-related treatment at the Transplant Center.

No receipts will be required for food reimbursement.

Reimbursement

Reimbursement requests for travel and lodging shall be submitted on an Expense Activity Report to Care Management. 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.

Hospice Care Benefit

The Benefits Administrator will pay for the usual, reasonable and customary charges for hospice care services provided in accordance with a hospice care program to a terminally ill Covered Individual. Care Management can assist with referral to a hospice program.

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 skilled nursing facility in the absence of the services and supplies provided by the hospice care program.

Hospice care expenses are **paid in full of maximum allowable charges with no deductible** if the hospice stay or services meet all of the following:

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

Notification is required. If the notification is made later than the designated time period a late notification penalty of \$400.00 will apply.

Mental Health Care, Serious Mental Illness and Substance Use Disorder

Benefits

The Plan provides benefits for the treatment of a mental disease, disorder or condition. Expense for mental health care is subject to deductible, coinsurance and duration (maximum number of visits) limits. **Serious Mental Illness and Substance Use Disorders are treated as any other illness.** An order by a court, a governmental or state agency for psychiatric treatment is not an indication of an eligible benefit.

Alternative Settings Benefit

Day Treatment

Expenses incurred by a Covered Individual for treatment provided in a day treatment facility will be covered on the same basis as if the expenses were inpatient hospital expenses. One day of day treatment will count as ½ of an inpatient day. The facility must treat a patient for a minimum of 4 hours in any 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.

Residential Treatment

Expenses incurred by a Covered Individual for the treatment of conditions while confined in a residential treatment center are covered subject to the following restrictions. The Covered Individual must have a mental condition that would otherwise necessitate hospital confinement and services must be based on an individual treatment plan utilizing properly licensed providers.

Mental Health Care

Outpatient Benefit

On an outpatient basis (not hospital confined and not receiving treatment at a day treatment facility), expenses are covered as stated above with a visit limit of sixty (60) individual or group outpatient therapy sessions per calendar year.

Inpatient Benefit

Expenses incurred by a Covered Individual for mental health care treatment while continuously hospital confined (except for therapeutic passes of eight hours or less) are covered as stated above with a visit limit of forty-five (45) inpatient days per calendar year. Day treatment will count as ½ inpatient day.

Substance use disorder

Expenses for the treatment of substance use disorder have a lifetime maximum of three (3) series of treatment. An order by a court or State agency for substance use disorder treatment is not an indication of an eligible benefit.

A series of treatments is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities and is complete when the covered individual is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient or a series of these levels of treatments without a lapse in treatment or is complete when a person fails to materially comply with the treatment program for a period of 30 days.

Serious Mental Illness

Expenses incurred by a Covered Individual for treatment of “Serious Mental Illness” are payable as any other illness. The term “Serious Mental Illness” is defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM III-R) and includes the following psychiatric illnesses:

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

General Plan Exclusions and Limitations

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.
10. Charges incurred in connection with remedying a condition by means of **cosmetic** surgery unless otherwise specifically covered under this plan.
11. Charges for **prophylactic procedures** and/or testing due to family history, unless otherwise specifically covered under this plan.
12. Charges incurred in connection with services and supplies which are not necessary for treatment of the injury or illness, or are in **excess of usual, reasonable and customary charges, or are not recommended and approved by a physician**, unless specifically shown as a Covered Expense elsewhere in the Plan.
13. Charges for services, supplies, or **treatments not recognized by the American Medical Association** as generally accepted for the diagnosis and/or treatment of an active illness or injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.
14. Charges for **services rendered by** a physician, nurse, or licensed therapist if such physician, nurse, or licensed therapist is in the **immediate family of the Covered Individual**, or resides in the same household of the Covered Individual.
15. Charges for hospitalization when such **confinement occurs primarily for physiotherapy**, hydrotherapy, or any routine physical examinations or tests not connected with the actual illness or injury.
16. Charges incurred in connection with **the purchase or fitting of eyeglasses, contact lenses or such similar aid devices**. (This exclusion shall not apply expenses listed as eligible under the plan.) This plan does not cover charges for the fitting of contact lenses.
17. Charges incurred for **dental treatment except those dental benefits specifically covered** under the medical plan. Refer to the Dental plan document for coverage that may be available.

