TML Health Benefits Pool

BRENHAM

Coverage Tiers: 4 Tier **Network:** Blue Choice PPO **Plan Type:** PPO | **Plan Description:** Copay-3K-7K ER

Prescription Plan: Mandatory Generic Program

Important Questions	*In-Network* Benefit	*Out-of-Network* Benefit	Why This Matters
What is the overall *deductible*?	Individual: $3000 Family: $6000	Individual: $6000 Family: $12000	Generally, you must pay all of the costs from *providers* up to the *deductible* amount before this *Plan* begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Charges applied to the out-of-network deductible do accumulate to the in-network deductible. **For any services that are subject to benefit maximum, only the amount up to the benefit maximum will apply toward your deductible/out-of-pocket if not already satisfied.**
Are there services covered before you meet your *deductible*?	Yes	No	This *Plan* covers some items and services even if you haven't yet met the *deductible* amount. But a *copayment* or *coinsurance* may apply. For example, this Plan covers certain *preventive services* without *cost sharing* and before you meet your deductible. Refer to your Medical Plan Booklet for a list of covered preventive services.
Are there other *deductibles* for specific services?	Facility Inpatient: None	Facility Inpatient: None	
Is there a *maximum out-of-pocket limit* on my expenses?	Individual: $7000 Family: $14000	Individual: $0 Family: $0 Never pays at 100%	The *maximum out-of-pocket limit* is the most you could pay in a year for covered services and includes in-network deductibles and coinsurance and medical and prescription copayments. If you have other family members in this *Plan*, they have to meet their own maximum out-of-pocket limits until the overall family maximum out-of-pocket limit has been met.
What is not included in the maximum *out-of-pocket limit*?			*Premiums*, penalties, non-covered services, and out-of-network expenses will not accumulate to your *maximum out-of-pocket* amount.
Is there an overall annual limit on what the *Plan* pays?	No	No	
Does this Plan use a *network of providers*?	Yes	N/A	This *Plan* uses a *provider* network. You will pay less if you use a provider in the Plan's *network*. You will pay the most if you use an *out-of-network provider*, and you might receive a bill from a provider for the difference between the provider's charge and what your Plan pays *(balance billing)*. See *www.BCBSTX.com* or call (855) 762-6084 for a list of participating providers.
Do I need a *referral* to see a *Specialist*?	No	No	
Are there any services the Plan does not cover?	Yes	Yes	Refer to the "*Excluded Services*" benefit information. A full list of Exclusions and Limitations can be found within the Medical Plan Booklet.
What is my *copayment*?	See below	N/A	This *Plan* does include medical copayments; unless otherwise specified, all charges apply towards *deductible* and *maximum out-of-pocket*.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Benefit (You will pay the least)	*Out-of-Network* Benefit (You will pay the most)	
If you visit a health care provider's office or clinic	*Primary care* visit to treat an injury or illness	20%*	50%	Includes Internist, General Physician, Family Practitioner, Pediatrician, Behavioral Health practitioner or Gynecologist. ***Plan pays exams, consultations, and psychotherapy at 100% after $30 copayment.** All other services subject to regular plan benefits.
	Specialist visit	20%*	50%	***Plan pays exams & consultations at 100% after $45 copayment.** All other services subject to regular plan benefits.
	Other practitioner office visit	20%*	50%	*Office visit copayment will be determined based upon specialty.
	MDLIVE Medical Consult	No Charge	N/A	
	MDLIVE Initial and Follow-Up Visit for Behavioral Health	$30 copay	N/A	
	MDLIVE Psychotherapy Visit for Behavioral Health	$30 copay	N/A	Outpatient and Intensive Outpatient Therapy programs limited to 26 visits per year.
	Preventive care/*screening*/ immunization	No charge	50%	See the Medical Plan Booklet for a list of covered preventive services, including those mandated by the US Preventive Task Force (USPSTF) at no charge. Colorectal DNA screening, (i.e. Cologuard), limited to one test every three years.
If you visit an *urgent care* clinic	Urgent care visit to treat an injury or illness	20%*	50%	***Plan pays exams & consultations at 100% after $75 copayment**. All other services subject to regular plan benefits.
If you have a test	Lab and X-ray in an office or outpatient facility setting	No Charge	50%	
	Lab and X-ray in an inpatient, out- patient surgery or *emergency room* setting	20%	50%	
	Other *Diagnostic Tests*	20%	50%	
	Major Imaging (CT/PET scans, MRIs)	20%	50%	See the "*Pre-Authorization* Requirements" section in the Medical Plan Booklet. Call (855) 762-6084 for information on how to control your out-of-pocket costs for these services.
