Benefit Beginning and End Date: October 1, 2020 through September 30, 2021
Plan Type: PPO Medical Plan E

Resource	Contact Information and Accessible Hours
TML Health	PO Box 149190 | Austin, Texas 78714-9190
Customer Care Helpline	(800) 282-5385 | 7:00 AM -6:00 PM Central | Monday thru Friday
Secured Customer Care E-mail: Medical	Visit tmlhealthbenefits.org ▸ click on the "Login" button ▸ click on "Login as a Member" ▸ click on "Contact Us" ▸ 8:30 AM - 5:00 PM Central
TML Health Internet Website	tmlhealthbenefits.org | Twenty-four (24) hours
*My*IEBP Mobile Access	iPhone–App Store, Droid–Google Play, All other Phones–tmlhealthbenefits.org | Twenty-four (24) hours
Information on how TML Health evaluates new technology for inclusion as a covered benefit	Visit tmlhealthbenefits.org ▸ click on "About Us" ▸ click on "Technology"
Medical Authorizations	(800) 282-5385 | 8:30 AM - 5:00 PM Central
Prescription Authorizations	Navitus | Toll Free: (855) 673-6504
Where to Mail Paper Medical Claims	TML Health | PO Box 149190 | Austin, Texas 78714-9190
Navitus Prescription Customer Service	(855) 673-6504
Lumicera Specialty/Biotech Pharmacy	Members: (855) 847-3553; Prescribers: (855) 847-3554
After Hours and/or Weekend Medical and Mental Healthcare Emergencies	Call 911 or immediately go to the emergency department.

Common Medical Event	In-Network Benefit	Out-of-network Benefit	Limitations, Exceptions, and Exclusions
Maximum Lifetime Benefit	N/A	N/A	None
Maximum Lifetime Benefit for Wigs *(oncology related)*	100% Deductible Waived	80% After Deductible Up to R&C	Limited to a $400 reasonable and customary limit per calendar year.
Maximum Lifetime Benefit for Prosthetic Bra/Breast Prosthesis *(oncology related)*	100% Deductible Waived	80% After Deductible Up to R&C	Limited to a $150 reasonable and customary limit per lifetime.
Maximum Lifetime Benefit for Sleep Studies	80% After Deductible	60% After Deductible Up to R&C	One (1) per sleep study per lifetime. Limited to Sleep Apnea and Narcolepsy
Maximum Lifetime Benefit for Morbid Obesity Treatment	50% After Deductible	N/A	Limited to $30,000 payable per lifetime. Never pays at 100% and expenses do not go towards the out-of-pocket.
Maximum Benefit for Hearing Appliances	80% After Deductible	60% After Deductible Up to R&C	Limited to a $3,500 reasonable and customary limit per three (3) calendar years. Includes repair and hearing aid batteries.
Maximum Benefit for Custom Molded Foot Orthotics	80% After Deductible	60% After Deductible Up to R&C	Limited to one (1) pair every thirty-six (36) months unless medically documented physiological changes.
Calendar Year Maximum for Private Duty Nursing	80% After Deductible	60% After Deductible Up to R&C	Limited to one hundred (100) visits per calendar year; includes inpatient and outpatient private duty nursing.

