Benefits Booklet

TRS-ActiveCare Primary
TRS-ActiveCare Primary+

Effective Sept. 1, 2020 – Aug. 31, 2021
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INTRODUCTION

In this benefits booklet, we refer to the Texas public school districts that participate in the Teacher Retirement System as your “employer” and the Teacher Retirement System (TRS) as your “group.”

The TRS-ActiveCare health plans are offered by your group as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for medically necessary services and supplies. Coverage under this plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this benefits booklet that affect your health care coverage. It is important that you read the benefits booklet carefully, so you will be aware of the benefits and requirements of this plan.

The defined terms in this benefits booklet are italicized and shown in the appropriate provision in the benefits booklet or in the DEFINITIONS section of the benefits booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may also be section headings describing provisions.

The terms “you” and “your”, as used in this benefits booklet, refer to the participant.

In-Network and Out-of-Network Benefits

In-Network Benefits

To receive benefits as indicated on your SCHEDULE OF COVERAGE, you must choose in-network providers for all care (other than for emergencies). You’re entitled to medical care and services from in-network providers including medically necessary medical, surgical, diagnostic, therapeutic and preventive services that are generally and customarily provided in the service area. Some services may not be covered.

To be covered, a service that is medically necessary must also be described in COVERED MEDICAL SERVICES. Even though a physician or professional other provider has performed, prescribed or recommended a service doesn’t mean it is medically necessary or that it is covered under COVERED MEDICAL SERVICES. Some covered services may also require preauthorization by Blue Cross and Blue Shield of Texas (BCBSTX).

Only services that are performed, prescribed, directed or authorized in advance by your PCP or BCBSTX are covered benefits under this plan. The exceptions are emergency care, urgent care, retail health clinics or covered services provided to female participants, who may directly access an obstetrician/gynecologist in the same limited provider network as their PCP for:

- well woman exams
- obstetrical care
- care for all active gynecological conditions
- diagnosis, treatment, and referral for any disease or condition within the scope of the professional practice of the obstetrician/gynecologist

PCPs in the limited provider network will be identified in the provider directory or you can call your Personal Health Guide at 1-866-355-5999.

BCBSTX and in-network providers don’t have any financial responsibility for any services you seek or receive from an out-of-network provider or facility, except as set forth below, unless both your PCP and BCBSTX have made prior referral authorization arrangements.

Out-of-Network Benefits

You may obtain covered services from providers outside the network when receiving emergency care. Also, court-ordered dependents living outside the service area may use out-of-network providers.

If covered services are not available from in-network providers within the access requirements established by law and regulation, BCBSTX will allow a referral by your PCP to an out-of-network provider, if approved by BCBSTX prior to the visit.
You won’t be required to change your PCP or specialist providers to receive covered services that are not available from in-network providers within the network, but the following apply.

- The request must be from an in-network provider.
- Reasonably requested documentation must be received by BCBSTX.
- The referral will be provided within an appropriate time, not to exceed five business days, based on the circumstances and your condition.
- When BCBSTX has allowed a referral to an out-of-network provider, BCBSTX will reimburse the out-of-network provider at the usual and customary rate or otherwise agreed rate, minus the applicable copay(s). You are responsible only for the copays for such covered services.
- Before BCBSTX denies a referral, a review will be conducted by a specialist of the same or similar specialty as the type of provider to whom a referral is requested.

### Important Contact Information

<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact Information</th>
<th>Accessible Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Service Helpline</td>
<td>1-866-355-5999</td>
<td>24 hours a day 7 days a week</td>
</tr>
<tr>
<td>Websites</td>
<td><a href="http://www.bcbstx.com/trsactivecare">www.bcbstx.com/trsactivecare</a></td>
<td>24 hours a day 7 days a week</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.trs.texas.gov">www.trs.texas.gov</a></td>
<td></td>
</tr>
</tbody>
</table>

**Customer Service Helpline**

*Personal Health Guides can:*

- identify your plan service area
- give you information about in-network providers
- distribute claim forms
- answer your questions on claims
- assist you in identifying an in-network provider (but won’t recommend specific in-network providers)
- provide information on the features of your health plan
- record comments about providers

**BCBSTX Website**

Visit the BCBSTX website at www.bcbstx.com/trsactivecare for information about BCBSTX, access to forms referenced in this benefits booklet, and much more.

**Mental Health/Substance Use Disorder Preauthorization**

*Preauthorization is required for all inpatient and certain outpatient care for participants seeking treatment for behavioral health services, mental health care, serious mental illness, and substance use disorder. Please refer to the PREAUTHORIZATION REQUIREMENTS section for more information. To preauthorize, you, your behavioral health provider, or a family member may call the Personal Health Guide number at 1-866-355-5999.*

**Medical Preauthorization**

To satisfy all medical preauthorization requirements for inpatient hospital admissions, extended care expenses, or home infusion therapy, call your Personal Health Guide at 1-866-355-5999.
SCHEDULE OF COVERAGE
TRS-ActiveCare Primary Plan

The following chart summarizes the coverage available under your TRS-ActiveCare Primary Plan. For details, refer to COVERED MEDICAL SERVICES.

All covered services (except in emergencies) must be provided by or through your in-network primary care provider, who may refer you for further treatment from in-network specialists and hospitals. Female participants may visit an in-network OB/GYN physician in their PCP's provider network for diagnosis and treatment without a referral from their PCP. Urgent care and retail health clinics don’t require PCP referral.

**IMPORTANT NOTE:** Copays and coinsurances shown below indicate the amount you’re required to pay. They’re expressed as either a fixed dollar amount or a percentage of the allowable amount and will be applied for each occurrence unless otherwise indicated. Copays, deductibles and maximum out-of-pocket may be adjusted for various reasons as permitted by applicable law.

<table>
<thead>
<tr>
<th>Deductibles Per Plan Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per individual</td>
</tr>
<tr>
<td>Per family</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum Out-of-Pocket Per Plan Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per individual</td>
</tr>
<tr>
<td>Per family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider (“PCP”) Office or Home Visit</td>
</tr>
<tr>
<td>In-Network Specialist Provider (“specialist”) Office or Home Visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Hospital Services</th>
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</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Facility Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
</tr>
<tr>
<td>Radiation Therapy</td>
</tr>
<tr>
<td>Chemotherapy Dialysis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Infusion Therapy Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infusion therapy - Hospital Setting</td>
</tr>
<tr>
<td>Infusion therapy - Home, Office, Infusion Suite Setting</td>
</tr>
</tbody>
</table>
### Outpatient Laboratory and X-Ray Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coinsurance/Benefit after Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arteriograms, Computerized Tomography (CT Scan), Magnetic Resonance Imaging (MRI), Electroencephalogram (EEG), Myelogram, Positron Emission Tomography (PET Scan)</td>
<td>30% coinsurance after deductible</td>
</tr>
<tr>
<td>Other X-Ray Services</td>
<td>30% coinsurance after deductible</td>
</tr>
<tr>
<td>Other Outpatient Lab</td>
<td>0% coinsurance</td>
</tr>
<tr>
<td>Lab – Outpatient Hospital setting</td>
<td>30% coinsurance after deductible</td>
</tr>
<tr>
<td>Lab and X-Ray Services – Office setting</td>
<td>0% coinsurance</td>
</tr>
</tbody>
</table>

### Rehabilitation Services

- **Rehabilitation Services and Therapies**, all services billed by a Chiropractor will apply to the visit maximum of 35

  - $30 copay regardless of provider specialty for Physical, Occupational and Speech Therapy,
  - $70 copay for Chiropractic services,
  - 30% coinsurance after deductible for Inpatient Hospital Services or
  - 30% coinsurance after deductible for Outpatient Facility Services, as applicable.

### Maternity Care Services

- **Maternity Care**
  - **Prenatal**
  - **Postnatal**
  - **Inpatient Hospital Services**, for each admission

  - $30 copay for PCP or $70 copay for specialist
  - $30 copay for PCP or $70 copay for specialist
  - 30% coinsurance after deductible

- **Family Planning Services**:
  - diagnostic counseling, consultations and planning services
  - insertion or removal of intrauterine device (IUD), including cost of device
  - diaphragm or cervical cap fitting, including cost of device
  - insertion or removal of birth control device implanted under the skin, including cost of device
  - injectable contraceptive drugs, including cost of drug
  - voluntary sterilization
  - vasectomy

  - $30 copay for PCP or $70 copay for specialist; unless otherwise covered under Contraceptive Services described in Preventive Care Services.
  - 30% coinsurance after deductible for Inpatient Hospital Services or
  - 30% coinsurance after deductible for Outpatient Surgery, as applicable.

- **Infertility Services**
  - treatment of underlying conditions

  - $30 copay for PCP or $70 copay for specialist
## SCHEDULE OF COVERAGE

**TRS-ActiveCare Primary Plan**

### Behavioral Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Mental Health Care</strong></td>
<td>$30 copay</td>
</tr>
<tr>
<td><strong>Inpatient Mental Health Care</strong></td>
<td>30% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Serious Mental Illness</strong></td>
<td>30% coinsurance after deductible for Inpatient Hospital Services or 30% coinsurance after deductible for Outpatient Facility Services, as applicable.</td>
</tr>
<tr>
<td><strong>Chemical Dependency Services</strong></td>
<td>30% coinsurance after deductible for Inpatient Hospital Services or 30% coinsurance after deductible for Outpatient Facility Services, as applicable.</td>
</tr>
<tr>
<td><strong>Teladoc</strong></td>
<td>$70 copay for behavioral health visit</td>
</tr>
</tbody>
</table>

### Emergency Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility</strong></td>
<td>30% coinsurance after deductible (if admitted, any charges described in Inpatient Hospital Services will apply). $500 copay, plus 30% coinsurance after deductible for services rendered at a Free-Standing Emergency Room.</td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td>30% coinsurance after deductible</td>
</tr>
</tbody>
</table>

### Urgent Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$50 copay per visit Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.</td>
</tr>
</tbody>
</table>

### Retail Health Clinics

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail Health Clinics</strong></td>
<td>$30 copay</td>
</tr>
</tbody>
</table>

### Ambulance Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance Services</strong>, per service</td>
<td>30% coinsurance after deductible</td>
</tr>
</tbody>
</table>

### Extended Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled Nursing Facility Services</strong>, for each day, up to 25 days per plan year</td>
<td>30% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Hospice Care</strong>, per visit</td>
<td>30% coinsurance after deductible; unless otherwise covered under Inpatient Hospital Services.</td>
</tr>
<tr>
<td><strong>Home Health Care</strong>, per visit, up to 60 visits per plan year</td>
<td>30% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong></td>
<td>30% coinsurance after deductible</td>
</tr>
</tbody>
</table>
### SCHEDULE OF COVERAGE
**TRS-ActiveCare Primary Plan**

#### Preventive Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well child care through age 17</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Periodic health assessments for <em>participants</em> age 18 and older</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td></td>
</tr>
<tr>
<td>• childhood immunizations required by law for <em>participants</em> through age 6</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• immunizations for <em>participants</em> over age 6</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Bone mass measurement for osteoporosis limited to one every two years for female <em>participants</em> age 65 and older and male <em>participants</em> age 70 and older.</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Well-woman exam, once per plan year, includes, but not limited to, exam for cervical cancer (Pap smear), for female <em>participants</em> age 18 and older</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Screening mammogram for female <em>participants</em> age 40 and over and for female <em>participants</em> with other risk factors, once per plan year</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• outpatient facility or imaging centers</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><strong>Contraceptive Services and Supplies</strong></td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• contraceptive education,</td>
<td></td>
</tr>
<tr>
<td>• counseling and</td>
<td></td>
</tr>
<tr>
<td>• certain female FDA approved contraceptive methods,</td>
<td></td>
</tr>
<tr>
<td>• female sterilization procedures and devices</td>
<td></td>
</tr>
<tr>
<td><strong>Breastfeeding Support, Counseling and Supplies</strong></td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• lactation counseling limited to six (6) visits per plan year</td>
<td></td>
</tr>
<tr>
<td>• electric breast pumps limited to two (2) per plan year</td>
<td></td>
</tr>
<tr>
<td>(<em>hospital</em> grade breast pumps are covered up to purchase price of $150)</td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Loss</strong></td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• screening test from birth through 30 days</td>
<td></td>
</tr>
<tr>
<td>• follow-up care from birth through 24 months</td>
<td></td>
</tr>
</tbody>
</table>
# Preventive Services (Cont’d)

<table>
<thead>
<tr>
<th>Preventive Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rectal screening for the detection of colorectal cancer for participants age 50 and older:</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• annual fecal occult blood test, once per plan year</td>
<td></td>
</tr>
<tr>
<td>• flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years</td>
<td></td>
</tr>
<tr>
<td>• colonoscopy, limited to 1 every 10 years</td>
<td></td>
</tr>
<tr>
<td>• Cologuard, limited to 1 every 3 years</td>
<td></td>
</tr>
<tr>
<td>Eye and ear screenings, once per plan year</td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
<tr>
<td>Early detection test for cardiovascular disease, limited to 1 every 5 years</td>
<td>30% coinsurance after deductible</td>
</tr>
<tr>
<td>• computer tomography (CT) scanning</td>
<td>30% coinsurance after deductible</td>
</tr>
<tr>
<td>• ultrasonography</td>
<td></td>
</tr>
<tr>
<td>Early detection test for ovarian cancer (CA125 blood test), once per plan year</td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
<tr>
<td>Exam for prostate cancer for participants age 45 and older or age 40 with family history, once per plan year</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>

## Dental Surgical Procedures

<table>
<thead>
<tr>
<th>Dental Surgical Procedures (limited covered services)</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Surgical Procedures</td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
<tr>
<td>30% coinsurance after deductible for Inpatient Hospital Services or</td>
<td></td>
</tr>
<tr>
<td>30% coinsurance after deductible for Outpatient Surgery, as applicable.</td>
<td></td>
</tr>
</tbody>
</table>

## Cosmetic, Reconstructive or Plastic Surgery

<table>
<thead>
<tr>
<th>Cosmetic, Reconstructive or Plastic Surgery (limited covered services)</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetic, Reconstructive or Plastic Surgery</td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
<tr>
<td>30% coinsurance after deductible for Inpatient Hospital Services or</td>
<td></td>
</tr>
<tr>
<td>30% coinsurance after deductible for Outpatient Surgery, as applicable.</td>
<td></td>
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</tbody>
</table>