	Specialty drugs administered in a medical setting	20%	50%	See the "Pre-Authorization Requirements" section in the Medical Plan Booklet.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center or outpatient hospital)	20%	50%	See the "*Pre-Authorization* Requirements" section in the Medical Plan Booklet. Out-of-Network *Specialist* services received at an in-network hospital will be paid as in-network and patients will be responsible for charges in excess of the allowable amount.
	Physician/surgeon fees	20%	50%	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Benefit (You will pay the least)	*Out-of-Network* Benefit (You will pay the most)	
If you need immediate medical attention Emergency room (ER)	*Emergency room facility services* for medical emergencies	$500 copay	20%* / 50%	For medical emergencies, the Emergency Room Copay applies to facility service only and Emergency Room services subject to Deductible and Coinsurance if admitted inpatient. For non-emergency treatment (In and Out of Network), a $500 Emergency Room Fee will apply. *Coinsurance* will apply after the *deductible* is met. *Out-of-Network charges will be paid as in-network for medical emergencies and patients will be responsible for charges in excess of the allowable amount.
	Emergency room facility services for non-emergency treatment	20%	20%* / 50%	
	Emergency room physician services for medical emergencies	20%	20%* / 50%	
	Emergency Ambulance services	20%	20%	• $2,500 maximum allowed per trip for Ground Ambulance. • $12,000 maximum allowed per trip for Air Ambulance. Contact Customer Service at (855) 762-6084 following payment of multiple ambulance trips made on the same day or air ambulance services. For Out-of-Network services, patients will be responsible for charges in excess of the allowable amount.
If you have a hospital stay	*Inpatient* Hospital	20%	50%	See the "*Pre-Authorization* Requirements" section in the Medical Plan Booklet. Out-of-Network *Specialist* services received at an in-network hospital will be paid as in-network and patient will be responsible for charges in excess of the allowable amount.
	Outpatient Hospital	20%	50%	
	Physician/surgeon fees	20%	50%	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	20%	50%	• Inpatient services limited to 14 days per year. • Residential services limited to 7 days per year. • Day Treatment limited to 14 days per year. • Outpatient and Intensive Outpatient Therapy programs limited to 26 visits per year. • In addition to the above, Chemical dependency/Substance Use Disorder benefit limited to a maximum of three (3) treatment series per lifetime. • Serious Mental Health Conditions are not subject to the above limits. See the Medical Plan Booklet for *Pre-Authorization* requirements and additional coverage information.
	Mental/Behavioral health inpatient services	20%	50%	
	Chemical dependency/Substance use disorder outpatient services	20%	50%	
	Chemical dependency/Substance use disorder inpatient services	20%	50%	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Benefit (You will pay the least)	*Out-of-Network* Benefit (You will pay the most)	
If you are pregnant	Prenatal and postnatal care	20%	50%	See the "*Pre-Authorization* Requirements" section in the Medical Plan Booklet. *Coinsurance* does not apply to certain services from *in-network providers*. Newborns are automatically covered for the first 31 days and must be enrolled within 60 days for continued coverage.
	Delivery and all inpatient services	20%	50%	
If you need help recovering or have other special health needs	*Home health care*	20%	50%	60 Home Health Care visits per year See the Medical Plan Booklet for *Pre-Authorization* requirements and additional coverage information.
	Rehabilitation/*Habilitation* services	20%	50%	The following frequency limits apply for office/outpatient services: • 30 Speech Therapy visits per year • 48 Physical, Occupational, and Aquatic visits combined per year • 10 Chiropractic Care visits per year • 35 Applied Behavior Analysis therapy visits per year for individuals with an Autism Spectrum Disorder diagnosis. See the Medical Plan Booklet for *Pre-Authorization* requirements for inpatients, and additional coverage information.
	Skilled nursing care	20%	50%	See the Medical Plan Booklet for *Pre-Authorization* requirements and additional coverage information. Inpatient private duty nursing is subject to medical necessity.
	Durable medical equipment	20%	50%	A prescription order from your Health Care practitioner is required. Reimbursement for rented equipment will not exceed purchase price.
	Hospice services	20%	50%	See the Medical Plan Booklet for *Pre-Authorization* requirements and additional coverage information.
	Other Eligible Medical Expenses	20%	50%	
If your child needs dental or eye care	Children's eye exam	N/A	N/A	Vision Acuity Screenings are paid as *Preventive* under the Medical Plan at 100% for in-network providers
	Children's glasses	N/A	N/A	Not covered under the Medical Plan. Glasses may be covered under a separate vision plan.
	Children's dental checkup	N/A	N/A	Pediatric oral fluoride varnish paid as *Preventive* under Medical Plan at 100% for in-network providers.