18. Expenses for **fertility treatments**, except for the initial diagnosis of infertility, which is a covered expense.
19. Charges for **in vitro fertilization**, embryo and fetal transplants, gamete or zygote intra-fallopian transfer, artificial insemination, surgical reversal of elective sterilization, and fertility drugs (this exclusion does not apply to any pregnancy that might be a result of one or more of these excluded services).
20. Charges for expenses related to a **surrogate pregnancy**.
21. Charges for **genetic testing**. Unless otherwise specifically listed as a Covered Expense under this plan.
22. Charges for professional **nursing services** if rendered by other than a registered nurse (RN) or licensed practical nurse (LPN), or licensed vocational nurse (LVN), unless such care was vital as a safeguard of the Covered Individual's life, and unless such care is specifically listed as a Covered Expense elsewhere in the Plan.
23. Charges resulting from or in connection with the **reversal of a sterilization procedure**.
24. Charges for **unproven procedures, drugs, or research studies**, or for any services or supplies not considered legal in the United States.
25. Charges incurred in connection with a **sex change** operation, including implants, prescription drugs and related hormone treatment.
26. Charges or information **submitted more than the later of twelve (12) months after the expense is incurred** or within ninety (90) days after a non-compensable claim decision is made by Workers' Compensation.
27. Charges for services or supplies rendered to any participant for **treatment of obesity or for weight reduction**. **The Plan does not pay for non-surgical or surgical procedures for obesity at any time.**
28. For **overnight hospital room and board charges for admission before surgery** unless it approved as an eligible benefit by Care Management.
29. Charges for **educational testing, hypnosis, biofeedback, marital counseling**, relationship therapy, recreational therapy, educational therapy, sleep therapy for behavior modification or any other behavior modification therapy, treatment of a developmental delay for covered persons ages ten (10) and older and any learning disability therapy.
30. Charges for **exercising or vibratory equipment, swimming therapy pools, health club memberships, massage therapy**, or any treatment or equipment that is beneficial after medical attention ceases or in the absence of a medical condition.
31. Charges for **drugs requiring the written prescription of a licensed physician**; unless it is an eligible benefit for the treatment of an illness or injury.
32. All charges for **prescription drugs covered under the Prescription Drug Benefit** are not considered eligible expenses under other provisions of the medical plan. **Drugs excluded from coverage under the Prescription Drug Benefit** are also excluded expenses under all provisions of the medical plan. This exclusion does not apply to identified SpecialtyRx/Biotech medications that are available under both the Prescription plan and the Medical plan.
33. **Drug testing** services that are not Evidence-Based Medicine or standard of practice;
34. For treatment of:
 - a. **Weak, strained, flat, unstable, or unbalanced feet, metatarsalgia or bunions**, except open cutting or operations.
 - b. **Corns, calluses or toenails**, except the removal of nail roots and necessary services in the treatment of metabolic or peripheral vascular disease.
35. Charges for **orthopedic shoes**, orthotic appliances for the feet, or other devices for support of the feet.
36. Charges for **elective abortions** for Covered Individuals except in the case of incest, rape, or situations that are life threatening to the mother.
37. Charges for **acupuncture or acupressure** services and/or treatment.
38. Charges for **air purification units**, humidifier, cooling or heating equipment.
39. Charges for radial Keratotomy or Keratoplasty or **LASIK surgery**.
40. Charges for chelation or **metallic ion therapy** (except as covered for acute metal poisoning).
41. **Services which do not meet the plan definition of an eligible expense.**

42. 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. (This exclusion does not apply to charges from the plan's contracted telemedicine services via the convenience of phone or online, video consultation, diagnostic and/or medication management services for many conditions including allergies, cold and flu symptoms, ear infection, and other minor medical conditions. Teladoc services are subject to a \$15 copay. Teladoc can be reached at 1 (800) Teladoc or (800) 835-2362.)
43. Any charges incurred by one person **that are due to the sickness or injury of another person**, except as provided in the transplant benefit of this plan.
44. Charges incurred as a result of travel **outside of the United States or its territories specifically to receive medical treatment**, unless otherwise specifically covered under this plan.

Definitions

These terms define words that may be used in the Plan Document or to the extent that they relate to the administration of the Plan benefits. 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.

ACTIVELY AT WORK – a regular employee who works for the City of San Marcos for at least thirty (30) hours a week in the usual course of the employers business and who is not a temporary employee. An employee who is on paid leave, unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), sick leave pool, or on any other Government required leave including Military leave, will be considered an active employee for the purposes of this plan.

ADOLESCENT DEPENDENT – An individual thirteen (13) through seventeen (17) 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 an Ambulatory Surgery Center.

AMENDMENT – a formal document changing the provisions of the Plan which are adopted by the Employer. Amendments apply to all Covered Individuals, including those persons who are covered before the amendment becomes effective, unless otherwise specified.

ANCILLARY SERVICES – All ancillary services, including radiology, anesthesiology, pathology and ER physician, provided at an in-network facility will be covered as In-Network.

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, out-of-pocket or payable by the Plan for a covered service or supply.

BENEFITS ADMINISTRATOR – TML MultiState Intergovernmental Employee Benefits Pool (IEBP).

BENEFIT PERCENTAGE – that portion of eligible expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan.

BENEFIT PERIOD – refers to a time period of one year, as shown on the Summary of Benefits and Coverage. Such benefit period will terminate on the earliest of the following dates:

1. The last day of the one year period so established;
2. The day the Maximum Benefit (if any) applicable to the Covered Individual becomes payable; or
3. The day the Covered Individual ceases to be covered under the Plan.

