



Summary of Plan Description (SPD) – City of San Marcos

Benefit Beginning and End Date: January 1, 2016 through December 31, 2016

Plan Type: PPO Medical Plan

Resource	Contact Information	Accessible Hours
TML MultiState Intergovernmental Employee Benefits Pool (IEBP)	1821 Rutherford Lane, Suite 300 Austin, Texas 78754 PO Box 149190 Austin, Texas 78714-9190	
Customer Care Helpline:	(800) 282-5385	8:30 AM - 5:00 PM Central
Secured Customer Care E-mail:	Visit www.iebp.org click on the "Login" button click on "Online Customer Care" under the "My Tools" menu click on "Send a Secure Email"	8:30 AM - 5:00 PM Central
Provider Benefit Information Portal: Provider information can be found under the Provider Services menu. Member specific information such as Eligibility, Claims, Summary of Benefits and Coverage, Provider Coding Guidelines, Medication Therapy Management Guide, Member Rights and Responsibilities, Provider/ Member Appeal Rights and IEBP Quality Improvement Plan information is also available.	Visit www.iebp.org to register, click on the "Sign Up" link under the provider section to login, click on the "Login" button at the top right hand side of the screen	
IEBP Internet Website:	www.iebp.org	Twenty-four (24) hrs
MyIEBP Mobile Access:	iPhone–App Store, Droid–Google Play, All other Phones - www.iebp.org	Twenty-four (24) hrs
Information on how IEBP evaluates new technology for inclusion as a covered benefit:	Visit www.iebp.org click on "About Us" click on "Technology"	
Medical Authorizations:	(800) 847-1213 Voicemail after hours with a return call	8:30 AM - 5:00 PM Central
Prescription Authorizations:	OptumRx Toll Free: (800) 711-4555	
Spanish Line:	(800) 385-9952	
Where to Mail Paper Medical Claims:	TML MultiState IEBP PO Box 149190 Austin, Texas 78714-9190	
Where to Mail Paper OptumRx Prescription Claims:	OptumRx PO Box 29044 Hot Springs, AR 71903	
OptumRx Prescription Pharmacist Service Center:	(800) 788-7871 www.optumrx.com	
OptumRx Prescription Member Customer Service:	(888) 543-1369	
OptumRx Prescription Mail Service Customer Service: Register at optumrx.com to receive e-mail reminders when it is time to refill your prescription.	(800) 797-9791 (TTY 711) www.optumrx.com	
OptumRx Specialty/Biotech Pharmacy:	(866) 218-5445 Fax: (800) 491-7997	
After Hours and/or Weekend Medical and Mental Healthcare Emergencies:	Call 911 or immediately go to the emergency department.	
Cultural Sensitive Counties: Summary of Benefits and Coverage (SBC) and benefit declinations can be requested in Spanish in the following counties. County list may be updated midyear.	Visit www.iebp.org click on the "Login" button click on "Online Customer Care" under the "My Tools" menu click on "Send a Secure Email"	
Counties for 2014: Andrews Atascosa Bailey Bastrop Bexar Brooks Calhoun Cameron Camp Castro Cochran Concho Crane Crockett Crosby Culberson Dallam Dallas Dawson Deaf Smith Dimmit Duval Ector Edwards El Paso Frio Gaines Garza Glasscock Gonzales Hale Hansford Harris Haskell Hemphill Hidalgo Howard Hudspeth Jeff Davis Jim Hogg Jim Wells Karnes Kenedy King Kinney Kleberg Knox Lamb La Salle Limestone Lipscomb Martin Matagorda Maverick McMullen Midland Moore Navarro Nueces Ochiltree Parmer Pecos Potter Presidio Reagan Reeves Sherman Starr Sterling Sutton Tarrant Terry Titus Travis Upton Uvalde Val Verde Ward Webb Willacy Winkler Yoakum Zapata Zavala * Now Excluded Counties: Collingsworth, Floyd, Hall, Lynn, San Patricio		