## Allergy Care

<table>
<thead>
<tr>
<th>Allergy Care</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing and Evaluation</td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
<tr>
<td>30% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td>Injections</td>
<td>30% coinsurance after deductible</td>
</tr>
<tr>
<td>Serum</td>
<td>30% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Diabetes Care</strong></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Diabetes Self-Management Training, for each visit</strong></td>
<td><strong>$30 copay for PCP or $70 copay for specialist</strong></td>
</tr>
<tr>
<td><strong>Diabetes Equipment</strong></td>
<td><strong>30% coinsurance after deductible</strong></td>
</tr>
<tr>
<td><strong>Diabetes Supplies</strong></td>
<td><strong>30% coinsurance after deductible</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Prosthetic Appliances and Orthotic Devices</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prosthetic Appliances and Orthotic Devices</strong></td>
<td><strong>30% coinsurance after deductible</strong></td>
</tr>
<tr>
<td><em>$1,000 lifetime maximum for wigs needed as a result of hair loss due to injury or treatment of a disease.</em></td>
<td></td>
</tr>
<tr>
<td><em>Two (2) pairs of therapeutic footwear per plan year, for the prevention of complications associated with diabetes.</em></td>
<td></td>
</tr>
<tr>
<td><strong>Cochlear Implants</strong></td>
<td><strong>30% coinsurance after deductible</strong></td>
</tr>
<tr>
<td><em>Limit one (1) per impaired ear for participants up to the age of 19, every three years, with replacements as medically necessary or audiologically necessary.</em></td>
<td><em>Any additional charges as described in Outpatient Surgery may also apply.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Durable Medical Equipment</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td><strong>30% coinsurance after deductible</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Hearing Aids</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearing Aids</strong></td>
<td><strong>30% coinsurance after deductible</strong></td>
</tr>
<tr>
<td><em>$1,000 maximum per 36 months for hearing aids (maximum applies to age 19 and older)</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Speech and Hearing Services</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Speech and Hearing Services</strong></td>
<td><strong>Benefits paid same as any other physical illness</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Telehealth Services</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teladoc</strong></td>
<td><strong>$0 copay for Medical visit and $70 copay for behavioral health visit</strong></td>
</tr>
<tr>
<td><strong>RediMD</strong></td>
<td><strong>$0 copay for Medical visit</strong></td>
</tr>
</tbody>
</table>
## Blue Distinction Centers

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bariatric Surgery</strong></td>
<td>30% coinsurance after deductible for Inpatient Hospital &amp; Outpatient Hospital services at a Blue Distinction Center Plus</td>
</tr>
<tr>
<td></td>
<td>$5,000 copay per procedure for Surgeon fees (copay for Surgeon fees doesn’t apply to maximum out-of-pocket.)</td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>0% coinsurance (no deductible applies) for Inpatient Hospital &amp; Outpatient Hospital services at a Blue Distinction Center Plus</td>
</tr>
<tr>
<td></td>
<td>0% coinsurance after deductible for Inpatient Hospital &amp; Outpatient Hospital services at a Blue Distinction Center</td>
</tr>
<tr>
<td></td>
<td>30% coinsurance after deductible for Inpatient Hospital &amp; Outpatient Hospital services at in-network</td>
</tr>
</tbody>
</table>
The following chart summarizes the coverage available under your **TRS-ActiveCare Primary+ Plan**. For details, refer to **COVERED MEDICAL SERVICES**.

All covered services (except in emergencies) must be provided by or through your *in-network* primary care provider (PCP), who may refer you for further treatment from *in-network* specialists and hospitals. Female participants may visit an *in-network* OB/GYN physician in their PCP’s provider network for diagnosis and treatment without a referral from their PCP. *Urgent care* and *retail health clinics* don’t require PCP referral.

**IMPORTANT NOTE:** Copays and coinsurance shown below indicate the amount you’re required to pay. They are expressed as either a fixed dollar amount or a percentage of the allowable amount and will be applied for each occurrence unless otherwise indicated. Copays/deductibles and maximum out-of-pocket may be adjusted for various reasons as permitted by applicable law.

### Deductibles Per Plan Year

<table>
<thead>
<tr>
<th></th>
<th>Per Individual</th>
<th>Per Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,200</td>
<td>$3,600</td>
<td></td>
</tr>
</tbody>
</table>

### Maximum Out-of-Pocket Per Plan Year

<table>
<thead>
<tr>
<th></th>
<th>Per Individual</th>
<th>Per Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>$6,900</td>
<td>$13,800</td>
<td></td>
</tr>
</tbody>
</table>

### Professional Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Copay/Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider (“PCP”) Office or Home</td>
<td>$30 copay</td>
</tr>
<tr>
<td>In-Network Specialist Provider (“specialist”)</td>
<td>$70 copay</td>
</tr>
</tbody>
</table>

### Inpatient Hospital Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Copay/Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

### Outpatient Facility Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Copay/Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Chemotherapy Dialysis</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

### Outpatient Infusion Therapy Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Copay/Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infusion therapy - Hospital Setting</td>
<td>$500 copay</td>
</tr>
<tr>
<td>Infusion therapy - Home, Office, <strong>Infusion Suite Setting</strong></td>
<td>$30 copay</td>
</tr>
</tbody>
</table>
## Outpatient Laboratory and X-Ray Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arteriograms, Computerized Tomography (CT Scan),</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI), Electroencephalogram (EEG), Myelogram,</td>
<td></td>
</tr>
<tr>
<td>Positron Emission Tomography (PET Scan)</td>
<td></td>
</tr>
<tr>
<td>Other X-Ray Services</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Other Outpatient Lab</td>
<td>0% coinsurance</td>
</tr>
<tr>
<td>Labs – Outpatient Hospital setting</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Labs and X-Ray Services – Office setting</td>
<td>0% coinsurance</td>
</tr>
</tbody>
</table>

## Rehabilitation Services

Rehabilitation Services and Therapies, all services billed by a Chiropractor will apply to the visit maximum of 35

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30 copay regardless of provider specialty for Physical, Occupational and Speech Therapy, Chiropractic services, 20% coinsurance after deductible for Inpatient Hospital Services or 20% coinsurance after deductible for Outpatient Facility Services, as applicable.</td>
<td></td>
</tr>
</tbody>
</table>

## Maternity Care and Family Planning Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Care</td>
<td></td>
</tr>
<tr>
<td>Prenatal</td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
<tr>
<td>Postnatal</td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
<tr>
<td>Inpatient Hospital Services, for each admission</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Family Planning Services:</td>
<td></td>
</tr>
<tr>
<td>• diagnostic counseling, consultations and planning services</td>
<td>$30 copay for PCP or $70 copay for specialist; unless otherwise covered under Contraceptive Services described in Preventive Care Services.</td>
</tr>
<tr>
<td>• insertion or removal of intrauterine device (IUD), including cost of device</td>
<td></td>
</tr>
<tr>
<td>• diaphragm or cervical cap fitting, including cost of device</td>
<td></td>
</tr>
<tr>
<td>• insertion or removal of birth control device implanted under the skin, including cost of device</td>
<td></td>
</tr>
<tr>
<td>• injectable contraceptive drugs, including cost of drug</td>
<td></td>
</tr>
<tr>
<td>• voluntary sterilization</td>
<td></td>
</tr>
<tr>
<td>• vasectomy</td>
<td></td>
</tr>
<tr>
<td>Infertility Services</td>
<td></td>
</tr>
<tr>
<td>• treatment of underlying conditions</td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
</tbody>
</table>
# SCHEDULE OF COVERAGE  
**TRS-ActiveCare Primary+ Plan**

## Behavioral Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Mental Health Care</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Inpatient Mental Health Care</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Serious Mental Illness</td>
<td>20% coinsurance after deductible for Inpatient Hospital Services or</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible for Outpatient Facility Services, as applicable.</td>
</tr>
<tr>
<td>Chemical Dependency Services</td>
<td>20% coinsurance after deductible for Inpatient Hospital Services or</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible for Outpatient Facility Services, as applicable.</td>
</tr>
<tr>
<td>Teladoc</td>
<td>$70 copay for behavioral health visit</td>
</tr>
</tbody>
</table>

## Emergency Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
<td>20% coinsurance after deductible (If admitted, any charges described in Inpatient Hospital Services will apply.)</td>
</tr>
<tr>
<td></td>
<td>$500 copay, plus 20% coinsurance after deductible for services rendered at a Free-Standing Emergency Room.</td>
</tr>
<tr>
<td>Physician</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

## Urgent Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>$50 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.</td>
</tr>
</tbody>
</table>

## Retail Health Clinics

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Health Clinics</td>
<td>$30 copay</td>
</tr>
</tbody>
</table>

## Ambulance Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services, per service</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

## Extended Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility Services</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible; unless otherwise covered under Inpatient Hospital Services.</td>
</tr>
<tr>
<td>Hospice Care, per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Home Health Care, per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>
## Preventive Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well child care through age 17</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Periodic health assessments for <em>participants</em> age 18 and older</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td></td>
</tr>
<tr>
<td>• childhood immunizations required by law for <em>participants</em> through age 6</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• immunizations for <em>participants</em> over age 6</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Bone mass measurement for osteoporosis limited to one every two years for female <em>participants</em> age 65 and older and male <em>participants</em> age 70 and older.</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Well-woman exam, once per plan year, includes, but not limited to, exam for cervical cancer (Pap smear), for female <em>participants</em> 18 and older</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Screening mammogram for female <em>participants</em> age 40 and over and for female <em>participants</em> with other risk factors, once per plan year</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• outpatient facility or imaging centers</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><strong>Contraceptive Services and Supplies</strong></td>
<td></td>
</tr>
<tr>
<td>• contraceptive education, counseling and certain female FDA approved contraceptive methods, female sterilization procedures and devices</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><strong>Breastfeeding Support, Counseling and Supplies</strong></td>
<td></td>
</tr>
<tr>
<td>• lactation counseling limited to six (6) visits per plan year</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• electric breast pumps limited to two (2) per plan year</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><em>(Hospital grade breast pumps are covered up to purchase price of $150)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Loss</strong></td>
<td></td>
</tr>
<tr>
<td>• screening test from birth through 30 days</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• follow-up care from birth through 24 months</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>
## Preventive Services (Cont’d)

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rectal screening for the detection of colorectal cancer for participants age 50 and older:</td>
<td></td>
</tr>
<tr>
<td>• annual fecal occult blood test, once per plan year</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• colonoscopy, limited to 1 every 10 years</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>• Cologuard, limited to 1 every 3 years</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Eye and ear screenings, once per plan year</td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
<tr>
<td>Early detection test for cardiovascular disease, limited to 1 every 5 years</td>
<td></td>
</tr>
<tr>
<td>• computer tomography (CT) scanning</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>• ultrasonography</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Early detection test for ovarian cancer (CA125 blood test), once per plan year</td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
<tr>
<td>Exam for prostate cancer for participants age 45 and older or age 40 with family history, once per plan year</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>

## Dental Surgical Procedures

<table>
<thead>
<tr>
<th>Dental Surgical Procedures (limited covered services)</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible for Inpatient Hospital Services or 20% coinsurance after deductible for Outpatient Surgery, as applicable.</td>
</tr>
</tbody>
</table>

## Cosmetic, Reconstructive or Plastic Surgery

<table>
<thead>
<tr>
<th>Cosmetic, Reconstructive or Plastic Surgery (limited covered services)</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible for Inpatient Hospital Services or 20% coinsurance after deductible for Outpatient Surgery, as applicable.</td>
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</table>

## Allergy Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing and Evaluation</td>
<td>$30 copay for PCP or $70 copay for specialist 20% coinsurance after deductible billed without an office visit</td>
</tr>
<tr>
<td>Injections</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Serum</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>
# SCHEDULE OF COVERAGE  
*TRS-ActiveCare Primary+ Plan*

## Diabetes Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Share Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Self-Management Training, for each visit</td>
<td>$30 copay for PCP or $70 copay for specialist</td>
</tr>
<tr>
<td>Diabetes Equipment</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Diabetes Supplies</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

## Prosthetic Appliances and Orthotic Devices

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<tr>
<th>Service</th>
<th>Cost Share Description</th>
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<tr>
<td>Prosthetic Appliances and Orthotic Devices</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>$1,000 lifetime maximum for wigs needed as a result of hair loss due to injury or treatment of a disease.</td>
<td></td>
</tr>
<tr>
<td>Two (2) pairs of therapeutic footwear per plan year, for the prevention of complications associated with diabetes</td>
<td></td>
</tr>
<tr>
<td>Cochlear Implants</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Limit one (1) per impaired ear every three years for participants up to the age of 19, with replacements as medically necessary or audiologically necessary.</td>
<td></td>
</tr>
<tr>
<td>Any additional charges as described in Outpatient Surgery may also apply.</td>
<td></td>
</tr>
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## Durable Medical Equipment

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Share Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

## Hearing Aids

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Share Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Aids</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>$1,000 maximum per 36 months for hearing aids (applies to participants over the age of 19)</td>
<td></td>
</tr>
</tbody>
</table>

## Speech and Hearing Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Share Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech and Hearing Services</td>
<td>Benefits paid same as any other physical illness</td>
</tr>
</tbody>
</table>

## Telehealth Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Share Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teladoc</td>
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<tr>
<td>RediMD</td>
<td>$0 copay for Medical visit</td>
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### Blue Distinction Centers

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<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bariatric Surgery</strong></td>
<td>20% coinsurance after deductible for Inpatient Hospital &amp; Outpatient Hospital services at a Blue Distinction Center Plus</td>
</tr>
<tr>
<td></td>
<td>$5,000 copay per procedure for Surgeon fees (copay for Surgeon fees doesn’t apply to maximum out-of-pocket.)</td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>0% coinsurance (no deductible applies) for Inpatient Hospital &amp; Outpatient Hospital services at a Blue Distinction Center Plus</td>
</tr>
<tr>
<td></td>
<td>0% coinsurance after deductible for Inpatient Hospital &amp; Outpatient Hospital services at a Blue Distinction Center</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible for Inpatient Hospital &amp; Outpatient Hospital services at in-network</td>
</tr>
</tbody>
</table>
Dependent Eligibility

*Dependent child* age limit to age 26.

*Dependent children* are eligible for *maternity care* benefits.