BENEFIT YEAR – a period of time commencing with the effective date of this Plan or the Plan Anniversary, and terminating on the date of the next succeeding Plan Anniversary.

BIRTHING CENTER – a free-standing facility licensed to provide for normal labor and delivery and that employs either a staff obstetrician or certified nurse-midwife/certified professional midwife with an obstetrician consultant, provided it meets all of the following tests and operates within the scope of its license:

1. Provides twenty-four (24) hour nursing service under the supervision of a physician or a registered nurse;
2. Maintains daily clinical records on each patient and has available at all times the services of a physician under an established agreement;
3. Provides appropriate methods of dispensing and administering drugs and medicines;
4. Provides for transfer arrangements with at least one hospital;
5. Has an established protocol for the management of medical emergencies;
6. Has a utilization review plan in effect; and
7. Has developed treatment policies with the advice of and reviewed by a group of professionals specializing in the care and treatment rendered by such a facility.

BODILY MALFUNCTION – impairment, disturbance, or abnormality of the functioning of an organ or limb.

CALENDAR YEAR – a period of twelve (12) consecutive months beginning 12:01 a.m. on January 1 and ending at midnight, December 31.

CARE MANAGEMENT – Care 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 Care Management. Followed by ongoing work with you and your provider to plan health care alternatives to meet your needs. The Care Manager will try to conserve your benefits by making sure that your care is handled as efficiently as possible.

The Care Management staff consists of licensed, professional nurses. The Nurses have years of experience in health care. They know the importance of not intruding in the doctor/patient relationship. By promoting health care alternatives that are acceptable to you, your doctors and your employer, Care Management helps to control health care cost and use your benefits wisely.

MEDICAL MANAGEMENT CARE MANAGEMENT SERVICES – A system that includes notification, concurrent review, discharge planning and retrospective review of healthcare services. Care Management Services does not include elective requests for clarification of coverage.

CLEAN CLAIM – A Clean Claim is 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-9 code, procedure narrative or CPT-4 codes, services and supplies provided, physician name and license number and provider charges. If a claim exceeds \$15,000 outpatient and \$20,000 inpatient, an itemized bill will be required to adjudicate the claim. Claim must be submitted by provider no later than the filing deadline. A "Clean Claim" does not include a claim where integration/coordination of benefits is actively pursued, medical claims review is necessary, subrogation is pursued or where a work related condition may exist.

If the provider fails to submit the claim within compliance of the filing deadline and the clean claim definition the provider forfeits the right to payment unless the failure to submit the claim in compliance is a result of a catastrophic event that substantially interferes with the normal business operations of the network provider.

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 (100 to 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 1000 to 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.

CONCURRENT REVIEW – A service provided by Care Management to review the necessity of continued treatment.

CONTRIBUTION – the amount payable by the Employer, the amount payable by the Employee, or the amount payable by the Employer/Employee jointly for participation in the benefits of the Plan. Also referred to as contributory.

COPAY – a specified amount that is the Covered Individual’s responsibility to pay to a health care provider. Copays are usually connected with specific benefits and may be in addition to or instead of the Plan deductible/Plan out of pocket expenses.

CONVALESCENT NURSING FACILITY – an institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an inpatient basis, for persons convalescing from injury or illness, professional nursing services rendered by a registered nurse (RN) or by a licensed practical nurse (LPN) under the direction of a registered nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;
2. Its services are provided for compensation from its patients and under the full-time supervision of a physician or registered nurse;
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse;
4. It maintains a complete medical record on each patient;
5. It has an effective utilization review plan;
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, individuals with mental retardation, custodial or education care, or care of mental disorders; and
7. It is approved and licensed by Medicare.

This term shall also apply to expenses incurred in an institution referring to itself as a Skilled Nursing Facility, Convalescent Nursing Home, or any such other similar nomenclature.

CONVALESCENT PERIOD – a period of time commencing with the date of confinement by a Covered Individual to a Convalescent Nursing Facility. Such confinement must meet all of the following conditions:

1. Such confinement must commence within fourteen (14) days of being discharged from a hospital;
2. Said hospital confinement must have been for a period of not less than three (3) consecutive days; and
3. Both the hospital and convalescent confinements must have been for the care and treatment of the same illness or injury.

A Convalescent Period will terminate when the Covered Individual has been free of confinement in any and all institutions providing hospital or nursing care for a period of ninety (90) consecutive days. A new convalescent period shall not commence until a previous convalescent period has terminated.

COSMETIC PROCEDURE – a procedure performed solely for the improvement of a Covered Individual’s appearance rather than for the improvement of restoration of bodily functions.

COVERED DEPENDENT – an eligible and enrolled dependent of a Covered Individual as defined in the Definitions section and in the Eligibility section of this Plan.

COVERED EMPLOYEE – an Employee who is eligible for coverage and who has enrolled in the Plan.

