2021
2022

Summary of Benefit Changes

TML Health Benefits Pool

Dear Valued TML Health Member,

This book summarizes the major changes in your medical, prescription, and optional dental benefits for the 2021-2022 plan year.

As we've worked to make healthcare better for you this past year, we have partnered with new vendors, bringing you an expanded medical and dental network through Blue Cross and Blue Shield of Texas and BlueCare Dental℠, and improved pharmacy benefits through Navitus.

If you'd like the rundown of what's different from your benefits last year, read on!

MEDICAL

Eligibility

Routine newborn care

Services incurred in a well-baby visit at the time of delivery, no longer covered as a part of the mother's charges and payable under the mother's file.

All newborns will be automatically covered under the plan for the first thirty-one (31) days and all services incurred will be payable under the baby's own file subject to deductible and coinsurance. For continued coverage, the baby must be enrolled under the plan within sixty (60) days of birth.

Covered Medical Expenses

Applied Behavioral Analysis (ABA) Therapy

Limited to 35 visits per year.

Colon cancer screening services with Cologuard

Cologuard lab test covered under the colon cancer screening preventive benefits at 100%. Lab Test limited to one every three years.

Cosmetic procedures

Certain potential Cosmetic procedures including but not limited to: Blepharoplasty, Uvulopalatoplasty, Reconstructive Surgery (facial/cosmetic/brows & chins/breasts). Strongly recommended that your physician submit a pre-determination of benefits request to confirm services will be covered.

Emergency Room fee for non-copay plans

For PPO and HDHP Plans, the Emergency Room Fee has increased to $500. After the application of the Access Copay, services subject to Deductible and Co-insurance.

Emergency Room copay for copay plans

The emergency room copay has increased to $500 for the facility fee.

Emergency Room benefit for copay plans

For True Emergency Treatment the facility benefit is a $500 Copay and Plan pays 100% of eligible services. For Non-Emergency Treatment (In Network and Out-of-Network), the facility benefit is a $500 Emergency Room fee followed by Deductible and Coinsurance.

Hearing aids

Hearing aid benefit allowance will be based upon the cost of the average standard model, limited to one paid every thirty-six (36) months.

Home health care

Home health care benefit of sixty (60) visits per year to include all services received within a home setting.

Benefits for cosmetic, reconstructive, or plastic surgery & benefits for the treatment of morbid obesity mandatory pre-determination

Your physician must submit a request for a pre-determination of benefits to determine the eligibility under the plan for the following services: Bariatric (weight-loss) surgery, and medically necessary cosmetic-types procedures.

Preferred lab-genetic testing

For Copay Plans, eligible genetic testing will be covered at no charge under the preferred lab benefit.

Preferred x-ray

For Copay Plans, the 100% x-ray benefit includes x-rays (excluding major imaging) and ultrasounds.

Bereavement counseling and respite care

Bereavement counseling and respite care are covered as a part of the Hospice benefit.

Dental accident

Services for dental accidents will be paid under the medical Plan for a period of twenty-four (24) months from the date of accident.

Diabetic footwear

Diabetic footwear is covered under the Plan with a diagnosis of diabetes.

Durable Medical Equipment

- Durable Medical Equipment will require a practitioner prescription.
- Non-standard equipment will be reviewed for medical necessity.
- Worn-out equipment is eligible for replacement after five years.

Nutritional counseling

Nutritional counseling from an In-Network practitioner is payable at 100%

Oncology bras and breast implants

Prosthetic bra, camisole, and/or breast prosthesis is covered following an oncology-related mastectomy.

Routine footcare

Routine footcare covered for the following diagnoses: diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

Surgical second opinion

Surgical second opinion paid at regular Plan benefits.

Congenital defect surgery

Surgical services to correct congenital defects covered for children under the age of nineteen (19) years.