Preexisting Conditions

Preexisting conditions are covered immediately.
WHO GETS BENEFITS

Employee Eligibility

Who can enroll in TRS-ActiveCare?

To be eligible for TRS-ActiveCare, you:

- must either be (i) a participating member who is currently employed by an employer in a position that is eligible for membership in the TRS pension, or (ii) currently employed by a participating district/entity for 10 or more regularly scheduled hours each week in a position that isn’t eligible for membership
- not receiving health care coverage as an employee or retiree under (i) the Texas State College and University Employees Uniform Insurance Benefits Act (e.g., coverage offered by The University of Texas System or the Texas A&M University System), (ii) the Texas Employees Uniform Group Insurance Benefits Act (e.g., coverage offered by ERS); or (iii) TRS-Care

If you are an eligible part-time employee during an enrollment opportunity for the current plan year, and later during the current plan year you become an eligible full-time employee, you will have a 31-day opportunity to enroll yourself and/or eligible dependents in TRS-ActiveCare.

Your 31-day enrollment opportunity will begin on the first day that you become an eligible full-time employee. This enrollment opportunity exists even if enrollment in TRS-ActiveCare during the current plan year was previously declined by you.

A full-time employee is a participating member of the TRS pension who:

- is currently employed by a participating entity
- is employed in a position that IS eligible for membership in the TRS pension
- isn’t receiving coverage as an employee or retiree from TRS-Care or from a uniform group insurance or health benefits program offered by ERS, the University of Texas, or Texas A&M University

A part-time employee is an individual who:

- is currently employed by a participating entity
- is employed in a position that ISN’T eligible for membership in the TRS pension or isn’t eligible for membership in the TRS pension because of a service or disability retirement
- isn’t receiving coverage as an employee or retiree from TRS-Care or from a uniform group insurance or health benefits program offered by ERS, the University of Texas, or Texas A&M University

Accordingly, for purposes of enrollment in TRS-ActiveCare, individuals who are hired in a substitute position or who have retired under the TRS pension will be considered part-time employees, regardless of the number of hours they work for the participating entity.

Part-time employees are not entitled to state assistance in the purchase of their TRS-ActiveCare coverage. The participating entity that employs a part-time employee may, but isn’t required to, provide assistance in the purchase of TRS-ActiveCare coverage for the part-time employee.

Note: Although under their particular circumstances, a retiree, a higher education employee, or a state employee may not be covered as an employee of a participating district/entity, they could be covered as a dependent of an eligible employee. Employees covered as dependents by a higher education entity or a state program may be able to also be covered under TRS-ActiveCare as an employee.
Who is eligible for TRS-ActiveCare coverage?
Teachers, administrative personnel, substitutes, bus drivers, librarians, crossing guards, cafeteria workers, and high school or college students, among others, are all eligible for coverage, provided no exception applies, if they are employees of the district/entity, not volunteers, and are either active, contributing TRS members or are employed by a participating district/entity for 10 or more regularly scheduled hours each week.

Independent contractors and volunteers are not employees and are therefore not eligible for TRS-ActiveCare coverage.

Note: The above eligibility guidelines apply only to TRS-ActiveCare and do not apply to eligibility for membership in the TRS pension plan. Only employees who are active contributing TRS members are eligible for funding provided under Chapter 1581, Texas Insurance Code.

Summer Deferment
Under Section 22.004(k), Texas Education Code, an employee who is participating in TRS-ActiveCare is entitled to continue participating in TRS-ActiveCare if the employee resigns after the end of the instructional year. TRS Rule §41.38, Texas Administrative Code, will be applied by TRS-ActiveCare in determining the appropriate termination date of TRS-ActiveCare coverage.

Note: Participants entitled to summer deferment must be given the opportunity to accept or decline TRS-ActiveCare coverage through the remainder of the plan year.

Eligible Dependents
An employee may also cover their eligible dependents at the same time they enroll in coverage. No person may be covered under TRS-ActiveCare as both an employee and as a dependent, or as a dependent of more than one employee.

Eligible dependents include:
- a spouse, including a common law spouse (a common law spouse isn’t considered eligible unless there is a Declaration of Informal Marriage filed with an authorized government agency)
- a child under the age of 26, who is one of the following:
  - a natural child
  - an adopted child or a child who is lawfully placed for legal adoption
  - a stepchild
  - a foster child
  - a child under the legal guardianship of the employee
- a grandchild* under age 26 whose primary residence is the household of the employee and who is a dependent of the employee for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect
  *For purposes of dependent eligibility under TRS-ActiveCare, a grandchild that doesn’t fit into the above definition isn’t considered a child.
- “any other dependent” (other than those listed above) under the age of 26 in a regular parent-child relationship with the employee, meeting all four of the following requirements:
  - the child’s primary residence is the household of the employee
  - the employee provides at least 50% of the child’s support
  - neither of the child’s natural parents resides in that household
  - the employee has the legal right to make decisions regarding the child’s medical care*
  *This requirement doesn’t apply to dependents age 18 and over.
• A child, age 26 or over, of a covered employee may be eligible for dependent coverage, provided that the child is either mentally or physically incapacitated to such an extent that they are dependent on the employee on a regular basis as determined by TRS, and meet other requirements as determined by TRS.

• A dependent doesn’t include a brother or a sister of an employee, unless the brother or sister is an individual under age 26 who is either: (1) under the legal guardianship of an employee, or (2) in a regular parent-child relationship with an employee, as defined in the “any other child” category above. Parents and grandparents of the covered employee don’t meet the definition of an eligible dependent.

Note: It is against the law to elect coverage for an ineligible person. Violations may result in prosecution and/or expulsion from the TRS-ActiveCare program for up to five years. TRS-ActiveCare eligibility audits may be conducted periodically. Audit notifications will be mailed to TRS-ActiveCare plan participants when TRS-ActiveCare needs to verify that participants, or their covered dependents, meet plan eligibility requirements.

During an eligibility audit, participants may be asked to provide satisfactory proof of eligibility to the Benefits Administrator, and if unsatisfactory, they will have a limited time to cancel coverage for the ineligible persons without incurring penalties that may include expulsion under TRS rules published in the Texas Administrative Code and recovery of paid claims. It is the responsibility of the Benefits Administrator to obtain and maintain documentation.

Making Changes/Special Enrollment Events
You may be able to enroll for coverage, change plan options, or change the dependents you cover during a plan year if you, or a dependent, has a special enrollment event under applicable law. Changes in your, or your dependents coverage must be requested within 31 days of the special enrollment event.

If you don’t request the appropriate changes during the applicable special enrollment period, the changes can’t be made until the next plan enrollment period or, if applicable, until another special enrollment event occurs.

If you or a dependent has a special enrollment event under applicable law, you may change plan options when exercising a special enrollment right. Plan changes are also permitted if you are directed by a court order or national medical support notice to provide health coverage for a dependent child or if you or a dependent loses coverage because you no longer live, work or reside in an HMO service area.

Refer to the Effective Date of Coverage chart for more information on special enrollment events, when coverage begins and when premium is due.

What is a special enrollment event?
An event, as defined by the Health Insurance Portability and Accountability Act (HIPAA), provides a special enrollment period for individuals and dependents when there is a loss of other coverage or a gain of additional dependents (e.g., birth, adoption/placement for adoption and marriage).

New Dependent
You may have a special enrollment event when a new dependent is added to your family as a result of marriage, birth, adoption or placement for adoption. A common law marriage isn’t considered a special enrollment event unless there is a Declaration of Common Law Marriage filed with an authorized government agency.

All applications to add a dependent or change plans due to a legal marriage must be accompanied with official documentation indicating the actual date of marriage in accordance with existing plan rules for special enrollment events.

Note: The COBRA election period is separate from the TRS-ActiveCare enrollment period(s), including special enrollment periods. For example, you have 60 days to elect COBRA coverage with a prior employer, but you must make a request for TRS-ActiveCare coverage within 31 days of the loss of coverage or the addition of a new dependent.
Can dependents be added throughout the plan year?
An employee may be able to add eligible dependents during a plan year if the employee has a qualified status change or special enrollment event. Such events may include marriage, birth, adoption or placement of adoption of a child, or a loss of coverage from another group plan. The cost of coverage may change based on the selected coverage category.

Special Eligibility Situations

- If an employee and spouse both work for a participating district/entity, the spouse may be covered as an employee or as a dependent of an eligible employee. Only one parent may enroll dependent children for coverage.

- A child (under age 26) who is employed by a district/entity and is a contributing TRS member can be covered as a dependent on their parent’s TRS-ActiveCare coverage. However, current law only allows pooling of state and district funds for “married couples.” An employee who is covered as a dependent child won’t be entitled to state or district funding.

- A retiree who returns to work for a participating entity in TRS-ActiveCare is eligible for TRS-ActiveCare coverage if the retiree meets TRS-ActiveCare eligibility requirements, regardless of any prior coverage under TRS-Care.

- Accordingly, for purposes of enrollment in TRS-ActiveCare, individuals who are hired in a substitute position or who have retired under the TRS pension will be considered part-time employees, regardless of the number of hours they work for the participating entity.

- Part-time employees are not entitled to state assistance in the purchase of their TRS-ActiveCare coverage. The participating entity that employs a part-time employee may, but isn’t required, to provide assistance in the purchase of TRS-ActiveCare coverage for the part-time employee.

- Upon termination of a retiree’s TRS-ActiveCare coverage, the retiree can only enroll in TRS-Care if the retiree: (A) turns age 65 or has a special enrollment event, and (B) is otherwise eligible to enroll in TRS-Care. The opportunity to enroll in TRS-Care under these rights is limited in time, so be sure to timely exercise your rights. For example, if a return-to-work retiree leaves employment and loses TRS-ActiveCare coverage, they have a special enrollment event to enroll in TRS-Care if otherwise eligible.

- If a participant has employee and spouse coverage, and the spouse is hired by a participating district/entity, the employee may drop the spouse (unless restricted by district/entity’s Section 125 cafeteria plan rules) so that the spouse may enroll as a new hire. (The cancellation reason would be considered voluntary and wouldn’t be eligible for COBRA.)

- If a participant has employee-only or employee and child coverage, and the spouse is hired by a participating district/entity, the employee can’t enroll the spouse because the spouse is a new hire; there must be a loss of other coverage. The employee may enroll the spouse within 31 days of the spouse’s event date for loss of other coverage.

Loss of Coverage
Loss of coverage qualifies as a special enrollment event if:

- You and/or your dependent(s) lost other group coverage due to a loss of eligibility.
- You and/or your dependent(s) elected to drop the other group health coverage because the employer stopped all employer contributions toward the premium (including any employer-paid COBRA premium).
- You and/or your dependent(s) exhausted your COBRA continuation coverage.
Note: For TRS-ActiveCare, the loss of coverage from the following also qualifies as a special enrollment event:

- Medicare
- Medicaid
- CHIP
- HIPP
- individual coverage when outside the control of the individual

For example: The insurance company claims bankruptcy, the insurance company withdraws from doing business in the state, or the insurance company cancels the block of business.

For loss of Medicaid, CHIP or HIPP you must notify the Benefits Administrator within 60 days from the date of the notification that coverage was terminated. Loss of Medicaid, CHIP or HIPP due to incorrect or missing information isn’t considered a special enrollment event. To qualify for a special enrollment event, the loss must be due to losing eligibility for the coverage due to age, income, etc.

The following reasons for dropping coverage don’t qualify as special enrollment events:

- an increase in the premium cost
- a reduction in the employer’s contribution to the premium
- any other voluntary termination of coverage, including failure to pay your premium
- any additional surcharge or benefit reduction for spouse coverage
- any reduction of benefits such as an increase in deductible or change in the coordination of benefits
- a doctor or other health care provider no longer participates in the plan’s network
- failure to act or respond to an employer’s eligibility audit, which results in loss of coverage for dependents

In order to have a special enrollment event, when you or your dependent loses other health coverage, you or your dependent must have had other health coverage when coverage under TRS-ActiveCare was previously declined in writing. If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA continuation coverage is exhausted.

If the other coverage was not COBRA continuation coverage, special enrollment can be requested when you or your dependent loses eligibility for the other coverage. Refer to the Loss of Coverage section on this page for additional information.

If you submit an Enrollment, Change and Declination Form due to “loss of other coverage,” your original application will be checked to verify that coverage was declined due to other coverage. If a declination was not completed, proof of coverage loss in lieu of a declination must be provided to your Benefits Administrator for a special enrollment event. If documentation isn’t made available, your request to add coverage will be denied.

Dropping Coverage

TRS-ActiveCare participants may drop TRS-ActiveCare coverage, or remove dependents, during a plan year, unless restricted from doing so by their district/entity’s Section 125 cafeteria plan’s rules.

If you drop coverage during the plan year you won’t be eligible to re-enroll in TRS-ActiveCare until the next plan enrollment period unless there is a special enrollment event. You can’t drop coverage retroactively; a future cancellation date is required. An employee can’t change plans when dropping a dependent from TRS-ActiveCare coverage, unless a special enrollment event has also occurred.

Court-Ordered Dependent Children

If the participating district/entity receives a court order or national medical support notice that directs an employee to provide health coverage for a dependent child, the court-ordered dependent child will be automatically enrolled from the date the participating district/entity receives the court order or national medical support notice.
A court order or national medical support notice that directs anyone other than the employee to provide health coverage for a dependent child doesn’t require TRS-ActiveCare to provide dependent coverage for the dependent child and isn’t a special enrollment event for the employee or any of the employee’s eligible dependents.

The court order or national medical support notice that is directed to the employee is a special enrollment event for an employee and the applicable dependents. Therefore, if an eligible employee isn’t covered by TRS-ActiveCare at the time the participating district/entity receives the court order or national medical support notice, the employee, the employee’s spouse, and the employee’s dependent child(ren) may be enrolled for coverage in TRS-ActiveCare.

With regard to any individuals who are not the subject of the court order or national medical support notice, normal eligibility and special enrollment event rules apply (for example, a request, along with supporting documentation, to enroll such individuals must be received within 31 days of the receipt by the participating district/entity of the court order or national medical support notice).

If a participating district/entity receives a court order or national medical support notice to add coverage for your dependent child(ren), the child(ren) may be added to your current TRS-ActiveCare plan if you are already enrolled in TRS-ActiveCare; you may select a different plan at this time.