COVERED EXPENSES – benefit eligible services, or supplies that are not specifically excluded from coverage elsewhere in this Plan.

COVERED INDIVIDUAL – a Covered Employee, Covered Dependent or Covered Spouse who is eligible and has enrolled in the Plan.

COVERED SPOUSE – the spouse of a Covered Individual who is eligible and enrolled in the Plan.

CRISIS STABILIZATION UNIT – a twenty-four (24) hour residential program, usually short-term in nature that provides intensive supervision and highly structured activities to persons who are demonstrating an acute psychiatric crisis of moderate to severe proportions.

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 psychiatric or substance use disorder treatment facility that meets all of the following requirements:

1. Provides treatment for individuals suffering from acute mental and nervous disorders and/or substance use disorder in a structured program using individual treatment plans with specific attainable goals and objectives appropriate for the patient;
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. The deductible is an out-of-pocket expense for the covered individual.

DEPENDENT – the legal spouse or eligible child of a Covered Individual/Retiree who is enrolled in the Plan. See the definition of "*Dependent Eligibility*" on pages 14-15.

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 percent (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, emotional, intellectual, speech and language, and/or adaptive development, sometimes called self-help skills, which include dressing, toileting, feeding, etc.

DISABILITY – any of the following conditions could be classified as a disability:

1. Illness;
2. Bodily malfunction;
3. Accidental injury;
4. Pregnancy;
5. Mental and nervous conditions; or
6. Substance use disorder.

A disabled person must be eligible for Medicare and have received Social Security due to disability. All expenses incurred as a result of the same or a related cause are considered one disability.

DISABLED CHILD – an over age dependent child who is mentally or physically incapable of supporting themselves and is primarily dependent upon the Covered Individual for financial support.

DURABLE MEDICAL EQUIPMENT – Equipment which:

1. can withstand repeated use;
2. is primarily and customarily used to serve a medical purpose;
3. generally is not useful to a person in the absence of an illness or injury; and
4. is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be Durable Medical Equipment.

ELIGIBLE BENEFITS – services or supplies which are covered benefits under this plan, as determined by this Plan Document and the Benefits Administrator.

ELIGIBLE EXPENSES – the fees and prices usually, reasonably, and customarily 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 where incurred. 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 Individual also must have a contractual obligation to pay the expense.

ELIGIBLE PERSONS – all active, regular full-time Employees, Qualified Retirees, and qualifying Dependents will be considered Eligible Persons.

EMERGENCY SERVICES (IMMEDIATE CARE) – See *Emergent/Immediate Care*.

EMERGENT/IMMEDIATE CARE – those 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 as diagnosed by the physician could reasonably be expected to result in the following:

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

EMPLOYEE – a person who works for the Employer.

EMPLOYER – the City of San Marcos.

ENROLL – to make written application for coverage on the prescribed forms. Enrollment is not completed until such forms are received by the Employer and approved by the Benefits Administrator.

ESSENTIAL BENEFITS – 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 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 and vision screening services 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.”

FULL-TIME EMPLOYMENT – a basis whereby a Participant is employed by the Employer for a **minimum of thirty (30) hours per week**. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Participant to travel, and for which he/she receives regular earnings from the Employer.

GENETIC MARKERS – Used to predict an individual’s response to drug therapy; aims to direct specific drug therapy only to individuals who can respond to the therapy and avoid therapy for individuals who cannot benefit (not for diagnosis).

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 individual’s blood, body fluid or tissue.

HEALTHCARE PROVIDER – a physician (MD) or a person acting within the scope of applicable state licensing/certification requirements, including, but not limited to, the following designations: Doctor of Osteopathy (DO), Doctor of Optometry (OD), State licensed Durable and Medical Equipment Device/Equipment Organizations, Certified Nurse Midwife (CNM), Certified Professional Midwife (CPM), Registered Respiratory Therapist (RRT), Certified Respiratory Therapist (CRT), Licensed Physical Therapist (LPT), Licensed Psychologist, Doctor of Chiropractic (DC), Doctor of Podiatry Medicine (DPM), Registered Nurse (RN), Licensed Vocational Nurse (LVN), Licensed Practical Nurse (LPN), Speech Therapist, Audiologist, Occupational Therapist or Licensed or Registered Dietitian (LD or RD), Physician Assistant, Licensed Professional Counselor (LPC), Licensed Master Social Worker (LMSW), CADAC and Advanced Nurse Practitioner (ANP).

HEALTH INSURANCE MARKETPLACE – Health insurance market plan through the Affordable Care Act’s Health Insurance Marketplace, www.HealthCare.gov.

HIPAA – Federal law referred to as the Health Insurance Portability and Accountability Act of 1996. HIPAA went into effect for most group health plans on the anniversary that occurred on or after July 1, 1997. HIPAA provides individuals certain rights and protections relating to healthcare coverage.

