2019-2020 Summary of Benefit Changes Medical Plan

TML Health Benefits Pool

At TML Health, we bring members together to provide quality healthcare benefits for you and your family at an exceptional value. We're excited about our new benefit plans. Here are some things we're doing to simplify healthcare.

Changes regarding Pre-Authorization Requirements

- Newborns who remain in the hospital after mother is discharged (where confinement exceeds mother's original Pre-authorization approval) will require pre-authorization
- "Dental Injury (inpatient and outpatient)" will no longer require pre-authorization.
- Transplant pre-authorization requirement is separated into two services.
    1. Pre-authorization is required for pre-evaluation inpatient and outpatient at least fifteen (15) working days prior to any pre-transplant evaluation. The late pre-authorization penalty is $400.
    2. Pre-authorization is required for transplant procedures twenty-four (24) hours after actual admission or by 5 PM the next calendar day for weekend/holiday admissions. The late pre-authorization penalty is $400. 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.
- Durable Medical Equipment requirement is separated into two services.
    1. Pre-authorization is required for purchased equipment exceeding $1,500 per base piece. The late pre-authorization penalty is $200.
    2. Pre-authorization is required for rental equipment exceeding $500 per monthly rental per base piece. The late pre-authorization penalty is $200.

Changes regarding Deductible and Out-of-Pocket Requirements

- In-Network and Out-of-Network deductibles will be separate. The Out-of-Network deductible will accumulate to the In-Network. However, the In-Network will not accumulate to the Out-of-Network deductible.
- If you are enrolled in a Qualified High Deductible/Health Savings Account (HSA) plan and are covering any dependents, the **entire family deductible** must be met before the Plan will begin to pay any benefits. This is also called an Aggregate (or Non-Embedded) Deductible. However, once any individual on the Plan meets the Federal Individual Maximum Out-Of-Pocket Maximum, the Plan will begin to pay for in-network services for that person.

- If you are on a Qualified High Deductible/HSA and are covering any dependents, the **family out-of-pocket** must be met before the Plan will pay the next level of benefits. This is also called an Aggregate (or Non-Embedded) Out-of-Pocket. However, once any individual on the Plan meets the Federal Individual Maximum Out-Of-Pocket Maximum, the plan will begin to pay 100% for in-network services for that person.

Changes regarding Eligible Benefits

Coverage is added for the following:

1. Diabetes Equipment and Supplies – Coverage for equipment and supplies for the treatment of diabetes for which a physician or practitioner has written an order, including:

    a. blood glucose monitors, including those designed to be used by or adapted for the legally blind*;
    b. test strips specified for use with a corresponding glucose monitor*;
    c. lancets and lancet devices*;
    d. visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein*;
    e. insulin and insulin analog preparations*;
    f. injection aids, including devices used to assist with insulin injection and needleless systems*;
    g. insulin syringes*;
    h. biohazard disposal containers;
    i. insulin pumps, both external and implantable, and associated appurtenances, which include:
        - insulin infusion devices;
        - batteries;
        - skin preparation items;
        - adhesive supplies;
        - infusion sets;
        - insulin cartridges;
        - durable and disposable devices to assist in the injection of insulin; and
        - other required disposable supplies;

    j. repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
    k. prescription medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level**(* These items are only covered under the Prescription Drug Plan)* ;
    l. podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
    m. glucagon emergency kits* *(* These items are only covered under the Prescription Drug Plan)*.

2. Hearing Evaluation and Appliance Selection: Necessary diagnostic follow-up care related to a screening test for hearing loss from birth through the date the child is twenty-four (24) months of age is covered.
3. Wigs will be covered for oncology related hair loss with a $400 maximum benefit per calendar year.
4. Out-of-network services are covered at 100% for mandated childhood immunizations.
5. Transplant Center changes:
    a. Instead of a maximum reimbursement per day, the $15,000 benefit limit includes combined charges for the recipient and adult companion for all food, travel, and lodging costs.
    b. The transplant facility distance is changed from "more than two hundred (200) miles" to "more than seventy-five (75) miles" one way from the recipient's place of employment to receive benefits for companion housing during transplant treatment.

6. Morbid Obesity Benefit changes:
    a. There is no longer a requirement to contact the health coach after discharge.
    b. Benefits will be limited to one (1) surgery per lifetime with a limited benefit of $30,000.

7. Mental Health Inpatient Treatment benefit is increased from 7 inpatient days to 14 inpatient days per calendar year.
8. Substance Use Disorder Inpatient Treatment benefit is increased from 7 inpatient days to 14 inpatient days.
9. The treatment of nicotine addiction (except as specifically covered under the prescription drug benefit) or for any treatment, service or supply incurred or any therapy or training designed to curb or alleviate a personal habit is now covered.
10. Over the counter (OTC) nutritional formulas used as food replacement without a physician's prescription are excluded.
11. The Air Ambulance benefit increased from $9,000 to $12,000 per trip.
12. The Speech Therapy benefit increased from 12 visits to 30 visits per calendar year.
13. A pre-determination of benefits is required for gene therapy, including the injectable Zolgensma, for the treatment of spinal muscular atrophy.