Telemedicine

Teladoc telemedicine will be replaced with MDLIVE. Services offered by MDLIVE:

- **General Consult**
  No charge unless HDHP, where access fee will be $44
- **Psychiatric evaluation with medical service provided by an MD** $175, (subject to regular plan benefits)
- **Behavioral health medication evaluation & management**
  $80 (subject to regular plan benefits)
- **Psychiatric evaluation from PhD/Masters Level practitioner**
  $80 (Subject to regular plan benefits)
- **Psychotherapy session 30 - 45 mins**
  $80 (Subject to regular plan benefits)

Bariatric Surgery

Bariatric, (weight-loss) surgery must be performed at a BCBSTX Center of Distinction. Benefits for bariatric surgery and related services limited to $30,000 per lifetime. Strongly recommended that your physician submit a pre-determination of benefits request to confirm services will be covered.

Deductible and Out of Pocket Year End Confinement Carry-Over

The deductible and out-of-pocket will reset for a hospital inpatient confinement that spans two (2) years, (either calendar or plan year based on group accumulator start over date)

Out-of-Network Provider

Extenuating Circumstance Benefit

If a Member requires care from a specialist care provider but there is not an In-Network specialist care provider within a seventy-five (75) mile radius from the Member's home, the provider would be paid as In-Network Benefits subject to Reasonable and Customary allowable amounts.

Transplant

- Approved organ transplants must be performed at a BCBSTX Center of Distinction.
- A lodging and travel benefit is available up to $15,000 per lifetime for the patient and companion having to travel more than seventy-five (75) miles one way based on Member's home address.

Ambulance

- Emergency ground ambulance benefit of $2,500 allowed per trip.
- Emergency air ambulance benefit of $12,00 allowed per trip.
- For multiple services received on the same day or for an air ambulance claim, you must call BCBSTX Customer Service (855-762-7084) after you receive your explanation of benefits for additional payment up to the listed benefit allowance.

Major Imaging Benefits Value Advisor, (BVA) Cost Comparison

The Benefit Value Advisor (BVA) program has been established to assist you in maximizing your benefits under the Plan and lowering your out-of-pocket costs for Major Imaging Service. BVAs are specially trained customer service representatives who assist you by comparing costs and providing information on Participating Providers for certain types of healthcare services. A BVA helps you navigate your benefits.

In addition to calling the BVA, you may have other call requirements. A call to a BVA does not satisfy any other call requirements you may have, including prior authorization requirements for MRI and CT Scan services.

A BVA may reach out to you about your pre-authorized MRI or CT scan. To search for information about your Participating Provider options and estimate costs, contact a BVA directly at the number shown on the back of your identification card, logging into the Blue Access for Members Provider Finder tool online, or through the mobile application.

Definitions

Primary Care Physicians

- For copay plans, the list of primary care physicians has been expanded to include Behavioral Health Specialists.
- Psychotherapy services have been added to the Primary Care Physician copay benefit. Services are subject to $30 patient copay and Plan pays the remainder of 100%

Non-Network Providers

For a Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered ("Non-Network Provider"), the Allowable Amount will be the lesser of:

1. The Non-Network Provider's Claim Charge, or;
2. Claim Administrator's Non-Contracting Allowable Amount. Except as otherwise provided in number 3, the Non-Contracting Allowable Amount is developed from base Medicare reimbursements adjusted by a predetermined factor established by Claim Administrator. Such factor shall be not less than seventy five percent (75%) and will exclude any Medicare adjustment(s) which is/are based on information on the Claim, or,
3. Services for Ambulance, Emergency Medicine, Lab, Pathology, and DME are covered at 200% of CMS.

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on a Claim, the non-contracting Allowable Amount for Non-Network Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by Claim Administrator. Such factor shall be not less than seventy five percent (75%) and shall be updated not less than every two years.