Title I:

- Refers to healthcare coverage reform and includes provisions for special enrollments and non-discrimination based on Health Status Factors;
- A self-funded, non-federal, governmental plan may exempt itself from HIPAA’s provisions for standards relating to benefits for mothers and newborns, parity in the application of certain limits for mental health benefits, coverage for reconstructive surgery following mastectomy/lumpectomy and coverage of dependent students on medically necessary leave of absence. 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 and Electronic Signature Standards (Security Rule) and Standards for Privacy of Individually Identifiable Health Information (Privacy Rule);
- A self-funded, non-federal, governmental health plan cannot exempt itself from the Title II requirements.

HOME HEALTH CARE AGENCY – a public or private agency or organization 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.

HOME HEALTH CARE PLAN – a program for care and treatment of the Covered Individual:

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 skilled nursing 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 physician and one 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 Covered Individual's attending physician 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 (JCAHO) and/or approved by Medicare and/or Texas Commission on Alcohol and Drug Abuse (TCADA);
2. maintains permanent and full-time facilities for care of five (5) or more patients;
3. provides diagnostic and therapeutic services and medical care and treatment to sick and injured persons on an inpatient basis; and
4. provides care and treatment at the Covered Individual'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.

ILLNESS – a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Individual. A recurrent illness will be considered one illness. Concurrent illnesses will be considered one illness unless the concurrent illnesses are totally unrelated. All such disorders existing simultaneously, which are due to the same or related causes, shall be considered one illness.

INCURRED EXPENSES – those services and supplies rendered to a Covered Individual. Such expenses shall be considered to have occurred at the time or date the service or supply is actually provided.

INJURY – a condition caused by accidental means which results in damage to the Covered Individual's body from an external force. Any loss which is caused by or contributed by a hernia of any kind will be considered a loss under the definition of illness, and not as a loss resulting from accidental injury.

INPATIENT – the classification of a Covered Individual when that Individual is admitted to a hospital, hospice, or convalescent facility for treatment for more than twenty-three (23) hours, and charges are made for room and board to the Covered Individual as a result of such treatment.

INTENSIVE CARE UNIT – a section, ward, or wing within the hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;
2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. Provides constant observation and treatment by registered nurses (RNs) or other highly trained hospital personnel.

LICENSED PRACTICAL NURSE – an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

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.

MEDICAL UTILIZATION/CATASTROPHIC CARE MANAGEMENT- 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 – means 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 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 – the programs established by Title I of Public Law 89-98 (79 Statutes 291) as amended entitled “Health Insurance for the Aged Act,” and which includes Parts A and B and Title XVIII of the Social Security Act (as amended by Public Law 89-97,79) as amended from time to time.

MENTAL HEALTH CONDITIONS – “mental illness” means a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a licensed or certified psychologist or a licensed, certified psychiatric social worker. A mental or nervous disorder includes, but is not limited to:

1. Schizophrenia
2. Bipolar disorder
3. Pervasive Mental Development Disorder
4. Panic disorder
5. Major depressive disorder
6. Psychotic depression
7. Obsessive compulsive disorder
8. Depression in childhood and adolescence

This disease must not be merely an expected response to a particular stimulus and must be defined in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association).

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 or more bed patients;
3. Provides a program for diagnosis, evaluation, and effective treatment of mental and nervous 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 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 biologicals;
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.

NAMED FIDUCIARY – the Employer that has the authority to control and manage the operation and administration of the Plan.

NOTIFICATION – The process for notifying Care Management of the need for medical treatment or services.

NURSE – a registered nurse (RN), a licensed vocational nurse (LVN) or a licensed practical nurse (LPN).

NURSE MIDWIFE/Certified Professional Midwife (CPM – a 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.

ORTHOTIC APPLIANCE – an external device intended to correct any defect in form or function of the human body.

OUT-OF-POCKET AMOUNT – the portion of eligible expenses for which a Covered Individual is responsible to pay.

OUTPATIENT – the classification of a Covered Individual when that Covered Individual received medical care, treatment, services, or supplies at a clinic, a physician's office, or at a hospital for twenty-three (23) hours or less, if not a registered bed patient at that hospital, an outpatient psychiatric facility or an outpatient alcoholism treatment facility.

OUTPATIENT ALCOHOLISM TREATMENT FACILITY – an institution which provides a program for diagnosis, evaluation, and effective treatment of alcoholism, provides detoxification services needed with its effective treatment program; provides infirmity-level medical services or arranges with a hospital in the area for any other medical services for twenty-three (23) hours or less; is at all times supervised by a staff of physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time registered nurse (RN); prepares and maintains a written plan of treatment for each patient based on medical, psychological, and social needs which is supervised by a physician; and meets licensing standards.

OUTPATIENT PSYCHIATRIC FACILITY – an administratively distinct governmental, public, private, or independent unit or part of such unit that provides outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PARTICIPANT – See *Employee*.