Excluded Services **& Other Covered Services:**

Services Your *Plan* Generally Does NOT Cover (Check your Medical Plan Booklet for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care
- Dental care (excluding dental injuries)
- Non-Emergency care when traveling outside the U.S.
- Personal comfort and convenience items
- Routine eye care
- Routine foot care
- Sterilization Reversal

Other Limited Benefits (The maximum benefits shown below will apply toward your deductible/out-of-pocket if not already satisfied). (This isn't a complete list. Please see your Medical Plan Booklet.)

- Custom-molded foot *orthotics*: 1 pair/36 months
- Hearing aids: One standard model pair every 3 years
- Morbid obesity treatment limited to BCBSTX Centers of Distinction: $30,000 allowed for total lifetime maximum. Pre-determination required.
- Wig for cancer related hair loss: $400 allowed benefit/year
- Removeable contacts or glasses following cataract surgery $200 allowed

Refer to the Medical Plan Booklet for a full list of services that require Pre-Authorization and additional coverage requirements.

TML Health is a non-profit trust organization created by political subdivisions to provide group benefits services to participating political subdivisions and is not an insurance company.

Extenuating Circumstances

If a Covered Person 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 employee's home, the provider will be paid at in-network benefits subject to the out-of-network *allowable amount*.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		***In-Network* Benefit (You will pay the least)**	***Out-of-Network* Benefit (You will pay the most)**	
If you need drugs to treat your illness or condition More information about *prescription drug coverage* is available at *tmlhealthbenefits.org*.	**Your Prescription Plan:** This is a Mandatory Generic Prescription Plan. This means if a brand name drug is dispensed and a generic alternate drug exists, you will pay the difference between the brand name and generic price in addition to the appropriate Copayment for the brand name. The cost difference between the brand name and generic price does not apply to any individual Deductibles or out of pocket amounts. **(For prescriptions purchased from a retail, mail order, or specialty pharmacy).**			
	Disease Management Maintenance (certain generic drugs to treat diabetes, high blood pressure, and high cholesterol)	$0	Not covered	**All *Copays* per 30 days for retail and mail order.** This benefit includes contraceptive drugs and devices obtainable from a pharmacy. No charge for generic FDA-approved women's contraceptives in-network and other drugs mandated by the US Preventive Task Force (USPSTF). *Pre-Authorization* and Step therapy are required for some drugs.
	Tier 1 drug – this includes **most generics** and **some lower cost brand** products	$10 copay	Not covered	
	Tier 2 drug – this includes **preferred brand** products and **certain higher cost generics**	$40 copay	Not covered	
	Tier 3 drug – this includes **non-preferred products**	$70 copay	Not covered	
	Tier 4 drug – this is a **Specialty** Drug and the member will be assessed the specialty copay	$100 copay	Not covered	
	Cost Share drug – the member will be assessed the **Cost Share** copay (also identified as a Tier 5 drug)	$150 copay	Not covered	

Your Rights to Continue Coverage

Federal and State laws may provide protections that allow you to continue *health coverage* after it would otherwise end. For more information about your rights and obligations under the *Plan* and under federal law, you should review the Medical Plan Booklet or contact TML Health, PO Box 149190, Austin, Texas 78714-9190 or by telephone (800)

282-5385. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance *Marketplace*. For more information about the Marketplace, visit *www.healthcare.gov* or call (800) 318-2596.

Your *Grievance* and *Appeals* Rights

If you have a complaint or are dissatisfied with a denial of coverage for *claims* under your *Plan*, you may be able to appeal or file a grievance. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your Medical Plan Booklet also provides complete information to submit a claim appeal or a grievance for any reason. For assistance, contact TML Health, PO Box 149190, Austin, Texas 78714-9190 or by telephone (800) 282-5385. You may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at (877) 267-2323 x61565 or *www.cciio.cms.gov*.

Does this Plan provide *Minimum Essential Coverage*? Yes.
The Affordable Care Act requires most people to have *health coverage* that qualifies as "minimum essential coverage". This *Plan* does provide minimum essential coverage.