If you are not covered and you decide not to enroll in TRS-ActiveCare, you may select a plan for the dependent child(ren). If only one child is being added to coverage, the child will be set up with a single ID number and the employee-only premium rate will be charged.

If you are adding more than one child, the youngest child will be set up with an ID number. The other child(ren) will be listed as dependents, and the employee and child(ren) premium rate will be charged.

**Other Court-Ordered Dependents**

A court order or national medical support notice that directs an employee to provide health coverage for an ex-spouse or other dependents that are not eligible children under TRS-ActiveCare eligibility standards doesn’t require TRS-ActiveCare to provide dependent coverage as a result of the court order or national medical support notice. Additionally, this type of court order or national medical support notice doesn’t qualify as a special enrollment event to make plan changes. An ex-spouse isn’t eligible for TRS-ActiveCare coverage unless the ex-spouse is already covered as a COBRA continuation participant.
Effective Date of Coverage

The effective date is the date TRS-ActiveCare begins for a participant. See the chart below to help determine the effective date of coverage. Pre-existing condition waiting periods and creditable coverage no longer apply.

<table>
<thead>
<tr>
<th>If...</th>
<th>Your effective date is...</th>
<th>Your eligible dependent’s effective date is...</th>
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</thead>
<tbody>
<tr>
<td><strong>New Entity</strong>&lt;br&gt;The district/entity first begins participation in TRS-ActiveCare on Sept. 1 and the employee enrolls for coverage during summer enrollment</td>
<td>Sept. 1</td>
<td>Sept. 1</td>
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<tr>
<td>The district/entity begins participation in TRS-ActiveCare after Sept. 1 and the employee enrolls for coverage</td>
<td>The date the district/entity first begins participation in TRS-ActiveCare</td>
<td>The same date as the employee’s effective date of coverage&lt;br&gt;&lt;em&gt;In no event will the dependent’s coverage become effective prior to the employee’s effective date&lt;/em&gt;</td>
</tr>
<tr>
<td><strong>Declines</strong>&lt;br&gt;The employee enrolls for coverage during the enrollment period and had originally declined coverage under TRS-ActiveCare</td>
<td>Sept. 1</td>
<td>Sept. 1</td>
</tr>
<tr>
<td><strong>New Hires</strong>&lt;br&gt;A new hire in a TRS-covered position who is a TRS member on their actively-at-work date enrolls for coverage within 31 days after the actively-at-work date</td>
<td>The employee’s choice of: their actively-at-work date, or the first of the month following the employee’s actively-at-work date&lt;br&gt;&lt;em&gt;Premium is billed for the full month in which coverage begins. New hires must choose the effective date of coverage within 31 days after the actively-at-work date&lt;/em&gt;</td>
<td>The same date as the employee’s effective date of coverage&lt;br&gt;&lt;em&gt;In no event will the dependent’s coverage become effective prior to the employee’s effective date&lt;/em&gt;</td>
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<tr>
<td>A new hire in a non-TRS covered position who is regularly scheduled to work 10 or more hours per week on their actively-at-work date enrolls for coverage within 31 days after the actively-at-work date</td>
<td>The employee’s choice of: (1) their Eligibility Date, or (2) the first of the month following the employee’s Eligibility Date.&lt;br&gt;&lt;em&gt;Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the actively-at-work date&lt;/em&gt;</td>
<td>The same date as the employee’s effective date of coverage&lt;br&gt;&lt;em&gt;In no event will the dependent’s coverage become effective prior to the employee’s effective date&lt;/em&gt;</td>
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<td>If...</td>
<td>Your effective date is...</td>
<td>Your eligible dependent’s effective date is...</td>
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<tr>
<td><strong>Non-TRS Covered Positions</strong>&lt;br&gt; An employee in a non-TRS covered position who works less than 10 regularly scheduled hours per week and becomes employed in a TRS-covered position and enrolls for coverage within 31 days after the date they become an eligible employee.</td>
<td>The employee’s choice of: (1) their Eligibility Date, or (2) the first of the month following the employee’s Eligibility Date. Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the Eligibility Date.</td>
<td>The same date as your effective date of coverage.&lt;br&gt; In no event will the dependent’s coverage become effective prior to the employee’s effective date.</td>
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<tr>
<td>Note: If a current employee was an eligible part-time employee during an enrollment opportunity for the current plan year, and later during the current plan year, the employee becomes an eligible full-time employee, the employee will have a 31-day opportunity to enroll themselves and/or eligible dependents in TRS-ActiveCare. Their 31-day enrollment opportunity will begin on the first day that this employee becomes an eligible full-time employee. This enrollment opportunity exists even if enrollment in TRS-ActiveCare during the current plan year was previously declined by this employee.</td>
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<tr>
<td>An employee in a non-TRS covered position that works less than 10 hours per week and begins to work 10 or more regularly scheduled hours per week and enrolls for coverage within 31 days after the date they become an eligible employee.</td>
<td>The employee’s choice of: (1) their Eligibility Date, or (2) the first of the month following the employee’s Eligibility Date. Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the Eligibility Date.</td>
<td>The same date as your effective date of coverage.&lt;br&gt; In no event will the dependent’s coverage become effective prior to the employee’s effective date.</td>
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<tr>
<td>Loss of Eligibility due to address change&lt;br&gt; The employee is enrolled in an approved HMO and loses eligibility because they no longer live, work or reside in that HMO service area, the employee may enroll in another approved HMO (if applicable) or TRS-ActiveCare plan within 31 days after losing eligibility.</td>
<td>The first of the month following the event date.</td>
<td>The same date as the employee’s effective date of coverage.&lt;br&gt; In no event will the dependent’s coverage become effective prior to the employee’s effective date.</td>
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<td>If...</td>
<td>Your effective date is...</td>
<td>Your eligible dependent’s effective date is...</td>
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<tr>
<td><strong>Military</strong></td>
<td>The employee’s choice of: (1) their actively-at-work date, or (2) the first of the month following the employee’s actively-at-work date</td>
<td>The same date as the employee's effective date of coverage</td>
</tr>
<tr>
<td>The employee returns from military service and enrolls (or re-enrolls) in TRS-ActiveCare within 31 days after their actively-at-work date... <strong>If the employee returns to active employment within the same plan year and chooses to re-enroll in TRS-ActiveCare, the employee must select the same plan option in which they were previously enrolled</strong></td>
<td>Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the actively-at-work date</td>
<td><em>In no event will the dependent's coverage become effective prior to the employee's effective date</em></td>
</tr>
<tr>
<td><strong>Leave Without Pay</strong></td>
<td>The employee’s choice of: (1) Their actively-at-work date, or (2) the first of the month following the employee’s actively-at-work date</td>
<td>The same date as the employee's effective date of coverage</td>
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<tr>
<td>The employee returns from leave-without-pay status and enrolls (or reenrolls) for coverage within 31 days after their actively-at-work date... <strong>If the employee returns to active employment within the same plan year and chooses to re-enroll in TRS-ActiveCare, the employee must select the same plan option in which they were previously enrolled</strong></td>
<td>Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the actively-at-work date</td>
<td><em>In no event will the dependent's coverage become effective prior to the employee's effective date</em></td>
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<td>If...</td>
<td>Your effective date is...</td>
<td>Your eligible dependent’s effective date is...</td>
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<td><strong>Newborn/Adoption/Legal Guardian</strong></td>
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<tr>
<td>A covered employee has a newborn child, the employee may enroll: (1) newborn only, or (2) spouse only, or (3) spouse and newborn. Other eligible dependents can also be added at this time. Subject to applicable law, the spouse and other eligible dependents can only be added within 31 days after the newborn’s date of birth.</td>
<td>The newborn’s date of birth. If only enrolling the newborn, premium is waived for the first calendar month if the date of birth is other than the first of the month. If enrolling any other eligible dependents, premium is billed for the full month in which coverage begins. For example: Employee adds child (no plan change) Child is born March 5. Effective date is March 5 and premium begins (if applicable) on April 1. Employee adds child (plan change) Child is born March 5. Effective date is March 5 on current plan. Plan change and new premium effective on April 1. Employee not adding child (first 31 days only) Child is born March 5. Coverage is effective March 5-April 5. No premium impact. TRS-ActiveCare automatically provides coverage for a newborn child of a covered employee for the first 31 days after the date of birth, but this coverage ends unless the newborn is added to employee’s coverage within 31 days of the newborn’s date of birth.</td>
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<tr>
<td>If...</td>
<td>Your effective date is...</td>
<td>Your eligible dependent's effective date is...</td>
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<tr>
<td><strong>Newborn/Adoption/Legal Guardian (cont.)</strong></td>
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</tbody>
</table>
| An eligible, but not covered employee adopts a child and chooses to enroll within 31 days after the date of adoption or date on which the child to be adopted is placed with the employee, the employee may enroll:  
  - employee only, or  
  - employee and spouse, or  
  - employee and adopted child, or  
  - employee, spouse and adopted child | The date of adoption or date on which the child to be adopted is placed with the employee | The date of adoption or the date on which the child to be adopted is placed with the employee |
| An eligible, but not covered employee, has a newborn child, the employee may enroll:  
  - employee only, or  
  - employee and spouse, or  
  - employee and newborn, or  
  - employee, spouse and newborn | The newborn’s date of birth | The newborn’s date of birth |
| A covered employee adopts a child and chooses to enroll within 31 days after the date of adoption or date on which the child to be adopted is placed with the employee, the employee may enroll:  
  - adopted child only, or  
  - spouse only, or  
  - spouse and/or adopted child | The date of adoption on which the child to be adopted is placed with the employee | The date of adoption on which the child to be adopted is placed with the employee |
| **A covered employee becomes a legal guardian of an eligible dependent child and chooses to enroll the dependent within 31 days after the date the legal guardianship is granted... Other eligible dependents can also be added at this time**  
*An award of legal guardianship isn’t a special enrollment event for a non-covered employee or their dependents* | **The date the guardianship is granted** | **Premium is waived for the first calendar month if the date of notification is other than the first of the month** |
| A covered employee adds a court-ordered eligible dependent child after the participating district/entity receives notice of the court order or national medical support notice  
*Other eligible dependents can also be added at this time*  
*A court order on the spouse (or ex-spouse) of a covered employee doesn’t require TRS-ActiveCare to provide dependent coverage* | The date the participating district/entity receives notification of the court order or national medical support notice | **Premium is waived for the first calendar month if the date of notification is other than the first of the month** |
<table>
<thead>
<tr>
<th>If...</th>
<th>Your effective date is...</th>
<th>Your eligible dependent’s effective date is...</th>
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</thead>
<tbody>
<tr>
<td>An eligible, but not covered employee adds a court-ordered eligible dependent child after the participating district/entity receives notice of the court order or national medical support notice... Other eligible dependents can also be added at this time. A court order is a special enrollment event for the employee. If the employee chooses to enroll themselves and other eligible dependents, they have 31 days after the date the participating district/entity receives the court order or national medical support notice to enroll</td>
<td>The date the participating district/entity receives notification of the court order or national medical support notice</td>
<td>The date the participating district/entity receives notification of the court order or national medical support notice</td>
</tr>
<tr>
<td>A covered employee adds an eligible newborn grandchild or another newborn child who is in a regular parent-child relationship with the employee within 31 days after the date of birth</td>
<td>Premium is billed for the full month in which coverage begins</td>
<td>Premium is billed for the full month in which coverage begins</td>
</tr>
<tr>
<td>A covered employee adds an eligible grandchild or another child who is in a regular parent-child relationship with the employee within 31 days after the child qualifies as a dependent... Adding a grandchild or another child who is in a regular parent-child relationship with the employee isn’t a special enrollment event for an non-covered employee or their dependents</td>
<td>First of the month following the date the child qualifies as a dependent</td>
<td></td>
</tr>
</tbody>
</table>

**Marriage/Name Change**

A covered employee gets married and chooses to enroll within 31 days after the date of marriage, you may enroll:
- spouse only
- spouse’s eligible children, or
- spouse and spouse’s eligible children

Other eligible dependents can also be added at this time

The first of the month following the date of marriage
### If...

Your effective date is...
Your eligible dependent’s effective date is...

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<thead>
<tr>
<th>If...</th>
<th>Your effective date is...</th>
<th>Your eligible dependent’s effective date is...</th>
</tr>
</thead>
<tbody>
<tr>
<td>An eligible, but not covered employee gets married and chooses to</td>
<td>The first of the month following the date of marriage</td>
<td>The first of the month following the date of marriage</td>
</tr>
<tr>
<td>enroll within 31 days after the date of marriage, the employee may</td>
<td></td>
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<tr>
<td>enroll:</td>
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<tr>
<td>• employee only, or</td>
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<tr>
<td>• employee and spouse, or</td>
<td></td>
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<tr>
<td>employee and spouse’s eligible children, or (4) employee, spouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and spouse’s eligible children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other eligible dependents can also be added at this time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Special enrollment situations

| An employee receives an Insurance Enrollment Notification letter from | The first of the month following the date of the notification letter | The first of the month following the date of the notification letter |
| the Texas Health and Human Services agency, regarding eligibility   |                                                                 |                                                                 |
| for HIPP and chooses to enroll within 60 days after the date of     |                                                                 |                                                                 |
| eligibility                                                         |                                                                 |                                                                 |
| The employee makes changes to coverage due to other special         | The first of the month following the event date                              | The first of the month following the event date |
| enrollment events within 31 days after the qualifying event         |                                                                 |                                                                 |

Promptly notify your Benefits Administrator to:

- terminate TRS-ActiveCare coverage for a spouse upon a divorce
- terminate TRS-ActiveCare coverage when a child, age 26 or over, that is either mentally or physically incapacitated marries

When coverage is terminated, benefits for expenses incurred after termination won’t be available. If you receive benefits to which you are not entitled, refunds will be requested.

Also remember to notify your Benefits Administrator if you or your covered dependents have an address change.