PHYSICIAN – a person acting within the scope of his license and holding the degree of Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Medical Dentistry (DMD), or Doctor of Chiropractic (DC) who is eligible for membership in his/her respective society or association.

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 San Marcos.

PRACTITIONER – *See Health Care Provider.*

PRE-ADMISSION TESTING – benefit eligible laboratory tests and x-rays performed by a hospital or facility from which a hospital will accept the test results that are rendered to the Covered Individual on an outpatient basis. The tests must be performed within 10 days of a scheduled inpatient hospital confinement. Charges that meet this definition must be clearly identified as such on the bill for services.

PREFERRED PROVIDER ORGANIZATION (PPO)/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, utilization review, and cost containment procedures for the delivery of health care and have contracted for such with the Benefits Administrator or Plan Administrator.

PREGNANCY – physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

PRIMARY CARE PHYSICIAN – Includes the following physicians: General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology and Pediatricians.

PSYCHIATRIC CARE – also known as psychoanalytic care; means treatment for a mental illness or disorder, a functional nervous disorder, alcoholism or drug addiction.

PSYCHOLOGIST – an individual licensed by the state to offer psychological services to the public.

RECONSTRUCTIVE SURGERY – A procedure performed incidental to an injury, sickness, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of reconstructive surgery does not classify such surgery as cosmetic when a functional impairment exists, and the surgery restores or improves function.

REGISTERED NURSE – an individual who has received specialized nursing training and is authorized to use the designation of “RN” and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

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 or nervous conditions or of substance abuse, 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 separates from active employment with the City of San Marcos and who is entitled to receive retirement benefits from the Texas Municipal Retirement System.

ROOM AND BOARD – refers to all charges by whatever name called, which are made by a hospital, hospice, or convalescent nursing facility as a condition of occupancy. Such charges do not include the professional services of physicians nor intensive nursing care by whatever name called.

SEMI-PRIVATE ROOM – a hospital room containing two (2) beds, but does not include an intensive care unit room.

SERIOUS MENTAL ILLNESS – is defined by the American Psychiatric Association in Diagnostic and Statistical Manual (DSM III-R) and includes Schizophrenia, Paranoia, and other psychiatric disorders, Bi-Polar disorder (mixed manic and depressives), major depressive disorder (single episode or recurrence), schizo-affective disorder (bi-polar or depressives), pervasive developmental disorders, obsessive compulsive disorders and depression in childhood and adolescence.

SKILLED NURSING 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) a group of professional personnel, including one or more physicians and one or more registered nurses, to govern the skilled nursing care and related medical care or other services provided;
3. has a physician, a registered nurse (R.N.), 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 (R.N.);
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;
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.

SOUND NATURAL TEETH – teeth that are free of active chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

SPECIAL ENROLLEE – the term “Special Enrollee” means an Employee or Dependent who is entitled to and who requests Special Enrollment within 31 days of losing other health coverage; or for a newly acquired Dependent, within 31 days of the marriage, birth, adoption, or placement for adoption.

SPECIALIST PHYSICIAN – a physician whose practice is other than those defined as a primary care physician.

SUBSTANCE ABUSE – See *Substance Use Disorder*.

SUBSTANCE USE DISORDER – habituation to, abuse of, and/or addiction to alcohol or another chemical substance, not including nicotine. This includes physiological and/or psychological dependence.

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 the requirements under #1, #2 and #3 or the requirements under #4:

1. Affiliated with a hospital under a contractual agreement with an established system for patient referral; and
2. Accredited as such a facility by the Joint Commission for Accreditation of Healthcare Organizations; and
3. Licensed as a substance use disorder treatment program by the Texas Commission on Alcohol and Drug Abuse; or

4. Licensed, certified, or approved as a substance use disorder treatment program 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. It does not include the use of telephone or fax.

TOTALLY DISABLED – a physical state of a Covered Individual resulting from an illness or injury which wholly prevents:

1. In the case of a Participant, from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and
2. In the case of a Dependent from performing the normal activities of a person of a like age and sex in good health.

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 Transplant Center 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 12-month survival rate of at least 80% for the transplant procedure, with the exception of bone marrow transplants.

TRANSPLANT EXPENSES – the amount of the usual, reasonable and customary expenses for services and supplies, which are eligible benefit appropriate for a transplant.

TREATMENT – any specific procedure or service which is eligible 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, psychiatric, substance abuse 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.

URAC (UTILIZATION REVIEW ACCREDITATION COMMISSION) – an independent organization, known as a leader in accreditation, education and measurement programs. URAC offers quality benchmarking programs and services to validate quality and accountability. URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry.

USUAL, REASONABLE AND CUSTOMARY – a usual, reasonable and customary charge is deemed to be 110% of the amount prescribed by the Centers for Medicare and Medicaid Services (CMS), RBRVS, the plan’s allowable, other specialty CMS fee schedules and the Ingenix Essential RBRVS Fee Schedule.