Does this Plan Meet *Minimum Value Standard*?
The Affordable Care Act establishes a minimum-value standard of benefits of a health *plan*. The minimum value standard is 60% (actuarial value). This *health coverage* does meet the minimum-value standard for the benefits it provides.

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

Having a Baby *(normal delivery)*	
• Amount owed to Providers:	$13,772.46
• Plan pays:	$11,247.46
• Covered Individual/Patient pays:	$2,500.00
Sample Care Costs	
Hospital charges (mother)	$5,829.57
Hospital charges (baby):	$1,505.65
Routine obstetric care:	$3,313.16
Anesthesia:	$2,200.00
Laboratory tests:	$325.96
Prescriptions:	$45.00
Radiology:	$553.12
Total:	**$13,722.46**
Covered Individual/Patient Pays	
Deductible:	$500.00
Copayments: Medical/Rx:	$25.00/$0.00
Coinsurance:	$1,975.00
Plan/Max Plan OOP:	$2,500.00
Limits or Exclusions:	$0.00

Managing Type 2 Diabetes *(routine maintenance of a well-controlled condition)*	
• Amount owed to Providers:	$8,673.52
• Plan pays:	$7,441.18
• Covered Individual/Patient pays:	$1,232.34
Sample Care Costs	
Prescriptions:	$7,138.32
Medical Equip. & Supplies:	$208.32
Office Visits and Procedures:	$858.20
Education:	$204.50
Laboratory tests:	$116.54
Vaccines, other preventive:	$147.64
Total:	**$8,673.52**
Covered Individual/Patient Pays	
Deductible:	$170.34
Copayments: Medical/Rx:	$150.00/$912.00
Coinsurance:	$0.00
Plan/Max Plan OOP:	$1,232.34
Limits or Exclusions:	$0.00

Simple Fracture *(with emergency room visit)*	
• Amount owed to Providers:	$3,383.56
• Plan pays:	$2,252.62
• Covered Individual/Patient pays:	$1,130.94
Sample Care Costs	
Emergency Services:	$2,319.54
Medical Equip. & Supplies:	$128.10
Office Visits and Procedures:	$598.13
Physical Therapy:	$307.74
Laboratory tests:	$0.00
Prescriptions:	$30.05
Total:	**$3,383.56**
Covered Individual/Patient Pays	
Deductible:	$500.00
Copayments: Medical/Rx:	$75.00/$0.00
Coinsurance:	$455.94
Plan/Max Plan OOP:	$1,030.94
Limits or Exclusions:	$100.00

Total:	**$2,500.00**	**Total**:	**$1,232.34**	**Total**:	**$1,130.94**

Guidance document appears at 77 Fed Reg. 8668 and 8706 respectively (2-14-12). To request a translated document, call (800) 282-5385.

For general definitions of common terms, such as *allowed amount*, *balance billing*, *coinsurance*, *copayment*, *deductible*, *provider*, or other hyperlinked terms, see the Glossary. You can view the Glossary at *www.healthcare.gov/sbc-glossary* or call (800) 282-5385 to request a copy.

Non-Discrimination

TML Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. TML Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

TML Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator. If you believe that TML Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, (800) 282-5385, TTY 711, Fax (512) 719-6539, *CRCoordinator@tmlhb.org*. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at *www.hhs.gov/ocr/office/file/index.html*.

TTY: 711

Language Assistance

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call (800) 282-5385.

Spanish ---------- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 282-5385.

Vietnamese ------ CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 282-5385.

Chinese ---------- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 282-5385.

Korean ---------- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 282-5385 번으로 전화해 주십시오.

Arabic ---------- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل - . برقم الصم هاتف والبكم (800) 282-5385 رقم)

Urdu ---------- خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال (800) 282-5385 کریں

Tagalog ---------- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 282-5385.

French ---------- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 282-5385.

Hindi ---------- ध्यान द: यद आप हदी बोलते ह तो आपके लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। (800) 282-5385 पर कॉल कर।

Persian (Farsi) -- **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما (800) 282-5385 فراهم می باشد. با تماس بگیرید.

German ---------- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 282-5385.

Gujarati ---------- **ચના: જો તમે જરાતી બોલતા હો, તો ન:લ્કુ ભાષા સહાય સેવાઓ તમારા મટ ઉપલબ્ધ છ. ફોન કરો** (800) 282-5385.

Russian ---------- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 282-5385.

Japanese -------- 注意事項： 日本語を話される場合、無料の言語支援をご利用いただけます。(800) 282-5385まで、お電話にてご連絡ください。

Laotian ---------- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (800) 282-5385.