### When Coverage Ends

Your TRS-ActiveCare employee coverage will end:

- the last day of the month in which your employment ends, unless otherwise provided by TRS rules or law
- the last day of the month you are expelled from the TRS-ActiveCare program
- the last day of the month in which you are no longer eligible for TRS-ActiveCare coverage (such as your TRS retirement date or as allowed by TRS Rule 41.38)
- when you stop making the required premium contribution payments
- the last day of the month in which you enter into active, full-time military, naval, or air service except as provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) or other applicable law
- the last day of the month in which eligibility for COBRA continuation coverage expires
- if a participating district/entity fails to make all premium payments for a period of at least 90 days
- when the TRS-ActiveCare program is terminated
A dependent’s coverage will end:
- when the employee’s coverage ends
- the last day of the month in which they lose their status as an eligible dependent (for example, your spouse’s coverage will end if you get divorced)
- the last day of the month in which they enter into active, full-time military, naval, or air service except as provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) or other applicable law
- the last day of the month in which eligibility for COBRA continuation coverage expires
- when you stop paying required premium contribution payments for dependent coverage

**Can coverage be dropped throughout the plan year?**

Unless restricted due to participation in an Internal Revenue Code Section 125 cafeteria plan, an employee can drop all coverage or drop dependent coverage. If coverage is dropped during the plan year, the individual won’t be eligible to re-enroll in TRS-ActiveCare until the next plan enrollment period unless a special enrollment event occurs. **Note:** You can’t elect to drop coverage retroactively; a future cancellation date is required.

**When is a dependent child no longer eligible for coverage?**

Coverage for a dependent child terminates at the end of the month in which the child turns 26, or enters into active, full-time military service, whichever occurs first, unless eligible as a disabled dependent.

If you have a disabled dependent child age 26 or over, your child may be eligible for dependent coverage if the child is either mentally or physically incapacitated to such an extent as to be dependent on you on a regular basis and the child meets other requirements as determined by TRS.

You (and your dependent’s attending physician) must complete a *Disabled Dependent Authorization* form to provide satisfactory proof of the disability and dependency. The form must be submitted to BCBSTX within 31 days after the date the child turns 26, or prior to the date the child turns 26. To avoid any gap in coverage, the form must be submitted and approved prior to the end of the month in which the child turns 26, or prior to the date the child turns 26.

If you miss the 31-day deadline for submission of the forms to BCBSTX, you may submit the forms for review prior to the Annual Enrollment deadline for an effective date of Sept. 1 (the beginning of the new plan year).

**Note:** A sibling who is over age 26 may qualify as a disabled dependent. Parents and grandparents of the covered employee don’t meet the definition of an eligible dependent.

**Continuation of Group Coverage (COBRA)**

Please refer to the *Continuation of Group Coverage - Federal* subsection in this benefits booklet for additional information.
HOW THE PLAN WORKS

Selecting a PCP
At the time of enrollment, you must choose a primary care provider (PCP). You may choose a PCP who is a family practitioner, internist, pediatrician, and/or obstetrician/gynecologist.

If any participant is a minor or otherwise incapable of selecting a PCP, the subscriber should select a PCP on the participant's behalf. If your dependents enroll, you and your dependents must choose a PCP from the directory of in-network providers in order to receive covered services.

For the most current list of in-network providers visit the website at www.bcbstx.com/trsactivecare. You may also call your Personal Health Guide at 1-866-355-5999.

BCBSTX may assign a PCP if one hasn’t been selected. Until a PCP is selected or assigned, benefits will be limited to coverage for emergency care.

Limited Provider Network
If your PCP is part of a limited provider network, a network of physicians in separate offices who form an association to provide health care services, this may affect the network of in-network providers available to you. Limited provider networks often refer patients to in-network provider who are associated with the same limited provider network.

Your limited provider network PCP can also refer you to in-network providers who are not associated with that group. You may be required to choose an obstetrician or gynecologist who belongs to the same limited provider network as your PCP but a female participant's right to directly access an obstetrician or gynecologist won't be infringed upon.

PCP's in a limited provider network will be identified in the provider directory or you can call your Personal Health Guide at 1-866-355-5999.

Participants who have been diagnosed with a chronic, disabling or life-threatening illness may request approval to choose an in-network Specialist as a PCP using the process described in Specialist as PCP.

Your PCP
Your PCP coordinates your medical care, as appropriate, either by providing treatment or by issuing referrals to direct you to in-network providers.

Except for emergency care/medical emergencies or certain direct-access specialist benefits described in this plan, only those services which are provided by or referred by your PCP will be covered. It is your responsibility to consult with the PCP in all matters regarding your medical care.

If your PCP performs, suggests, or recommends a course of treatment for you that includes services that are not covered services, the entire cost of any such non-covered services will be your responsibility.

Changing Your PCP
You may change your PCP whenever necessary. If you utilize Blue Access for Members (BAM) to update your PCP on your health plan, it won’t take effect until the first of the following month.

If you need an urgent PCP update, call your Personal Health Guide at 1-866-355-5999. The Personal Health Guide will be able to make the PCP update retroactive to the first day of the current month.

In the event of termination of an in-network provider of any kind, BCBSTX will use best efforts to provide reasonable notice to participants receiving care from such in-network provider that termination is imminent. Special circumstances may render you eligible to continue receiving treatment from an in-network provider after the effective date of termination, which is fully described in Continuity of Care.
Continuity of Care

If you are under the care of an in-network provider who stops participating in the network, BCBSTX will continue coverage for that provider's covered services if all the following conditions are met:

- You have a disability, acute condition, life-threatening illness or are past the thirteenth (13th) week of pregnancy.
- The provider submits a written request to BCBSTX to continue coverage of your care that identifies the condition for which you are being treated and indicates that the provider reasonably believes that discontinuing treatment could cause you harm.
- The provider agrees to continue accepting the same reimbursement that applied when participating in the network, and not to seek payment from you for any amounts for which you wouldn’t be responsible if the provider were still participating in the network.

Continuity of coverage shall not extend for more than ninety (90) days (or more than nine (9) months if you have been diagnosed with a terminal illness) beyond the date the provider's termination takes effect. If you are past the thirteenth (13th) week of pregnancy when the provider's termination takes effect, coverage may be extended through delivery, immediate postpartum care and the follow-up check-up within the first six (6) weeks of delivery.

Specialist as PCP

If you have been diagnosed with a chronic, disabling, or life-threatening illness, you may contact your Personal Health Guide at 1-866-355-5999 to get information to submit for approval from the Medical Director to choose an in-network Specialist as your PCP. The Medical Director will require both you and the in-network Specialist interested in serving as your PCP to sign a certification of medical need, to submit along with all supporting documentation.

The in-network Specialist must meet the requirements for PCP participation and be willing to accept the coordination of all your health care needs.

If your request is denied, you may appeal the decision as described in CLAIM FILING AND APPEALS PROCEDURES. If your request is approved, the Specialist's designation as your PCP won’t be effective retroactively. As used herein, “life threatening,” means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Availability of Providers

BCBSTX cannot guarantee the availability or continued participation of a particular provider. If the PCP initially selected can’t accept additional patients, you will be given an opportunity to make another PCP selection. You must then cooperate with BCBSTX to select another PCP.

Inpatient Care by Non-PCP

During an inpatient stay at an in-network hospital, skilled nursing facility or other in-network facility, it may be appropriate for a physician other than your PCP to direct and oversee your care, if your PCP doesn’t do so. However, upon discharge, you must return to the care of your PCP or have your PCP coordinate care that may be medically necessary.

Provider Communication

BCBSTX won’t prohibit, attempt to prohibit or discourage any provider from discussing or communicating to you or your designee any information or opinions regarding your health care, any provisions of your health plan as it relates to your medical needs or the fact that the provider’s contract with BCBSTX has terminated or that the provider will no longer be providing services under BCBSTX.
Your Responsibilities

- You shall complete and submit to BCBSTX an application or other forms or statements that BCBSTX may reasonably request. You agree that all information contained in the applications, forms and statements submitted to BCBSTX due to enrollment under this plan or the administration herein shall be true, correct, and complete to the best of your knowledge and belief.
- You shall notify your employer immediately of any change of address for you or any of your covered dependents.
- You understand that BCBSTX is acting in reliance upon all information you provided to BCBSTX at time of enrollment and afterwards and represents that information so provided is true and accurate.
- By electing coverage pursuant to this plan, or accepting benefits hereunder, all participants who are legally capable of contracting, and the legal representatives of all participants who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.
- You are subject to and shall abide by the rules and regulations of each provider from which benefits are provided.

Refusal to Accept Treatment

You may, for personal reasons, refuse to accept procedures or treatment by an in-network provider. In-network providers may regard such refusal to accept their recommendations as incompatible with continuance of the provider-patient relationship and as obstructing the provision of proper medical care.

In-network providers shall use their best efforts to render all necessary and appropriate Professional Services in a manner compatible with your wishes, as long as this can be done consistent with the in-network provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the in-network provider informed you of their belief that no professionally acceptable alternative exists, neither BCBSTX nor any in-network provider shall have any further responsibility to provide care for the condition under treatment.

Identification Card

The Identification Card tells providers that you are entitled to benefits under your employer's plan. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- **your subscriber identification number**
  This unique identification number is preceded by a three-character alpha prefix that identifies BCBSTX as your Claim Administrator.
- **your group number**
  This is the number assigned to identify your employer's plan with BCBSTX.
- **any copays that may apply to your coverage**
- **important telephone numbers**

Always remember to carry your ID Card with you and present it to your providers when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new ID Card to be issued to you (refer to the WHO GETS BENEFITS section for instructions when changes are made). Upon receipt of the change in information, BCBSTX will provide a new ID Card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

- the unauthorized, fraudulent, improper, or abusive use of ID Cards issued to you and your covered dependents will include, but not be limited to, the following actions, when intentional:
  a. use of the ID Card prior to your effective date
  b. use of the ID Card after your date of termination of coverage under your health plan
  c. obtaining benefits for persons not covered under your health plan
  d. obtaining benefits that are not covered under your health plan
• the fraudulent or intentionally unauthorized, abusive, or other improper use of ID Cards by any participant can result in, but isn’t limited to, the following sanctions being applied to all participants covered under your coverage:
  a. denial of benefits
  b. cancellation of coverage under your health plan for all participants under your coverage
  c. recoupment from you or any of your covered dependents of any benefit payments made
  d. denial of pre-approval of medical services for all participants receiving benefits under your coverage
  e. notice to proper authorities of potential violations of law or professional ethics

**Participant Claims Refund**

You are not expected to make payments, other than required copays/coinsurance, for any benefits provided hereunder. However, if you make such payments, you may send BCBSTX a claim for refund, and when a refund is in order, the provider shall make such refund to you.

Your claim will be allowed only if you notify BCBSTX within ninety (90) days from the date on which covered expenses were first incurred, unless it can be shown that it was not reasonably possible to give notice within the time limit, and that notice was given as soon as reasonably possible. However, benefits won’t be allowed if notice of claim is made beyond one (1) year from the date covered expenses were incurred.

You must provide written proof of such payment to BCBSTX within one (1) year of occurrence.

**Claim or Benefit Reconsideration**

If a claim or a request for benefits is partly or completely denied by BCBSTX, you will receive a written explanation of the reason for the denial and are entitled to a full review. If you wish to request a review or have questions regarding the explanation of benefits, call your Personal Health Guide at 1-866-355-5999.

If you are not satisfied with the information received either on the call or in written correspondence, you may request an appeal of the decision. You may obtain a review of the denial by following the process set out in **CLAIM REVIEW AND APPEAL PROCEDURES**.

**Service Area**

The service area includes a statewide network covering all 254 counties.
Preauthorization Requirements

Note: Participants on the TRS-ActiveCare Primary or TRS-ActiveCare Primary+ plans, your PCP will handle any preauthorization or referral requirements for you.

Preauthorization establishes in advance the medical necessity or experimental/investigational nature of certain care and services covered under this plan. It ensures that the preauthorized care and services described below won’t be denied based on medical necessity or experimental/investigational. However, preauthorization doesn’t guarantee payment of benefits.

Coverage is always subject to other requirements of your health plan, such as limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

The following types of services require Preauthorization:

- all inpatient hospital admissions
- extended care expenses
- home health
- home infusion therapy
- home hospice
- molecular genetic testing
- outpatient radiation therapy
- outpatient transplant evaluations
- non-emergency fixed-wing air ambulance transportation (please refer to the fixed-wing air ambulance definition in the DEFINITIONS section of this Benefits booklet)
- outpatient procedures/services:
  a. Cardiac (heart related):
     1. cardiac advanced imaging
     2. stress testing (myocardial perfusion imaging – single-photon emission computed tomography SPECT and PET)
     3. cardiac CT and MRI
     4. echocardiography (stress, transthoracic and transesophageal)
     5. implantable device services: pacemakers, implantable cardioverter-defibrillators
     6. MRI, magnetic resonance angiogram (MRA), PET, PET-CT, CT, computed tomography angiography (CTA), nuclear medicine
     7. lipid apheresis
  b. Ears, Nose and Throat (ENT):
     1. bone conduction hearing aids
     2. cochlear implants
     3. nasal and sinus surgery
  c. Gastroenterology (Stomach):
     1. gastric electrical stimulation (GES)
  d. Neurological:
     1. deep brain stimulation
     2. sacral nerve neuromodulation/stimulation
     3. vagus nerve stimulation (VNS)
e. **Orthopedic (Musculoskeletal):**
   (1) artificial intervertebral disc
   (2) autologous chondrocyte implantation (ACI) for focal articular cartilage lesions
   (3) joint and spine surgery
   (4) functional neuromuscular electrical stimulation (FNMES)
   (5) lumbar spinal fusion
   (6) orthopedic applications of stem-cell therapy
   (7) spinal decompression and fusion surgeries
   (8) total disc replacement surgery
   (9) pneumatic compression devices - durable medical equipment (DME)

f. **Pain Management:**
   (1) epidural steroid spinal injections
   (2) surgical deactivation of headache trigger sites
   (3) interventional pain management
   (4) facet joint spinal injections
   (5) radiofrequency spinal facet joint ablation/denervation
   (6) spinal cord stimulators
   (7) regional sympathetic blocks
   (8) sacroiliac joint injections
   (9) implantable intrathecal drug delivery systems

g. **Radiology:**
   (1) advanced imaging services: MRI, magnetic resonance angiogram (MRA), PET, PET-CT, CT, computed tomography angiography (CTA), Nuclear Medicine (including Cardiology)
   (2) diagnostic ultrasound: head and neck, pediatric, breast, abdomen and retroperitoneum, extremity, arterial and venous

h. **Sleep Medicine:**
   (1) diagnostic attended sleep studies and home sleep testing
   (2) positive airway pressure (PAP) therapy devices and supplies; (Sleep CPAP and BiPAP machines)
   (3) positive airway pressure (PAP) therapy compliance monitoring and intervention for non-compliance

i. **Surgical Procedures:**
   (1) orthognathic surgery; face reconstruction
   (2) mastopexy, breast lift
   (3) reduction mammoplasty; breast reduction

j. **Specialty Pharmacy:**
   (1) medical benefit specialty drugs (specialty drugs administered by your provider)

k. **Wound Care:**
   (1) hyperbaric oxygen (HBO2) therapy

For specific details about the preauthorization requirement for the above referenced outpatient procedures/services, please call your Personal Health Guide at 1-866-355-5999. BCBSTX reserves the right to no longer require preauthorization for certain services during the plan year. Updates to the list of services requiring preauthorization may be confirmed by calling your Personal Health Guide at 1-866-355-5999.
Behavioral Health Services

For an inpatient hospital admission, see the below section entitled Preauthorization for Inpatient Hospital Admissions. In order to receive maximum benefits under this benefits booklet, you must get preauthorization for emergency and non-emergency admissions for mental health care/serious mental illness, residential treatment centers and partial hospitalization programs. BCBSTX will obtain information regarding the service(s) and may discuss proposed treatment with your behavioral health provider.