Prior Authorization Requirement

- Non-emergent air ambulance
- Home infusion therapy
- Outpatient electroconvulsive therapy
- Repetitive transcranial magnetic stimulation
- Psych/neuro testing, some non-defined instances
- Lipid apheresis
- Gastric electrical stimulation
- Sacral nerve stimulation
- Vagus nerve stimulation
- Deep brain stimulation
- Bone conduction hearing aids
- Surgical deactivation of headache trigger sites
- Orthopedic stem cell therapy
- Functional neuromuscular electrical stimulation
- Stress testing
- Nuclear medicine/myocardial perfusion imaging (MPI)
- Sleep studies
- Positive airway pressure (PAP) therapy
- Therapy compliance monitoring
- Artificial intervertebral disc surgery
- Genetic Testing: Sequencing tests (e.g., BRCA)

PRESCRIPTION

New Tier Classification

- Tier 1
- Tier 2
- Tier 3
- Tier 4
- Tier 5

Copay Tiers

- **Generic - Tier 1** *(includes most generics and some lower cost brands)* $10 $20 $30
- **Preferred Brand - Tier 2** *(includes preferred brand and higher cost generics)* $40 $80 $120
- **Non-Preferred Brand - Tier 3** *(includes non-preferred products)* $70 $140 $210

Disease Management Copay

$0 copayment for sixty (60) day(s) and ninety (90) day(s) prescription fills for generic drugs under this program.

DENTAL

Comprehensive Exams	Limited to once every thirty-six (36) months, if same dentist
Periapical X-rays	Limited to six (6) per year
Bitewing X-rays	Four (4) horizontal or eight (8) vertical images once per calendar year
Collection of micro-organisms	Not covered
Sealants	Three (3) per permanent molar per lifetime under age fourteen (14) years
Preventive resin restoration	Each code once per tooth per thirty-six (36) months
Amalgam restoration	Each code once per tooth per thirty-six (36) months
Resin-based composite restorations	Each code once per tooth per thirty-six (36) months
Recement/rebond appliance	Two (2) times per year
Prefabricated stainless steel and resin crowns	Replacement after five (5) years and unserviceable
Adjustments to dentures	After six (6) months
Rebase or reline of dentures	One procedure every thirty-six (36) months
Appliance therapy	Once per Lifetime
Treatment of complications – additional fee	Not covered

CONTACT INFORMATION

Questions about...	Access	Contact Info	Hours
• Medical benefits • Medical procedures • Major imaging like MRI, CT, etc. - *Call before your appointment* • Cost estimates for procedures • Medical claims, EOBs • Select or change PCP • Deductibles, co-payments, co-insurance	BlueCross BlueShield of Texas Helpline	855-762-6084	24 hours a day 7 Days a week
• Enrolling in benefits • Adding, removing, or changing any TML Health administered benefit • Changing your contact information • Spending accounts, including balances • Life insurance • TML Health website • TML Health Online password reset • General questions	TML Health Member Service	800-282-5385	Monday-Friday 7:00 am-6:00 pm CT
• Prescription drugs covered by the plan • Rx Copays and lower cost options • Mail-order pharmacy • Specialty pharmacy • Pharmacy network • Prescription drug plan benefits	Navitus Customer Care	855-673-6504	24 hours a day 7 Days a week
• Medical procedures requiring prior approval *(also known as a prior authorization)*	Medical Preauthorization Helpline	800-441-9188	Monday-Friday 6:00 am-6:00 pm CT
• Mental health prior authorization • Substance use prior authorization	Mental Health/Chemical Dependency (SUD) Preauthorization Helpline	800-528-7264	24 hours a day 7 Days a week
• TML Health Online access • Access to benefits books • Health and wellness resources	TML Health Website	www.tmlhb.org	24 hours a day 7 Days a week
• Blue Access for Members (BAM) • Find an in-network provider	BCBSTX Website	www.BCBSTX.com	24 hours a day 7 Days a week

"From day one, our focus has never been on profit, but the service and lives of our members."

Jay Stokes, *TML Health Board Member*

TML Health Benefits Pool

1821 Rutherford Lane, Suite 300
Austin, TX 78754-5151
(800) 282-5385

For more information, visit us at
tmlhealthbenefits.org

Follow us: **@TMLHealth**