Common Medical Event	Network Benefit	Non Network Benefit	Limitations, Exceptions, and Exclusions
Maximum Lifetime Benefit	None	None	None
Allergy Injections	100% Deductible waived	50% after Deductible	The Network benefit only applies when there is not an office visit billed.
Contraceptive Management	100% Deductible waived	50% after Deductible	Physician charges for the insertion and/or removal of a physician inserted contraceptive device and the charges for the device. This benefit also includes charges for any associated labs or tests.
Emergency Room Physician Charges –for Emergent/Immediate care Facility Charges –for Emergent/Immediate care Physician Charges – for Non Emergent/Immediate care Facility Charges – for Non Emergent/Immediate care	100% Deductible waived 100% Deductible waived 80% after Deductible 80% after Deductible and \$250 access fee	100% Deductible waived 100% Deductible waived 50% after Deductible 50% after Deductible and \$250 access fee	All Emergency Room Facility charges are subject to a \$250 facility access fee. The Emergency Room access fee is waived if admitted. The ER access fee also applies to emergent/ immediate care. In addition to the access fee, charges for non-emergent/ non-immediate care will be subject to the deductible and coinsurance.
Chiropractic Care	80% after Deductible	50% after Deductible	Limited to fifteen (15) visits per calendar year. Does not apply to Airrosti providers.
Airrosti	100% after \$50 Specialist copay; Deductible waived	N/A	

Common Medical Event	Network Benefit	Non Network Benefit	Limitations, Exceptions, and Exclusions
Treatment of Sleep Disorders	80% after Deductible	50% after Deductible	
Wigs (oncology related)	100% Deductible waived	50% after Deductible	Limited to a \$300 usual and reasonable limit per lifetime.
Prosthetic Bra/Breast Prosthesis (oncology related)	100% Deductible waived	50% after Deductible	Limited to a \$500 usual and reasonable limit per lifetime.
Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) and/or Aquatic Therapy (AT)	80% after Deductible	50% after Deductible	Limited to forty-five (45) outpatient days per calendar year for all services combined. The maximum calendar year benefit is for Network and Non Network combined.
Skilled Nursing Facility	80% after Deductible	50% after Deductible	
Home Health Care	100% Deductible waived	50% after Deductible	
Urgent Care Facility charges, labs, x-rays, infusions, injections, and allergy serum, injection and/or testing charges	100% after \$50 copay; Deductible waived	50% after Deductible	
All other charges, such as major imaging, supplies and chemotherapy	80% after Deductible	50% after Deductible	
Maternity – Physician Charges	100% after \$30 copay; Deductible waived	50% after Deductible	After initial visit to a Network provider for Maternity services, charges will be subject to the deductible and coinsurance.
Sterilization (ie: vasectomy or tubal ligation)	80% after Deductible	50% after Deductible	
Physician All Other Services	80% after deductible	50% after Deductible	
Preferred Lab Benefit	100% Deductible waived	N/A	Includes laboratory expenses from a Preferred Lab Provider and Preferred Lab drawing site. Eligible network <u>preventive/wellness</u> benefits and preferred lab benefits pay at no cost share to the covered individual.
Newborn Hearing Screening	80% Deductible waived	50% after Deductible	Includes a screening test for hearing loss from birth through the date the child is 30 days old and the necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.
Treatment Episode of the Medically Necessary Hearing Appliance	80% after Deductible	50% after Deductible	Limited to \$1,000 Maximum Benefit every thirty-six (36) months
SpecialtyRx/Biotech Medications	100% after a \$100 copay	Not Covered	SpecialtyRx/Biotech medications are covered under the Medical plan when they are provided by a Network provider. SpecialtyRx/Biotech medications are also available under the prescription plan.
Diabetic Related Therapeutic Footwear/Shoes	80% after Deductible	50% after Deductible	Limited to two (2) pairs Calendar Year (CY)
Transplants	80% after Deductible	50% after Deductible	
Other Eligible Major Medical Expenses	80% after Deductible	50% after Deductible	
Does this coverage provide <u>minimum essential coverage</u>?	Yes	Yes	The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan does provide minimum essential coverage.
Does this coverage meet the <u>minimum value standard</u>?	Yes	Yes	The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60 percent (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.
Maximum Calendar Year Benefit	None	None	This plan does not have a calendar year maximum. The plan does have some limits on lifetime and calendar year benefits for specific conditions and/or treatments, as indicated.
Physician Charges for Surgical Procedures (non-office)	80% After Deductible	50% After Deductible	Inpatient and Outpatient surgical procedures are not covered under a copay.
Durable Medical Equipment and Related Supplies	80% After Deductible	50% After Deductible	Notification is required for charges in excess of \$1,000 per base piece of durable medical equipment prior to purchase, lease or rental; limited to the U&R charges of standard models as determined by Medical Intelligence Care Management.
Prosthetics/Non Foot Orthotics	80% After Deductible	50% After Deductible	Limited to the U&R charges of standard models as determined by Medical Intelligence Care Management.
Medical Supplies	80% After Deductible	50% After Deductible	