The following types of behavioral health services require Preauthorization:

- all inpatient treatment of mental health care/serious mental illness and substance use disorder including partial hospitalization programs and treatment received at residential treatment centers
- if you transfer to another facility or to or from a specialty unit within the facility
- the following outpatient treatment of mental health care, serious mental illness and substance use disorder:
  - psychological testing or neuropsychological testing in some cases (BCBSTX will notify your provider if preauthorization is required for these testing services)
  - applied behavioral analysis (Please see coverage details as described in the Benefits for Autism Spectrum Disorder in the COVERED MEDICAL SERVICES section of this Benefits booklet)
  - outpatient electroconvulsive therapy
  - intensive outpatient program
  - repetitive transcranial magnetic stimulation

In-network benefits will be available if you use an in-network provider or in-network specialty care provider. In-network providers will Preauthorize services for you, when required.

However, if such services and supplies are not available from an in-network provider, contact BCBSTX prior to electing to use an out-of-network provider, and BCBSTX will determine how to maximize your benefits.

Your network provider is required to obtain preauthorization for inpatient hospital admissions. You are responsible for satisfying all other preauthorization requirements.

This means that you must ensure that you, your family member, your physician, behavioral health provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the section entitled Failure to Preauthorize.

Preauthorization for Inpatient Hospital Admissions

In the case of an elective inpatient hospital admission, the call for preauthorization should be made at least two working days (excluding weekends and holidays) before you are admitted unless it would delay emergency care. In an emergency, preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

Your in-network provider is required to obtain preauthorization for any inpatient admissions. If preauthorization isn’t obtained, the in-network provider will be sanctioned based on BCBSTX’s contractual agreement with the provider, and you will be held harmless for the provider sanction.

If the physician or provider of services isn’t an in-network provider then you, your physician, the in-network provider of services, or a family member should obtain preauthorization by BCBSTX by calling your Personal Health Guide at 1-866-355-5999.

The call should be made between 7:00 a.m. and 6:00 p.m., Central Time, on business days and 9:00 a.m. and 12:00 p.m., Central Time on Saturdays, Sundays and legal holidays. Calls made after these hours will be recorded and returned no later than 24 hours after the call is received. We will follow-up with your provider's office.
After working hours or on weekends, please call your **Personal Health Guide** at 1-866-355-5999. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your provider's office. All timelines for preauthorization requirements are provided in keeping with applicable state and federal regulations.

**In-network benefits** will be available if you use an in-network provider or network specialty care provider. However, if care isn't available from in-network providers as determined by BCBSTX, and BCBSTX authorizes your visit to an out-of-network provider to be covered at the in-network Benefit level prior to the visit, in-network benefits will be paid.

When an inpatient hospital admission is preauthorized, a length-of-stay is assigned. If you require a longer stay than was first preauthorized, your provider may seek an extension for the additional days. Benefits won't be available for room and board charges for medically unnecessary days.

**Preauthorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested**

Your plan is required to provide a minimum length-of-stay in a hospital facility for the following:

- **maternity care**
  - 48 hours following an uncomplicated vaginal delivery
  - 96 hours following an uncomplicated delivery by caesarean section
- **treatment of breast cancer**
  - 48 hours following a mastectomy
  - 24 hours following a lymph node dissection

You or your provider won't be required to obtain preauthorization from BCBSTX for a length of stay less than 48 hours (or 96 hours) for maternity care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you or your provider must seek an extension for the additional days by obtaining preauthorization from BCBSTX.

**Preauthorization for Extended Care Expenses and Home Infusion Therapy**

Preauthorization for extended care expenses and home infusion therapy may be obtained by having the agency or facility providing the services contact BCBSTX to request preauthorization. The request should be made:

- prior to initiating extended care expenses or home infusion therapy
- when an extension of the initially preauthorized service is required
- when the treatment plan is altered

BCBSTX will review the information submitted prior to the start of extended care expenses or home infusion therapy and will send a letter to you and the agency or facility confirming preauthorization or denying benefits.

If extended care expenses or home infusion therapy is to take place in less than one week, the agency or facility should call your **Personal Health Guide** at the telephone number indicated in this benefits booklet or shown on your ID Card.

If BCBSTX has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

**Preauthorization for Mental Health Care, Serious Mental Illness, and Treatment of Substance Use Disorder**

In order to receive maximum benefits, all inpatient treatment for mental health care, serious mental illness, and substance use disorder must be preauthorized by your health plan. Preauthorization is also required for certain outpatient services.

- outpatient services requiring preauthorization include
  - psychological testing
  - neuropsychological testing
  - repetitive transcranial magnetic stimulation
• intensive outpatient programs
• applied behavior analysis
• outpatient electroconvulsive therapy

Preauthorization isn’t required for therapy visits to a physician, behavioral health provider and/or professional other provider.

To satisfy preauthorization requirements, you, a family member or your behavioral health provider must call your Personal Health Guide at 1-866-355-5999. Your Personal Health Guide is available 24 hours a day, 7 days a week.

All timelines for preauthorization requirements are provided in keeping with applicable state and federal regulations.

However, if care isn’t available from in-network providers as determined by BCBSTX, and BCBSTX authorizes your visit to an out-of-network provider to be covered at the in-network Benefit level prior to the visit, in-network benefits will be paid.

When a treatment or service is preauthorized, a length of stay or length of service is assigned. If you require a longer stay or length of service than was first preauthorized, your behavioral health provider may seek an extension for the additional days or visits.

Benefits won’t be available for medically unnecessary treatments or services.

Failure to Preauthorize

If preauthorization for inpatient hospital admissions, extended care expense, home infusion therapy, outpatient medical services, all inpatient and the above specified outpatient treatment of mental health care, treatment of serious mental illness, and treatment of substance use disorder isn’t obtained:

• BCBSTX will review the medical necessity of your treatment or service prior to the final benefit determination.
• If BCBSTX determines the treatment or service isn’t medically necessary or is experimental/investigational, benefits will be reduced or denied.
• you may be responsible for a penalty in connection with the following covered services, if indicated on your SCHEDULE OF COVERAGE:
  a. inpatient hospital admission
  b. inpatient treatment of mental health care, treatment of serious mental illness, and treatment of substance use disorder

In-network providers are responsible for satisfying the preauthorization requirements for any inpatient admissions. If preauthorization isn’t obtained, the in-network provider will be sanctioned based on the BCBSTX contractual agreement with the provider and no penalty charges will be deducted.

The penalty charge will be deducted from any benefit payment which may be due for Covered Services.

If any of the following treatment or services isn’t preauthorized and it is determined that the treatment, service, or extension was not medically necessary or was experimental/investigational, benefits will be reduced or denied:

• inpatient hospital admission
• extended care expense
• home infusion therapy
• any treatment of mental health care
• treatment of serious mental illness
• treatment of substance use disorder

Preauthorization Renewal Process

Renewal of an existing preauthorization issued by BCBSTX can be requested by a physician or health care provider up to 60 days prior to the expiration of the existing preauthorization.
CLAIM FILING AND APPEALS PROCEDURES

Claim Filing Procedures

Filing of Claims Required

Claim Forms
When BCBSTX receives notice of claim, it will provide to you, or to your employer for delivery to you, the hospital, or your physician or professional other provider, the claim forms that are usually provided by it for filing proof of loss.

BCBSTX for your health plan must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Providers that contract with BCBSTX and, if applicable, some other health care providers (such as ParPlan providers) will submit your claims directly to BCBSTX for services provided to you or any of your covered dependents. At the time services are provided, inquire if they will file claim forms for you. To assist providers in filing your claims, you should carry your ID Card with you.

Contracting Providers
When you receive treatment or care from a provider that contracts with BCBSTX, you will generally not be required to file claim forms. The provider will usually submit the claims directly to BCBSTX for you.

ParticipantFiled Claims

Medical Claims
If your provider doesn’t submit your claims, you will need to submit them to BCBSTX using a subscriber-filed claim form provided by BCBSTX.

You can obtain copies of claim forms from the BCBSTX website at www.bcbstx.com/trsactivecare, or by calling your Personal Health Guide at 1-866-355-5999. Follow the instructions on the reverse side of the form to complete the claim.

Remember to file each participant's expenses separately because any copays, deductibles, maximum benefits, and other provisions are applied to each participant separately. Include itemized bills from the health care providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the participant involved.

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION www.bcbstx.com/trsactivecare

Where to Mail Completed Claim Forms

Medical Claims
Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, TX 75266-0044

Who Receives Payment

Benefit payments will be made directly to contracting providers when they bill BCBSTX. Written agreements between BCBSTX and some providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Except as provided in the section Assignment and Payment of Benefits, rights and benefits under your health plan are not assignable, either before or after services and supplies are provided.
Benefit Payments to a Managing Conservator

Benefits for services provided to your minor dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child
- BCBSTX hasn't already paid any portion of the claim

For benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to BCBSTX, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

BCBSTX for the plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your provider, or deduction by your health plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under your health plan.

An Explanation of Benefits summary is sent to you, so you will know what has been paid.

When to Submit Claims

All claims for benefits under the plan must be properly submitted to BCBSTX within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by BCBSTX after that date won’t be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by BCBSTX

A claim will be considered received by BCBSTX for processing upon actual delivery to the Administrative Office of BCBSTX in the proper manner and form and with all the information required. If the claim isn’t complete, it may be denied, or BCBSTX may contact either you or the provider for the additional information.

After processing the claim, BCBSTX will notify the participant by way of an Explanation of Benefits summary.

Review of Claim Determinations

Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority and discretion under your health plan to interpret and determine benefits in accordance with the plan provisions. BCBSTX will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between BCBSTX and your health plan Administrator.

You have the right to seek and obtain a full and fair review of your claim in accordance with the benefits and procedures detailed in your health plan.
**Timing of Required Notices and Extensions for Initial Determinations**

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are four types of Claims as described below.

- **Urgent Care Claim** is any Pre-Service Claim that requires preauthorization, as described in this benefits booklet, for benefits for medical care or Treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that can’t be adequately managed without the care or Treatment.

- **Pre-Service Claim** is any non-urgent request for benefits with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

- **Concurrent Care Claim** is a claim for a health benefit which BCBSTX, after having previously approved an ongoing course of treatment provided over a period of time or a specific number of treatments, subsequently reduces or terminates coverage for the treatments (other than by plan amendment or termination) or a request to extend the course of the treatment beyond what was previously approved that is an urgent care Claim.

- **Post-Service Claim** is any other claim for a benefit for a service that has been provided to you. Your Claim must be in a form acceptable to BCBSTX. Your Claim must include full details of the service received, including your name, age, sex, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which BCBSTX may request in connection with services rendered to you.
The following table summarizes the applicable deadlines and extension periods for each type of claim:

<table>
<thead>
<tr>
<th>What is the general deadline for initial determination?</th>
<th>Urgent Care Claims</th>
<th>Pre-Service Claims</th>
<th>Post-Service Claims</th>
<th>Concurrent Care Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>No later than 72 hours from receipt of the claim</td>
<td>15 calendar days from receipt of the claim</td>
<td>30 calendar days from receipt of the claim</td>
<td>Must be provided sufficiently in advance to give you an opportunity to appeal and obtain a decision before the previously approved treatment is reduced or terminated. A request to extend an approved course of treatment that is an Urgent Care Claim will receive a response within 24 hours, if the request is made at least 24 hours prior to the expiration of the previously approved period or number of treatments. <strong>Note:</strong> If such requests for an extension are not made at least 24 hours prior to the expiration of the previously approved period of time or number of treatments, then the claim will be handled as an Urgent Care Claim. If a request to extend a course of treatment isn’t an Urgent Care Claim, the request may be treated as a new Pre-Service or Post-Service claim depending on the circumstances.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Are there any extensions? | No, but see below for extensions based on insufficient information | Yes. One 15 calendar day extension is allowed if BCBSTX determines it is necessary due to matters beyond its control and informs you of the extension within the initial 15 calendar day timeframe. | Yes. One 15 calendar day extension is allowed if BCBSTX determines it is necessary due to matters beyond its control and informs you of the extension within the initial 30 calendar day timeframe. | No |</p>
<table>
<thead>
<tr>
<th>What if additional information is needed?</th>
<th>Urgent Care Claims</th>
<th>Pre-Service Claims</th>
<th>Post-Service Claims</th>
<th>Concurrent Care Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>You must be notified of the need for additional information to decide the outcome of a claim within 24 hours. You must be given at least 48 hours to respond.</td>
<td></td>
<td>If an extension is necessary because you failed to provide the information necessary to decide the claim, notice of extension must specify the information needed. You must be given at least 45 calendar days to respond. The timeframe for the initial claims determination is suspended until the end of the prescribed response period or until the information is received, whichever is earlier.</td>
<td>If an extension is necessary because you failed to provide information necessary to decide the claim, notice of extension must specify the information needed. You must be given at least 45 calendar days to respond. The timeframe for the initial claims determination is suspended until the end of the prescribed response period or until the information is received, whichever is earlier.</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

What is the deadline if additional information is needed?

| You must be notified of the decision no later than 48 hours after the earlier of: 1) BCBSTX’s receipt of the requested information; or 2) the end of the prescribed response period. | If there is an extension, you must be notified of the decision no later than 15 calendar days after BCBSTX receives a response to the request for information or 15 calendar days after the end of the deadline for you to provide the information, whichever is earlier. | If there is an extension, you must be notified of the decision no later than 15 calendar days after BCBSTX receives a response to the request for information or 15 calendar days after the end of the deadline for you to provide the information, whichever is earlier. |

**NOTE:** Improperly Filed Claims; for Pre-Service Claims which name a specific claimant, medical condition, and service or supply for which approval is requested and which are submitted to a representative of BCBSTX responsible for handling benefit matters, but which otherwise fail to follow the procedures for filing Pre-Service Claims, you will be notified on the failure within 5 days (within 24 hours in the case of an Urgent Care Claim) and of the proper procedures to be followed. The notice may be oral, but you may also request a written notice.
If a Claim Is Denied or Not Paid in Full

On occasion, BCBSTX may deny all or part of your claim. There are several reasons why this may happen. If, after reviewing the *Explanation of Benefits* and this benefits booklet, you have additional information that you believe could change the decision, send it to BCBSTX and request a review of the decision as described in **Claim Appeal Procedures** below.