WAITING PERIOD – the required period of time an Active Employee must complete before an employee or his/her eligible dependents can be effective for coverage under the Plan. The waiting period for the Plan is thirty (30) days. Participant coverage under the Plan shall become effective with respect to an eligible person on the first of the month following the 30th day of eligibility.

WELL-BABY CARE – medical treatment, services, or supplies rendered to a child or newborn solely for the purposes of health maintenance and not for the treatment of an illness or injury.

Special Enrollment Notice

*If you do not enroll yourself or an eligible dependent in the City of San Marcos' medical plan because you or your dependent has other medical coverage, you may enroll in the medical plan at a later date if you or your dependent **loses** coverage under the other medical plan. To enroll in a medical plan, the loss of other coverage must be due to loss of eligibility for coverage or because the employer who sponsors the other plan stops contributing toward the cost of you or your dependent's coverage. Also, you must request enrollment in the medical plan within thirty-one (31) days of the date you or your dependent's other coverage ends. In general, only the person who **loses** other coverage may enroll in the City of San Marcos' medical plan as a result of this special enrollment opportunity.*

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in the medical plan if you request enrollment within thirty-one (31) days of the date of the marriage, birth, adoption or placement for adoption.

If you or a dependent becomes eligible for payment assistance through Medicaid or CHIP with the cost of coverage under a City of San Marcos medical plan, you and your plan-eligible dependents will be able to enroll in a City of San Marcos medical plan. You must request coverage within sixty (60) days of the date you or your dependent becomes eligible for payment assistance.

To request special enrollment or for more information about special enrollment opportunities, call IEBP's customer service staff at (800) 282-5385.

Initial Notice of Benefits for Wellness Services

Preventive Care/Wellness Benefit

The **Wellness Benefit** is payable at 100% with no deductible when services are received In-Network (and Non Network for Routine Eye Exams). For Out-of-Network, refer to the Summary of Benefits and Coverage. The Routine procedures will be reimbursed subject to usual, reasonable and customary charges. To be considered under this benefit, the provider's bill must designate a routine diagnosis code (except for refractions). The Wellness Benefit does not include virtual colonoscopies.

Tests/Procedures

- › Routine Physical
- › Breast cancer annual chemoprevention counseling for women at high risk
- › Genetic Counseling for BRCA testing
- › BRCA testing for women without any history of BRCA related cancer
- › Well Baby/Child Exams
- › Well Woman Exam
- › Routine Mammogram
- › Routine Eye Exams (including refractions, regardless of the diagnosis) – charges for contact lens fitting are not covered and will be denied.
- › Routine Hearing Exams
- › Routine Hearing Exams
- › Routine Labs and X-rays
- › Routine Venipuncture
- › General Health Panel
- › Coronary Risk Profile (lipid panel)
- › Urinalysis
- › Prostate Specific Antigen (PSA)
- › (TB) Tuberculosis test
- › Handling of specimen to/from physician's office to a laboratory
- › Occult Stool Test
- › Examination for the detection of skin cancer
- › Autism Screenings for 18 (eighteen) and twenty-four (24) months of age

Recommended at and after age 40 (this is a recommendation not a requirement)

- › Chest X-Ray (front & lateral)
- › EKG (electrocardiogram)
- › Digital Rectal Exam
- › Osteoporosis Screening

Immunizations/Inoculations

Charges for immunizations and administrative fees are covered under the plan, subject to usual, reasonable and customary limits. Allergy injections and expenses related to routine newborn care are not considered as part of this benefit.

This benefit included state-mandated and non state-mandated immunizations and is available to all covered persons under the plan, with no age limitations. To be considered under this benefit, the provider's bill must designate a routine diagnosis code. This list is a guideline, not an inclusive list.

- › DT (Diphtheria and Tetanus Toxoids)

- › DtaP Diphtheria, Tetanus Toxoids and Pertussis
- › Td (Tetanus) booster
- › MMR (Measles, Mumps, Rubella)
- › MMR booster
- › Poliomyelitis Vaccine
- › Oral Polio
- › Varicella Vaccine (Chicken Pox)
- › Influenza
- › Hepatitis A
- › Hepatitis B
- › Pneumococcal (Pneumonia)
- › Pediarix (Diphtheria and Tetanus Toxoids and Acellular Pertussis Absorbed, Hepatitis B (Recombinant) and Inactivated Poliovirus Vaccine Combined)
- › Hib (Haemophilus Influenza B)
- › HPV (Genital Human Papillomavirus)
- › Rotavirus
- › Zosetavax (Shingles Vaccine)

Colon-Rectal Screening

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 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 routine or non-routine diagnosis. This includes when they are billed with a diagnosis of personal or family history of polyps (or colon cancer).

Notice of Benefits for Mastectomy and Breast Reconstruction

This medical plan provides comprehensive benefits 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 prosthetics due to complications. Reconstructive surgery includes tissue expanders, breast implants, nipple reconstruction, and nipple tattooing.