Common Medical Event	Network Benefit	Non Network Benefit	Limitations, Exceptions, and Exclusions
Major Radiology	80% After Deductible	50% After Deductible	
Maximum Lifetime Benefit for Sleep Studies	80% After Deductible	50% After Deductible	
Outpatient X-Rays and Major Imaging	80% After Deductible	50% After Deductible	
Outpatient Non-Preferred Lab	80% After Deductible	50% After Deductible	

Extenuating Circumstances. 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 from the employer’s place of business, the provider would be paid at the Network benefit, subject, subject to usual, reasonable and customary allowable amounts.

Ancillary Provider Charges. When a Covered Individual uses a Network facility, all ancillary providers and specialists, including, but not limited to, surgeons, emergency room physicians, anesthesiologist, pathologist, and radiologist will be paid at the Network benefit and subject to the Network out of pocket and Network deductible, subject to usual, reasonable and customary allowable amounts

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 • 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 (1st) 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. Intake staff will return your call the next business day.	\$400
<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 and/or Substance Use Disorder 	Prior to admission for non-emergency admissions	\$400
Pregnancy/Maternity (Delivery Admission)	Within forty-eight (48) hours or the first (1st) business day	\$400
<ul style="list-style-type: none"> ▪ Normal Vaginal delivery 		
Pregnancy/Maternity (Delivery Admission)	Within ninety-six (96) hours or first (1st) business day	\$400
<ul style="list-style-type: none"> ▪ Cesarean Section delivery 		
Transplant Services	No later than prior to services being rendered	\$400
Newborn (if newborn requires more than routine care)	Within forty-eight (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’s Medical Intelligence 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 exceed \$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 Generic Testing to Direct Treatment (includes evidence based BRCA testing)	No later than prior to services being rendered	\$400

Medical Intelligence Utilization Management/Catastrophic Care. Utilization Management services help you use your benefits wisely during periods of treatment due to serious sickness or injury. This is done through early identification of the need for Utilization Management for catastrophic cases (chemotherapy, radiation therapy, transplants, NICU babies, brain injuries, multiple trauma etc.) that require intensive management. The UM/RNs are responsible for accurate and timely processing of requests for all events/services. The Utilization Management staff consists of licensed, professional nurses. The nurses have years of experience in health care and know the importance of not intruding in the doctor/patient relationship. By promoting health care alternatives such as Case Management or Healthcare Coaching for assistance with personal management of health and wellbeing that are acceptable to you, your doctors and your employer, to help control health care costs and use your benefits wisely. The Utilization Management Team will coordinate care and document Notification communication.

Medical Intensive Care Management Medical Intensive Care Management is designed to help manage the care of patients who have catastrophic or long-term illnesses or injuries requiring extensive care. The purpose of intensive care management is to identify and coordinate effective medical care alternatives which achieve treatment goals in a cost effective manner and meet accepted standards of medical practice. Intensive care management also monitors the care of the patient, offers emotional support to the family and coordinates communications among health care providers, patients, and others. This will be accomplished for plan participants through various resources including benefits of this plan (and non-plan benefits as arranged by Care Management) to patients who are eligible. Employees are encouraged to take advantage of this resource.