If the claim is denied in whole or in part, you will receive a written notice from BCBSTX with the following information, if applicable:

- the reasons for the determination
- a reference to the *plan* provisions on which the determination is based
- a description of additional information which may be necessary to complete the claim and an explanation of why such material is necessary
- information sufficient to identify the claim including the date of service, health care provider, claim amount (if applicable), denial codes with their meanings and the standards used.

Please note: Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.

- an explanation of the internal review/appeals and external review processes available to you (and how to initiate internal review or external review) and applicable time limits, information on any voluntary appeal procedures offered by your health plan
- in certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s)
- in certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX
- the right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits
- any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request
- an explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request
- in the case of a denial of an Urgent Care Claim, a description of the expedited internal and external review procedures applicable to such claims

An Urgent Care Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification

- contact information for any applicable office of health insurance consumer assistance or ombudsman

**Claim Review/Appeal Procedures**

**Claim Appeal Procedures - Definitions**

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide in response to a claim, Pre-Service Claim or Urgent Care Claims, or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

If an ongoing course of treatment had been approved by BCBSTX and BCBSTX reduces or terminates such treatment (other than by amendment or termination of the *employer’s* benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination.
A “Final Internal Adverse Benefit Determination” means an Adverse Benefit Determination that has been upheld by BCBSTX at the completion of the internal review/appeal process of an Adverse Benefit Determination with respect to which the internal review/appeal process has been deemed exhausted.

**Note: Expedited Internal Review of Urgent Care Claims**

If your claim is an Urgent Care Claim, you have the right to an expedited review. You also have the right to request an expedited external review of your Urgent Care Claim at the same time you request expedited internal review.

**How to Appeal an Adverse Benefit Determination**

You have the right to seek and obtain a full and fair internal review of your claim and an Adverse Benefit Determination in accordance with the benefits and procedures detailed below and in your plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In Urgent Care Claim situations, a health care provider may appeal on your behalf. Except for Urgent Care Claim situations, your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call your Personal Health Guide at 1-866-355-5999.

If you believe BCBSTX incorrectly denied all or part of your benefits, you may have your claim reviewed. BCBSTX will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial of your claim, you must call or write to BCBSTX's Administrative Office. BCBSTX will need to know the reasons why you don’t agree with the denial or partial denial. Send your appeal request to:
  
  Claim Review Section
  
  Blue Cross and Blue Shield of Texas
  
  P. O. Box 660044
  
  Dallas, Texas 75266-0044

- BCBSTX will honor telephone requests for information. However, such inquiries won’t constitute a request for review.

- In support of your claim review, you have the option of presenting evidence and testimony to BCBSTX. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information during the internal review process.

  BCBSTX will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the internal review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a Final Internal Adverse Benefit Determination on the appeal is made in order to give you a chance to respond before the final determination is made. If the information is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, the time periods below for providing notice of Final Internal Adverse Benefit Determination will be tolled until you have had a reasonable opportunity to respond. After you respond or have had a reasonable opportunity to respond but failed to do so, BCBSTX will notify you of the benefit determination in a reasonably prompt time considering the medical exigencies.

  The appeal determination will be made by BCBSTX based on review by a physician associated or contracted with BCBSTX, who was not involved in making the initial denial. Before you or your authorized representative may bring any action to recover benefits you must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by BCBSTX.

- If you have any questions about the claims procedure or the review procedure, write to BCBSTX's Administrative Office or call your Personal Health Guide at 1-866-355-5999.

If you don't appeal on time, you lose your right to later object to the decision on the claim.
Timing of Appeal Determinations - Note: Your plan provides for one level of internal review

<table>
<thead>
<tr>
<th></th>
<th>Urgent Care Claim</th>
<th>Pre-Service Claim</th>
<th>Post-Service Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deadline by which a claimant</td>
<td>As soon as possible considering the medical exigencies, but no more than 72</td>
<td>Not later than 30 days after receipt of the request for review.</td>
<td>Not later than 60 days after receipt of the request for review.</td>
</tr>
<tr>
<td>will be notified of an appeals</td>
<td>hours after receipt of the request for review. Note: The request may be submitted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>decision</td>
<td>in writing or orally.</td>
<td></td>
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</tbody>
</table>

Notice of Appeal Determination

BCBSTX will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice to you or your authorized representative will include:

- a reason for the determination
- a reference to the benefit plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination
- information sufficient to identify the claim including the date of service, health care provider, claim amount (if applicable), denial codes with their meanings and the standards used
- an explanation of the external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action following a final denial on internal review and the timeframe within which such action must be filed
- in certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s)
- in certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX
- the right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits
- any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request
- an explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request
- a description of the standard that was used in denying the claim and a discussion of the decision
- contact information for any applicable office of health insurance consumer assistance or ombudsman

If BCBSTX’s decision is to continue to deny or partially deny your claim or you don’t receive timely decision and your claim meets the External Review Criteria below, you have the right to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the Standard External Review section below.

If You Need Assistance

If you have any questions about the claims procedures or the review procedures, write or call BCBSTX Headquarters at 1-866-355-5999. Your Personal Health Guide at 1-866-355-5999 is accessible from 24 hours a day, 7 days a week.
If you need assistance with the internal claims and appeals or the external review processes that are described below herein, you may call your Personal Health Guide at 1-866-355-5999 for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

**External Review Criteria**

External Review is available for Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations that involve rescission and determinations that involve medical judgment including, but not limited to, those based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; determinations that a treatment is experimental or investigational; determinations whether you are entitled to a reasonable alternative standard for a reward under a wellness program; or a determination of compliance with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act.

**Standard External Review**

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an Independent Review Organization (IRO).

- **request for external review**
  
  Within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from BCBSTX, you or your authorized representative must file your request for standard external review.

- **preliminary review**
  
  Within five business days following the date of receipt of the external review request, BCBSTX must complete a preliminary review of the request to determine whether:
  
  a. You are, or were, covered under your health plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under your health plan at the time the health care item or service was provided;
  
  b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination doesn’t relate to your failure to meet the requirements for eligibility under the terms of your health plan (e.g., worker classification or similar determination);
  
  c. You have exhausted BCBSTX’s internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **Exhaustion** section below for additional information and exhaustion of the internal appeal process;
  
  d. You or your authorized representative have provided all the information and forms required to process an external review.

  You will be notified within one business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four-month external review request period (or 48 hours following receipt of the notice), whichever is later, to perfect the request for external review. If your claim isn’t eligible for external review, we will outline the reasons it is ineligible in the notice and provide contact information for the Department of Labor’s Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)).

- **referral to Independent Review Organization (IRO)**
  
  When an eligible request for external review is completed within the time period allowed, BCBSTX will assign the matter to an IRO. The IRO assigned will be accredited by Utilization Review Accreditation Commission (URAC) or by similar nationally-recognized accrediting organization. Moreover, BCBSTX will ensure that the IRO is unbiased and independent. Accordingly, BCBSTX
must contract with at least three IROs for assignments under your health plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

a. Utilize legal experts where appropriate to make coverage determinations under your health plan.

b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO isn’t required to, but may, accept and consider additional information submitted after 10 business days.

c. Within five business days after the date of assignment of the IRO, BCBSTX must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by BCBSTX to timely provide the documents and information must not delay the conduct of the external review. If BCBSTX fails to timely provide the documents and information, the assigned IRO may terminate the external review and decide to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify BCBSTX and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to BCBSTX. Upon receipt of any such information, BCBSTX may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by BCBSTX must not delay the external review. The external review may be terminated as a result of the reconsideration only if BCBSTX decides, upon completion of its reconsideration, to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, BCBSTX must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSTX.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO won’t be bound by the decisions or conclusions of BCBSTX. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) your medical records
(2) the attending health care professional's recommendation
(3) reports from appropriate health care professionals and other documents submitted by BCBSTX, you, or your treating provider
(4) the terms of your plan to ensure that the IRO's decision isn't contrary to the terms of your health plan, unless the terms are inconsistent with applicable law
(5) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations
(6) any applicable clinical review criteria developed and used by BCBSTX, unless the criteria are inconsistent with the terms of your health plan or with applicable law
(7) the opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate
f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to BCBSTX and you or your authorized representative.

g. The notice of final external review decision will contain:
   (1) a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial)
   (2) the date the IRO received the assignment to conduct the external review and the date of the IRO decision
   (3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision
   (4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision
   (5) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either BCBSTX or you or your authorized representative
   (6) a statement that judicial review may be available to you or your authorized representative
   (7) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service (PHS) Act section 2793

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by BCBSTX, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

- reversal of plan's decision

Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, BCBSTX must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

**Expedited External Review**

- request for expedited external review

You may request for an expedited external review with BCBSTX at the time you receive:

a. an Adverse Benefit Determination, if the Adverse Benefit Determination involved a medical condition of yours for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal

b. a Final Internal Adverse Benefit Determination, if the determination involved a medical condition of yours for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility
• preliminary review
Immediately upon receipt of the request for expedited external review, BCBSTX must determine whether the request meets the reviewability requirements set forth in the Standard External Review section above. BCBSTX must immediately send you a notice of its eligibility determination that meets the requirements set forth in Standard External Review section above.

• referral to Independent Review Organization (IRO)
Upon a determination that a request is eligible for external review following the preliminary review, BCBSTX will assign an IRO pursuant to the requirements set forth in the Standard External Review section above. BCBSTX must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO isn’t bound by the decisions or conclusions of BCBSTX.

• notice of final external review decision
The assigned IRO will provide notice of the final external review decision, in accordance with the requirements set forth in the Standard External Review section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice isn’t in writing, within 48 hours after the date of providing verbal notice, the assigned IRO must provide written confirmation of the decision to BCBSTX and you or your authorized representative.

Exhaustion
For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if BCBSTX waives the internal review process or BCBSTX has failed to comply with the internal claims and appeals process other than a minor failure. In the event you have been deemed to exhaust the internal review process due to the failure by BCBSTX to comply with the internal claims and appeals process other than a minor failure, you also have the right to pursue any available remedies under state law.

The internal review process won’t be deemed exhausted based on minor violations that don’t cause, and are not likely to cause, prejudice or harm to you so long as BCBSTX demonstrates that the violation was for good cause or due to matters beyond the control of BCBSTX and that the violation occurred in the context of an ongoing, good faith exchange of information between you and BCBSTX.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

Except as described above, you must exhaust the mandatory levels of appeal before you request external review or seek other legal recourse.
Interpretation of Employer's Plan Provisions

The plan has given BCBSTX the final authority to establish or construe the terms and conditions of the plan and the discretion to interpret and determine benefits in accordance with the plan's provisions.

The plan has all powers and authority necessary or appropriate to control and manage the operation and administration of the plan, including, but not limited to, a person's eligibility to be covered under the plan.

All powers to be exercised by BCBSTX or the plan shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.
ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

Your health plan provides coverage for the following categories of eligible expenses:

- inpatient hospital expenses
- medical-surgical expenses
- extended care expenses
- special provisions expenses

Wherever SCHEDULE OF COVERAGE is mentioned, please refer to your applicable Schedule(s) in this benefits booklet. Your benefits are calculated on a plan year benefit period basis unless otherwise stated. At the end of a plan year, a new benefit period starts for each participant.

Copays

Some of the care and treatment you receive under your health plan will require that a copay be paid at the time you receive the services. Refer to your SCHEDULE OF COVERAGE for your specific plan information.

A copay is required for the initial office visit for maternity care but won’t be required for subsequent visits.

A different copay as indicated on your SCHEDULE OF COVERAGE will be required for each provider visit charge when services are received by a Specialty Care provider as classified by the American Board of Medical Specialties as a specialty care provider.

In-network Preventive Care Services are not subject to this copay provision.

The following services are not payable under this copay provision but instead are considered medical-surgical expense and may be subject to any deductible shown on your SCHEDULE OF COVERAGE:

- surgery performed in the physician's office
- occupational modalities in conjunction with physical therapy
- allergy injections billed separately from an office visit
- therapeutic injections
- any services requiring preauthorization
- services provided by an Independent Lab, imaging center, radiologist, pathologist, and anesthesiologist
- outpatient treatment therapies or services such as renal dialysis

A copay, if shown on your SCHEDULE OF COVERAGE, will be required for each visit to an urgent care center. If the services provided require a return office visit (lab services for instance) on a different day, a new copay will be required. The following services are not payable under this copay provision but instead are considered medical-surgical expense, shown on your SCHEDULE OF COVERAGE:

- surgery performed in the urgent care center
- physical therapy billed separately from an urgent care visit
- occupational modalities in conjunction with physical therapy
- allergy injections billed separately from an urgent care visit
- therapeutic injections
- any services requiring preauthorization
- certain diagnostic procedures
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis
A copay, if shown on your SCHEDULE OF COVERAGE, will be required for facility charges for each hospital outpatient emergency room visit. If admitted to the hospital as a direct result of the emergency condition or accident, the copay will be waived.

A copay, if shown on your SCHEDULE OF COVERAGE, will be required for facility charges for each Inpatient Hospital visit.

A copay, if shown on your SCHEDULE OF COVERAGE, will be required for each incident of outpatient surgery.