Common Medical Event	In-Network Benefit	Out-of-network Benefit	Limitations, Exceptions, and Exclusions
Contraceptive Management	100% Deductible Waived	60% After Deductible Up to R&C	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. Preferred Lab benefits are also available.
Allergy Injections	100% after $20 copay	60% After Deductible Up to R&C	Includes charges for Allergy Serum and Allergy Testing. If an Allergy Injection is billed without an office visit, a copay will still apply. If an office visit is billed with a charge for an allergy injection, only one office visit copay will apply.
Diabetic Education	80% After Deductible	80% After Deductible Up to R&C	
Preadmission Testing	80% After Deductible	60% After Deductible Up to R&C	
Second Surgical Opinions	100% after $20 copay	60% After Deductible Up to R&C	
SpecialtyRx/Biotech Medications	100% after $20 copay	Not Covered	SpecialtyRx/Biotech medications are covered under the Medical plan when they are provided by an In-Network provider, subject to Pre-Authorization requirements. There are no benefits for Specialty/Biotech drugs obtained from and/or administered by an Out-of-Network provider. SpecialtyRx/Biotech medications are also available under the prescription plan.
Temporomandibular Jaw Treatment (Surgical and Non-Surgical)	80% After Deductible	60% After Deductible up to R&C	Single exam including history/physical, x-rays, muscle testing, range of motion, therapeutic injections, and psychological evaluation, as necessary. Includes Physical Therapy and a single Orthotic Appliance. See Medical Plan Document for complete coverage requirements. Pre-authorization required for surgery/surgical procedures.
Nutritional Counseling (Routine/Wellness)	100% Deductible Waived	60% After Deductible up to R&C	Rendered by a Licensed Dietitian or Physician.
Nutritional Counseling (Diabetes Diagnosis)	80% After Deductible	60% After Deductible Up to R&C	Covered as part of the Diabetic Self-Management Training/Education benefit. Rendered by a Licensed Dietitian or Physician.
Nutritional Counseling (Morbid Obesity)	50% After Deductible	N/A	Covered under the Morbid Obesity benefit. Must meet Morbid Obesity requirements.
Nutritional Counseling (All Other Diagnoses)	80% After Deductible	60% After Deductible Up to R&C	Based on Medical Necessity and rendered by a Licensed Dietitian or Physician. Services rendered as part of Home Health Care are subject to the Home Health Care benefit limits.
Other Eligible Major Medical Expenses	80% After Deductible	60% After Deductible up to R&C	
Does this coverage provide minimum essential coverage?	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 minimum value standard?	Yes	Yes	The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60 percent (60%; actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Pre-authorization Requirements

Pre-authorization 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.

Pre-authorization is required for the following admissions and/or procedures:

Service	Pre-authorization	Late Pre-authorization Penalty
Inpatient Admissions		
Emergency Admissions	Facility: twenty-four (24) hours after emergency admission or by 5:00 PM the next calendar day for weekend/holiday admissions In an emergency, Voice Mail records and dates your pre-authorization request twenty-four (24) hours-a-day. Intake Staff will return your call the next business day.	$500*
Scheduled Specialty Admissions • Orthopedic/Spine Surgeries (spinal surgeries, total knee replacements, and total hip replacements) • Reconstructive procedures • Congenital Heart Disease	Prior to services and must be authorized before services are rendered to avoid penalty	$500*
Other Scheduled Admissions • All Inpatient Admissions • Observation Stays in excess of 23 hours • Inpatient Hospice • Skilled Nursing Facility • Mental Health/Substance Use Disorder Inpatient • Mental Health/Substance Use Day Treatment • Mental Health/Substance Use Disorder Residential Treatment • Acute Care Hospital/Facility • Long Term Acute Care Facility • Convalescent Nursing Home for Rehabilitation Services • Rehabilitation Facility • Inpatient maternity care that does not result in a delivery	Prior to services and must be authorized before services are rendered to avoid penalty	$500*
Inpatient Pregnancy/Maternity (Delivery Admission) • Vaginal delivery in excess of forty-eight (48) hours •	Facility: twenty-four (24) hours after the forty-eight (48) hours after the delivery, or by 5 PM on the following day after a weekend or holiday.	$500
Inpatient Pregnancy/Maternity (Delivery Admission) • Cesarean Section delivery in excess of ninety-six (96) hours	Facility: twenty-four (24) hours after the ninety-six (96) hours after the delivery, or by 5 PM on the following day after a weekend or holiday.	
• Newborns who remain in the hospital after mother is discharged (where confinement exceeds mother's original Pre-Authorization approval) • Newborns who are admitted to a Neonatal Intensive Care Unit (NICU)	A pre-authorization request is required no later than twenty-four (24) hours of mother's discharge or the time newborn is placed in the NICU	$500*