Prescription Drug Plan

Changes regarding the Copay Structure

1. The "Preferred Retail Pharmacies" (HEB and Walmart) copay structure is no longer available.

2. Retail and Mail Order copay structure is now combined:

- Retail Preferred Brand, 30-day supply decreased from $43 to $40.
- Retail Non-Preferred Brand, 30-day supply increased from $65 to $70.
- Mail Order Generic, 31-90-day supply increased from $15 to:
  - $20 (31-60 day); and
  - $30 (61-90 day).
- Mail Order Preferred Brand, 31-90-day supply changed from $114 to:
  - $80 (31-60 day); and
  - $120 (61-90 day).
- Mail Order Non-Preferred Brand, 31-90-day supply changed from $180 to:
  - $140 (31-60 day); and
  - $210 (61-90 day).

The Following Drugs Will No Longer Require Step Therapy

Antibiotics – metronidazole, metronidazole SR, Dificid®, Vancocin HCl®, vancomycin

The Following Drugs Will No Longer Require Prior Authorization

1. Antibiotics - Bexdela®, linezolid, Zyvox®
2. CNS Stimulants – armodafinil, modafinil, Nuvigil®, Provigil®
3. Diabetes - Jardiance®, Synjardy®/Synjardy XR®, Victoza®
4. Acne Medications: only required for Tretinoin all dosage forms (e.g. Retin-A, Differin, Tazorac)
5. Narcolepsy Medications including Xyrem®
6. Testosterone medications including injectable products

The Following Drugs Will No Longer Be Excluded

1. ADLYXIN INJ 10/20MCG; 20MCG
2. ALOG/PIOGLIT TAB 12.5-15MG, 12.5-30, 12.5-45, 25-15, 25-30, 25-45; OSENI TAB 12.5-15MG, 12.5-30, 12.5-45, 25-15, 25-30, 25-45
3. ALOGLIPTIN TAB 12.5MG, 25, 6.25; NESINA TAB 12.5MG, 25, 6.25
4. ALOGLIPTIN/TAB METFORM, KAZANO 12.5- TAB 1000MG, 12.5- TAB 500MG
5. BYDUREON BC INJ 2/0.85ML
6. BYDUREON INJ 2MG
7. BYDUREON PEN INJ 2MG
8. BYETTA INJ 10MCG, 5MCG
9. CRESEMBA INJ 372MG
10. FARXIGA TAB 10MG, 5MG
11. GLYXAMBI TAB 10-5MG, 25-5MG
12. JANUMET TAB 50-1000MG, 50-500MG
13. JANUMET XR TAB 100-1000MG, 50-1000, 50-500
14. JANUVIA TAB 100MG, 25, 50
15. JENTADUETO TAB 2.5-1000, 2.5-500, 2.5-850
16. JENTADUETO TAB XR
17. KOMBIGLYZ XR TAB 2.5-1000MG, 5-1000, 5-500
18. ONGLYZA TAB 2.5MG, 5MG
19. OZEMPIC INJ 2/1.5ML
20. QTERN TAB 10MG/5MG
21. SEGLUROMET TAB 2.5-1000, 2.5-500, 7.5-1000, 7.5-500
22. SOLIQUA INJ 100/33
23. STEGLATRO TAB 15MG, 5MG
24. STEGLUJAN TAB 15-100MG, 5-100MG
25. TANZEUM INJ 30MG, 50MG
26. TRADJENTA TAB 5MG
27. TRULICITY INJ 0.75/0.5, 1.5/0.5
28. VASCEPA CAP 1GM
29. XIGDUO XR TAB 10-1000MG, 10-500, 2.5-1000, 5-1000, 5-500
30. XULTOPHY INJ 100/3.6

The Following Drugs Will Be Excluded

- Any drug that is available over-the-counter (OTC).
- Zolgensma injectible for the treatment of spinal muscular atrophy
- All non-injectable testosterone (including pellet and buccal formulations)
- All nasal steroids (e.g. Beconase® AQ, Nasonex®, QNASL®, etc.)
- All non-sedating/low-sedating antihistamines (e.g. Claritin®, Clarinex®, desloratadine, levocetirizine, Zyrtec®, etc.)
- All proton pump inhibitors (e.g. Dexilant®, Nexium®, Prilosec®, Protonix, etc.) and H_2 Antagonists (e.g. Pepcid®, Tagamet®, Zantac®, etc.)
- All topical non-narcotic pain medications (e.g. Sinelee®, Flector®, Solaraze®, etc.)
- Certain acne medications: Absorica®, all benzoyl peroxide, Altreno®, Cleocin-T® gel, Clindagel®, Clindamycin® gel, Duac® gel, Fabior®, Refissa®, Renova®, tretinoin emulsion cream, Retin-A®, and Riax®
- Certain analgesic/anti-inflammatory/pain agents: Belbuca®, Bunavail®, Nalocet®, Oxaydo®, Roxybond®, Sprix spray®, Suboxone®, bupren/naloxone (generic Suboxone®), and Zubsolv®
- Certain antibiotics: Impavido®, Furadantin® suspension, and its generic equivalent if over 7 years old
- Certain anticonvulsants: Briviact®, Keppra® XR, levetiracetam ER, and roweepra XR
- Certain antidiabetic medications: Symlin®; Invokana®, Invokamet®, and Invokamet® XR
- Certain antiemetics: Bonjesta®, Cinvanti®, Diclegis®, and Sustol®
- Certain antifungals: Luliconazole®, Luzu®, Naftin®, Tolsura ®, Vytone®, and Xolegel®
- Certain antipsychotics: Abilify® Myci (only), Aristada®, Nuplazid®, and Rexulti®