If you would like more information on benefits for mastectomy or breast reconstruction, call IEBP's customer service staff at (800) 282-5385.

Initial Notice of Medicaid & The Children’s Health Insurance Program

Premium Assistance Subsidy

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but who also have access to health coverage through their employer. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be eligible to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.HealthCare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or go to www.insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that might help you pay for an employer-sponsored health plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have question about enrolling in your employer plan, you can contact the Centers for Medicare & Medicaid Services electronically at www.cms.gov or by calling toll-free (877) 267-2323, ext. 61565.

If you live in one of the following States, you may be eligible for assistance paying for coverage under your employer health plan. The following list of States is current as of January 31, 2015. Contact your State for further information on eligibility.

ALABAMA – Medicaid Website: www.mayalhipp.com Phone: 1-855-692-5447	MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
ALASKA – Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	MONTANA – Medicaid Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084
COLORADO – Medicaid Website: http://www.colorado.gov/hcpf Phone: 1-800-221-3943	NEBRASKA – Medicaid Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
FLORIDA - Medicaid Website: https://www.flmedicaidprecovery.com Phone: 1-877-357-3268	NEVADA – Medicaid Website: http://dwss.nv.gov/ Phone: 1-800-992-0900
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	NEW HAMSHIRE – Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	NEW YORK – Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	NORTH CAROLINA – Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100

MINNESOTA – Medicaid Website: http://www.dhs.state.mn.us/if_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	UTAH – Medicaid and CHIP Medicaid Website: http://health.utah.gov/medicaid CHIP Website: http://health.utah.gov/chip Phone: 1-866-435-7414
OREGON – Medicaid Website: http://www.oregonhealthykids.gov http://www.hijosaludablesoregon.gov Phone: 1-800-699-9075	VERMONT – Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	VIRGINIA – Medicaid and CHIP Website: http://www.conserva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid Website: www.ohhs.ri.gov Phone: 401-462-5300	WASHINGTON – Medicaid Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid Website: http://www.scdhhs.gov Phone: 1-888-549-0820	WEST VIRGINIA – Medicaid Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA – Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059	WISCONSIN – Medicaid Website: https://www.dhs.wisconsin.gov/badgerscareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	WYOMING – Medicaid Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other States have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

City of San Marcos 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 San Marcos'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, care management, 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 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 the Plan 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 its business associates, to you; or (2) a promotional gift of nominal value given by the Plan, or one 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 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 60 days of the date the Plan receives your written request. However, the Plan is allowed an additional 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 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 San Marcos
Attn: Director of Human Resources
630 E Hopkins
San Marcos, TX 78666-6397

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 60 days after it receives your request to respond. If the Plan is not able to respond, it is allowed one 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.

In writing:

City of San Marcos
Attn: Director of Human Resources
630 E Hopkins
San Marcos, TX 78666-6397

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 are the privacy practices described in this notice effective?

This privacy notice has an effective date of September 1, 2013, and it replaces 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. The Plan and IEBP (the Plan's Group Benefits Administrator) will maintain their current privacy notice's on IEBP's website at: www.iebp.org. If a revision is made during your plan year, IEBP will post the revised notices to the website on the date the new notice goes into effect.

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

The Plan is required to maintain your records for at least six 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 San Marcos
 Attn: Director of Human Resources
 630 E Hopkins
 San Marcos, TX 78666-6397

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

Write to: City of San Marcos
 Attn: Director of Human Resources
 630 E Hopkins
 San Marcos, TX 78666-6397

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

City of San Marcos HIPAA Exemption Notice Plan Year 2016

Notice of Election of Exemption under the Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans as follows:

1. Limitations on pre-existing condition exclusion periods;
2. Special enrollment periods for individuals (and dependents) losing other coverage;
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status;
4. Standards relating to benefits for mothers and newborns;
5. Parity in the application of certain limits to mental health benefits; and
6. Required coverage for reconstructive surgery following mastectomies.

However, HIPAA permits certain governmental group health plans the right of exemption from certain provisions of this federal law. For the plan year from January 1, 2016 through December 31, 2016, the City of San Marcos has elected to exempt the City of San Marcos Employee Medical Plan from HIPAA provision 5 above. This exemption provides the City the ability to manage the benefits provided for mental health care, serious mental illness and substance use disorders in compliance with Texas requirements.

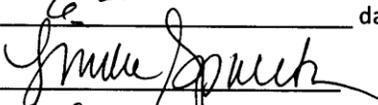
If you have any questions, please contact IEBP's customer service staff at (800) 282-5385.

Signature Page

The effective date of the City of San Marcos Group Medical Plan Document is August 1, 2001 with amendments through January 1, 2016.

It is hereby agreed by the City of San Marcos that the provisions of this document are correct to the best of our knowledge and will be the basis for the administration of the City of San Marcos Group Medical Plan.

Dated this 16th day of January, 2016

By 

Title H.R. Director

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