Service	Pre-authorization	Late Pre-authorization Penalty
Scheduled Outpatient/Office Surgical Procedures		
• Blepharoplasty (eyelid surgery) • Breast Surgery (excludes Breast Biopsies) • Carpal Tunnel Release (nerve decompression) • Jaw Surgery (including mandibular joint) • Joint Surgery (excluding fingers & toes) • Laparoscopy (except sterilization) • Nasal Surgery • Uvulopalatoplasty (roof of mouth) • Cochlear Device and/or Implantation	Prior to services and must be authorized before services are rendered to avoid penalty	$500 $500
Outpatient/Office/Medication Therapy		
• Pain Management Therapy (IV) • Oncological Chemotherapy (IV/Injectable/Oral)	Prior to services and must be authorized before services are rendered to avoid penalty	$500
Miscellaneous		
• Mental Health/Substance Use Disorder Day Treatment and Intensive Outpatient Treatment • Radiation Therapy • Total Parenteral Nutrition • Administration of IV Antibiotics • Home Health Care • Physician Home Visit • Cardiac Rehabilitation • Pulmonary/Respiratory Rehabilitation • Positron Emission Tomography (PET) scans • Computerized Axial Tomography (CAT) scans • Computerized Tomographic Angiography (CTA) scans • Magnetic Resonance Imaging (MRI) scans • Magnetic Resonance Angiography (MRA) scans • Single Photon Emission Computed Tomography (SPECT) • Hyperbaric Oxygen Therapy • Medically Necessary Evidence-Based Genetic/Genomic Testing to direct treatment (after diagnosis has been established) • Bariatric surgery: after the approved six (6) consecutive months (within the most recent twelve (12) months) with a psychiatric evaluation and a physician supervised weight management treatment plan • Diabetic Self-Management Education (for charges in excess of $1,000) • Intraoperative Monitoring (inpatient and outpatient)	Prior to services and must be authorized before services are rendered to avoid penalty	$500
• Applied Behavior Analysis Therapy (ABAT) for Autism Spectrum Disorder	Prior to services and must be authorized before services are rendered/drugs are administered.	$500

Service	Pre-authorization	Late Pre-authorization Penalty
• Specialty/Biotech Drugs administered in a clinical setting	Prior to services and must be authorized before services are rendered/drugs are administered. Specialty/Biotech drugs not pre-authorized prior to administration will be denied.	A $100 copay will apply if preauthorized. If denied and then approved upon appeal, no penalty but the $100 copay will apply
• Durable Medical Equipment (including repairs) for purchased equipment	Prior to dispensing/delivery of standard durable medical equipment in excess of $1,500 per base piece of durable medical equipment	$500
• Durable Medical Equipment for rental equipment	Prior to dispensing/delivery of standard durable medical equipment in excess of $500 per monthly rental per base piece of durable medical equipment	$500
• Prosthetics and non-foot Orthotics (including repairs) • Implantable and/or removable ocular prosthetic lens (including repairs)	Prior to dispensing/delivery of standard prosthetics/non-foot orthotics and/or implantable-removable ocular prosthetic lens in excess of $1,000	$500

* **The attending provider and the facility are responsible for the Pre-authorization requirements. Non-compliant providers will receive the penalty. Providers cannot balance bill a member for the lack of Pre-authorization penalties and denied services.**

Extenuating Circumstances

If a Covered Individual requires emergent/immediate care until stabilized or if a specialist care provider is required but there is not an In-Network specialist care provider within a seventy-five (75) mile radius from the employee's place of business, the provider would be paid at the In-Network benefit, subject to the In-Network deductible and In-Network Out-of-pocket, subject to reasonable and customary allowable amounts.

Ancillary Provider Charges

When a Covered Person uses an In-Network facility, all ancillary providers and specialists, including, but not limited to, anesthesiologist, pathologist, and radiologist will be paid at the In-Network benefit and subject to the In-Network out-of-pocket and In-Network deductible. Reasonable and Customary guidelines will still apply to Out-of-Network Charges.

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(s) is/are 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% of the allowable amount; non-MD at 14% of the allowable amount or per the primary contract.

Multi-Anesthesiologist

Appropriate modifier will be paid at 50% of the allowable amount or per the primary contract; if no modifier, payment will be paid no more than 100% of allowable amount.

Important Disclaimer

The information presented in this Summary of Plan Description (SPD) **IS NOT** a guarantee of payment. The benefits described are subject to all plan limitations, pre-existing information, late entrants, filing deadlines, exclusions, and eligibility requirements. All benefits are based on the plan document language.

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.