- Certain COPD medications: Daliresp®, Lonhala Magn®, Trelegy®, and Yupelri®
- Certain gastrointestinal agents: Mytesi®, Viberzi®, and Xermelo®
- Certain ophthalmic agents: Inveltys®, Rhopressa®, and Vyzulta®
- Topical steroids: all brands with generics available, all gels, aerosols, sprays, shampoos, tapes, and lotions

Miscellaneous Exclusions

1. ADDYI
2. ALEVAMAX CRE
3. ALPAWASH OIN
4. ARAKODA
5. ATOPADERM CRE
6. ATOPICLAIR CRE
7. AUVI-Q
8. BALCOLTRA
9. BEAU RX GEL
10. CAROSPIR
11. CELACYN GEL
12. CERACADE EMU
13. COPASIL GEL
14. CRINONE GEL VAG
15. DERMACINRX PAK DPN PAK
16. DERMACINRX PAK INFLAMMA
17. DERMACINRX PAK THERAZOL
18. DERMACINRX SOL BASE
19. DERMASORB XM KIT
20. DEXAMETHASON TAB 10-DAY
21. DEXAMETHASON TAB 13-DAY
22. DEXAMETHASON TAB 6-DAY
23. DEXERYL CRE
24. DOXEPIN HCL CREAM
25. ELETONE CRE
26. ELETONE CRE TWINPACK
27. EMULSION SB EMU
28. EMVERM CHW
29. ENDOMETRIN SUP 100MG
30. ENTTY EMU SPRAY
31. EPICERAM EMU
32. EPISIL LIQ
33. FLEXIPAK PAK
34. GONITRO POW
35. HIDEX 6-DAY PAK 1.5MG
36. HPR PLUS CRE
37. HYLATOPIC CRE PLUS
38. IMIQUIMOD CRE PMP
39. INFLAMMACIN MIS
40. KAMDOY EMU
41. KELARX GEL
42. LOKELMA PAK
43. LOYON SOL
44. LUCEMYRA
45. MACRILEN PAK 60MG
46. MEMANT TITRA PAK 5-10MG
47. MEMANTINE HC ER
48. MEMANTINE HC SOL
49. METOPIC CRE 41%
50. MIMYX CRE
51. NAMENDA TAB 5-10MG
52. NAMENDA XR CAP TITRATION
53. NASCOBAL SPR 500MCG
54. NEOCERA CRE
55. NEOSALUS CP CRE
56. NEOSALUS CRE
57. NIVATOPIC CRE PLUS
58. NOCDURNA SUB
59. NOCDURNA SUB 55.3MCG
60. NOCTIVA EMU
61. NOCTIVA SPR
62. NORITATE CRE
63. NUDICLO PAK
64. NUVAIL SOL
65. ORAFATE PST
66. ORILISSAOSMOLEX ER
67. PEG BASE OIN
68. PENLEN EMU SPRAY
69. PHLAG SPR
70. POLYPEG OIN BASE
71. PREVIDOLRX PAK PLUS
72. PROTHELIAL PST
73. PRUCLAIR CRE
74. PRUDOXIN CRE
75. PRUMYX CRE
76. QBREXZA PAD
77. RECEDO GEL
78. REMIGEN CREA CRE
79. RESTIZAN GEL
80. SCAR MANAGE GEL
81. SCARCIN GEL
82. SCARSILK GEL
83. SOLOSEC GRA 2GM
84. SUVICORT EMU
85. SYNERDERM EMU
86. TAPERDEX PAK 7-DAY
87. TDM SOLUTION SOL
88. TETRIX CRE
89. TIGLUTIK SUS
90. TOLAK CRE
91. UREA CRE 41%
92. UTOPIC CRE 41%
93. VALCHLOR GEL
94. XENAFLAMM PAK
95. XERALUX CRE
96. ZONALON CRE
97. ZYCLARA

Changes regarding Prescription List Revisions

Each of the following prescription lists are revised. Please see the Prescription Drug Plan Booklet for the exact changes.

- Step Therapy
- Prior Authorization
- Specialty
- Cost Share
- Covered and Non-Covered Drugs
- High Deductible Health Plan Wellness Drugs
- Formulary