What Happens on Treatment in Excess of Twenty-three (23) Hours Inpatient Treatment? The Covered Individual must provide Notification to Medical Intelligence of a scheduled admission prior to the date of service or within forty-eight (48) hours after an emergency admission. If the Notification is made after the above-referenced time frames, a penalty may apply. Concurrent stay review requirements apply to all inpatient confinements. Failure to provide Notification to Medical Intelligence will result in no paid benefits for related charges and claims for benefits will not be considered unless an appeal is filed and a retrospective-review is granted.

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

Title I: Refers to healthcare coverage reform and includes provisions for special enrollments and non-discrimination based on Health Status Factors; A self-funded, non-federal, governmental plan may exempt itself from HIPAA's provisions for standards relating to benefits for mothers and newborns, parity in the application of certain limits for mental health benefits, coverage for reconstructive surgery following mastectomy/lumpectomy and coverage of dependent students on medically necessary leave of absence. The Plan has opted out of and is exempt from these provisions. However, the Plan may comply voluntarily, in part or in whole, with some of the HIPAA requirements listed.

Title II: Effective April 14, 2003, Administrative Simplification guidelines were mandated. The administrative simplification process includes standards for electronic transactions and code sets, national identifiers (for Employers, health plan and providers), Security and Electronic Signature Standards (Security Rule) and Standards for Privacy of Individually Identifiable Health Information (Privacy Rule); A self-funded, non-federal, governmental health plan cannot exempt itself from the Title II requirements.

Privacy of Your Health Information. A Federal regulation, called the "Privacy Rule," requires IEBP to protect the privacy of each Covered Individual's identifiable health information. Under the Privacy Rule, IEBP may use and disclose a Covered Individual's identifiable health information only for certain permitted purposes, such as the payment of claims under the health plan. If IEBP needs to use or disclose a Covered Individual's health information for a purpose not permitted under the Privacy Rule, IEBP must first obtain a written authorization signed by the Covered Individual. IEBP has administrative, physical and technical safeguards in place to protect the privacy of health information. IEBP will notify you regarding privacy breaches per Health and Human Services requirements. In addition to restrictions on how IEBP may use and disclose a Covered Individual's identifiable health information, the Privacy Rule gives each Covered Individual certain rights. These include the right of a Covered Individual to access his or her health information, to amend his or her health information, and to receive an accounting of certain disclosures of his or her health information. IEBP's Notice of Privacy Practices explains fully how IEBP may use and disclose a Covered Individual's identifiable health information and a Covered Individual's rights under the Privacy Rule. IEBP's Notice of Privacy Practices is available on IEBP's website at www.iebp.org, or an individual may request a paper copy of the notice by calling IEBP's customer care number at (800) 282-5385.

Security of Your Health Information. A Federal regulation, called the "Security Rule", requires IEBP to ensure the confidentiality, integrity and availability of a Covered Individual's identifiable health information that IEBP receives, creates, maintains or transmits electronically. IEBP has implemented administrative, physical and technical safeguards that meet both Federal requirements and industry standards for the security of electronic health information.

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

Humanitarian Use Device (HUD). The coverage determination on an HUD will be made according to the hierarchy of evidence applied towards the evaluation of any technology, in the same way the evaluation would be applied to a service or technology that is FDA approved without a Humanitarian Device Exemption. If the device is determined to be proven for the use it should be covered; if the device is determined to be unproven for use then it should not be covered.

Usual and Reasonable (U&R). A U&R charge is deemed to be 110% of the amount prescribed by the Centers for Medicare and Medicaid Services (CMS), Resource-Based Relative Value Scale (RBRVS), other specialty CMS fee schedules and the Ingenix Essential RBRVS/Reference-Based Pricing Fee Schedule.

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

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

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