A copay, if shown on your SCHEDULE OF COVERAGE, will be required for each Certain Diagnostic Procedure.

A copay, if shown on your SCHEDULE OF COVERAGE, will be required for each freestanding emergency room visit.

A copay, if shown on your SCHEDULE OF COVERAGE, will be required for each visit to a retail health clinic.

**Deductibles**

The benefits of your health plan will be available after satisfaction of the applicable deductibles as shown on your SCHEDULE OF COVERAGE.

The deductibles are explained as follows:

- The individual deductible amount shown under "deductibles" on your SCHEDULE OF COVERAGE must be satisfied by each participant under your coverage each plan year. This deductible, unless otherwise indicated, will be applied to all categories of eligible expenses, before benefits are available under your health plan.

  **Note:** You must only meet your own deductible before the plan begins to pay coinsurance.

- If you have several covered dependents, all charges used to apply toward an “individual” deductible amount will be applied toward the “family” deductible amount shown on your SCHEDULE OF COVERAGE. When that family deductible amount is reached, no further individual deductibles will have to be satisfied for the remainder of that plan year. No participant will contribute more than the individual deductible amount to the “family” deductible amount.

The following are exceptions to the deductibles described above:

- **In-network Preventive Care Services** are not subject to deductibles.

- Eligible expenses applied toward satisfying the “individual” and “family” in-network deductible will only apply to the in-network deductible.

**Maximum Out-of-Pocket**

Most of your Eligible Expense payment obligations are applied to the maximum out-of-pocket.

Your maximum out-of-pocket won’t include:

- services, supplies, or charges limited or excluded by your health plan
- expenses not covered because a benefit maximum has been reached
- any eligible expenses paid by the primary plan when your health plan is the secondary plan for purposes of coordination of benefits
- penalties applied for failure to preauthorize
**Individual Maximum Out-of-Pocket**

When the **coinsurance** for a **participant** equals the “individual” “**maximum out-of-pocket**” shown on your **SCHEDULE OF COVERAGE**, your health plan pays 100% for additional **eligible expenses** incurred by that **participant** for the remainder of that **plan year**.

**Family Maximum Out-of-Pocket**

When the **coinsurance** for all **participants** equals the “family” “**maximum out-of-pocket**” shown on your **SCHEDULE OF COVERAGE**, your health plan pays 100% for additional **eligible expenses** incurred by all **participants** for the remainder of that **plan year**. No **participant** will be required to contribute more than the individual **maximum out-of-pocket** to the family “**maximum out-of-pocket**.”

**Changes in Benefits**

Changes to covered benefits will apply to all services provided to each **participant** under the **plan**. Benefits for **eligible expenses** incurred during an admission in a **hospital or facility other provider** that begins before the change will be those benefits in effect on the day of admission.

**Benefit Requirements**

All covered services, unless otherwise specifically described:

- must be **medically necessary**
- must be performed, prescribed, directed or authorized in advanced by the PCP and/or BCBSTX;
- must be rendered by an **in-network provider**
- are subject to the **copay/coinsurance** and any other amount shown in the **SCHEDULE OF COVERAGE(S)**
- may have limitations, restrictions or exclusions described in **MEDICAL LIMITATIONS AND EXCLUSIONS**
- may require **preauthorization**

Services and supplies provided by **out-of-network providers** are **not covered** except for:

- **emergency care**
- when authorized by BCBSTX and your PCP

Self-referral to an **in-network provider** isn’t **covered** except for female **participants**. Female **participants** may directly access an obstetrician/gynecologist for:

- **well-woman exams**
- **obstetrical care**
- **care for all active gynecological conditions**
- **diagnosis, treatment and referral for any disease or condition within the scope of the professional practice of obstetrician/gynecologist**
COVERED MEDICAL SERVICES

Inpatient Hospital Expenses

Your health plan provides coverage for inpatient hospital expenses for you and your eligible dependents. Each inpatient hospital admission requires preauthorization. Refer to the PREAUTHORIZATION REQUIREMENTS subsection of this benefits booklet for additional information.

For eligible inpatient hospital expenses, you must pay a percentage of eligible expenses after you have met your deductible. This is shown in the SCHEDULE OF COVERAGE section of this benefits booklet. After your share has been calculated, this plan pays the rest of the eligible expenses, up to maximum benefit visit limits, if any. You pay a lower percentage of covered charges when you visit an in-network provider.

All inpatient hospital expenses, except emergency care and treatment of breast cancer, must be arranged by your PCP and preauthorized. Inpatient care may be directed by a network physician other than your PCP.

If services and supplies are not available from an in-network provider, contact BCBSTX prior to electing to use an out-of-network provider, and BCBSTX will determine how to maximize your benefits.

Refer to your SCHEDULE OF COVERAGE for information regarding deductibles, coinsurance percentages, and penalties for failure to preauthorize that may apply to your coverage.

Medical-Surgical Expenses

Your health plan provides coverage for medical-surgical expenses for you and your covered dependents. Some services require preauthorization. Refer to the PREAUTHORIZATION REQUIREMENTS subsection of this benefits booklet for more information.

Note: Medical-surgical expenses are available when rendered by an in-network provider, prescribed or arranged by the PCP and any preauthorization requirements are met.

Applicable copays must be paid to your network provider or other in-network providers at the time you receive services.

For eligible medical-surgical expenses, you must pay a percentage of eligible expenses after you have met your deductible. This is shown in the SCHEDULE OF COVERAGE section of this benefits booklet. After your share has been calculated, this plan pays the rest of the eligible expenses, up to maximum benefit visit limits, if any. You pay a lower percentage of covered charges when you visit an in-network provider.

Medical-surgical expense shall include:

- services of physicians and professional other providers
- consultation services of a physician and professional other provider
- services of a certified registered nurse-anesthetist (CRNA)
- diagnostic x-ray and laboratory procedures
- radiation therapy
- rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by your health plan;
  
  the term "durable medical equipment (DME)" shall not include:
  
  a. equipment primarily designed for alleviation of pain or provision of patient comfort
  b. home air fluidized bed therapy
Examples of non-covered equipment include, but are not limited to:

- a. air conditioners
- b. air purifiers
- c. humidifiers
- d. physical fitness equipment
- e. whirlpool bath equipment

- for emergency care, ground or air ambulance transportation to the nearest hospital appropriately equipped and staffed for treatment of the participant's condition

Non-emergency ground ambulance transportation from one acute care hospital to another acute care hospital for diagnostic or therapeutic services (e.g., MRI, CT scans, acute interventional cardiology, intensive care unit services, etc.) may be considered medically necessary when specific criteria are met. Non-emergency ground ambulance transportation to or from a hospital or medical facility, outside of an acute care hospital setting, may be considered medically necessary when the following criteria are met:

  a. participant's condition is such that trained ambulance attendants are required to monitor the participant's clinical status (e.g., vital signs and oxygenation), or provide treatment such as oxygen, intravenous fluids or medications, to safely transport the participant

  b. the participant is confined to bed and can’t be safely transported by any other means

Non-emergency ground ambulance transportation services provided primarily for the convenience of the participant, the participant's family/caregivers or physician, or the transferring facility are considered not medically necessary.

Non-emergency air ambulance transportation means transportation from a hospital emergency department, health care facility, or Inpatient setting to an equivalent or higher level of acuity facility may be considered medically necessary when the participant requires acute Inpatient care and services are not available at the originating facility and commercial air transport or safe discharge can’t occur. Non-emergency air ambulance transportation services provided primarily for the convenience of the participant, the participant's family/caregivers or physician, or the transferring facility are considered not medically necessary.

Note: Non-emergency ground and air ambulance transportation services are only covered when:

  a. authorized by the PCP or BCBSTX
  b. ambulance transportation is medically necessary
  c. terrain, distance, your physical condition, or other circumstances require the use of air ambulance services rather than ground ambulance services

- anesthetics and its administration, when performed by someone other than the operating physician or professional other provider

- oxygen and its administration provided the oxygen is used

- blood, including cost of blood, blood plasma, and blood plasma expanders, which isn’t replaced by or for the participant

- prosthetic appliances, including replacements necessitated by growth to maturity of the participant

- orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including:
  a. rigid back, leg, or neck braces
  b. casts for treatment of any part of the legs, arms, shoulders, hips, or back
  c. special surgical and back corsets
  d. physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for assisting the function of a joint
• **home infusion therapy**

• **outpatient infusion therapy**

Some outpatient infusion services for routine maintenance drugs have been identified as capable of being safely administered, outside of an outpatient *hospital* setting. The *participants'* out of pocket expenses may be lower when covered services are provided in an infusion suite, a home, or an office instead of a *hospital*. Non-maintenance outpatient infusion therapy services will be covered the same as any other illness. The **SCHEDULE OF COVERAGE** describes payment for infusion services. For the purpose of this section, an infusion suite is an alternative to *hospital* and clinic-based infusion settings where specialty medications can be infused.

• services or supplies used by the *participant* during an outpatient visit to a *hospital*, a *therapeutic center*, or a *substance use disorder treatment center*, or scheduled services in the outpatient treatment room of a *hospital*

• **certain diagnostic procedures**

• **outpatient contraceptive services**, prescription contraceptive devices and specified FDA-approved over-the-counter female contraceptives with a **written prescription** by a Health Care *provider* to women with reproductive capacity as shown in **Benefits for Preventive Care Services**

The *participant* will be responsible for submitting a claim form, written prescription and the itemized receipt for the over-the-counter female contraceptive. Visit the BCBSTX website at www.bcbstx.com/trsactivecare to obtain a claim form.

• **telehealth services and telemedicine medical services**

• foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes

• elective male and female sterilizations

• dietary formula necessary for treatment of phenylketonuria or other heritable diseases; all other enteral formula isn’t covered

• wigs, when hair loss is due to
  a. injury
  b. treatment of a disease
  c. alopecia caused by chemotherapy
  d. fungal infections
  e. lupus
  f. radiation therapy

• private duty nursing

• acupuncture, in lieu of anesthesia or for nausea during pregnancy

**Extended Care Expenses**

Your health plan also provides benefits for *extended care expenses* for you and your covered *dependents*. All *extended care expenses* require previewation. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this benefits booklet for more information.

**Note:** *Extended care expenses* are available when rendered by an *in-network provider*, prescribed or arranged by the PCP and any *preauthorization* requirements are met.
Your benefit obligation as shown on your **SCHEDULE OF COVERAGE** will be:

- at the benefit percentage under "**Extended Care Services**"
- up to the number of days or visits shown for each category of **Extended Care Services** on your **SCHEDULE OF COVERAGE**

All payments made by your health plan will apply toward the benefit visit maximums, if any.

The benefit visit maximums will also include any benefits provided to a **participant** for **extended care expenses** under a **plan** held by the **employer** with BCBSTX immediately prior to the **participant**'s **effective date** of coverage under your health plan.

Any unpaid **extended care expenses** in excess of the benefit visit maximums shown on your **SCHEDULE OF COVERAGE** won't be applied to any **maximum out-of-pocket**.

Any charges incurred as **home health care** or home **hospice care** for drugs (including antibiotic therapy) and laboratory services won't be **extended care expenses** but will be considered **medical-surgical expenses**.

**Services and supplies for extended care expenses:**

- for **skilled nursing facility**:
  a. all usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.)
  b. room and board and all routine services, supplies, and equipment provided by the **skilled nursing facility**
  c. physical, occupational, speech, and respiratory therapy services by licensed therapists

- for **home health care**:
  a. part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.)
  b. part-time or intermittent home health aide services which consist primarily of caring for the patient
  c. physical, occupational, speech, and respiratory therapy services by licensed therapists
  d. supplies and equipment routinely provided by the **home health agency**

Benefits **won't** be provided for **home health care** for the following:

- food or home delivered meals
- social case work or homemaker services
- services provided primarily for custodial care
- transportation services
- home infusion therapy
- durable medical equipment

- for **hospice care**:
  a. home **hospice care**:
     1. part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.)
     2. part-time or intermittent home health aide services which consist primarily of caring for the patient
     3. physical, speech, and respiratory therapy services by licensed therapists
     4. homemaker and counseling services routinely provided by the hospice agency, including bereavement counseling
  b. facility **hospice care**:
     1. all usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.)
     2. room and board and all routine services, supplies, and equipment provided by the hospice facility
     3. physical, speech, and respiratory therapy services by licensed therapists
Special Provisions Expenses

The benefits available under this Special Provisions Expenses subsection are generally determined on the same basis as other inpatient hospital expenses, medical-surgical expenses, and extended care expenses, except to the extent described in each item. Benefits for medically necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require Preauthorization and that any copays, coinsurance, and deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the PREAUTHORIZATION REQUIREMENTS subsection of this benefits booklet for more information.

Note: Special Provisions Expenses are available when rendered by an in-network provider, prescribed or arranged by the PCP and any preauthorization requirements are met.

Benefits for Treatment of Complications of Pregnancy

Benefits for eligible expenses incurred for treatment of complications of pregnancy will be determined on the same basis as treatment for any other sickness and may require preauthorization. Dependent children will be eligible for treatment of complications of pregnancy.

Benefits for Maternity Care

Benefits for eligible expenses incurred for maternity care will be determined on the same basis as for any other treatment of sickness. Dependent children will be eligible for maternity care benefits.

Benefits for eligible expenses for prenatal care will be determined as shown on your SCHEDULE OF COVERAGE. A copay may be required for the initial office visit for maternity care but won’t be required for subsequent visits.

Services and supplies incurred by a participant for delivery of a child shall be considered maternity care and are subject to all provisions of your health plan.

Your health plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery
- 96 hours following an uncomplicated delivery by caesarean section

If the mother or newborn is discharged before the minimum hours of coverage, your health plan provides coverage for Postdelivery Care for the mother and newborn. The Postdelivery Care may be provided at the mother's home, a health care provider's office, or a health care facility.

Postdelivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes:

- parent education
- assistance and training in breast-feeding and bottle feeding
- the performance of any necessary and appropriate clinical tests

Charges for well-baby nursery care, including the initial examination, of a newborn child during the mother's hospital admission for the delivery will be considered inpatient hospital expense of the child and will be subject to the benefit provisions as described under Inpatient Hospital Expenses. Benefits will also be subject to any deductible amounts shown on your SCHEDULE OF COVERAGE.

Note: A separate hospital admission copay/coinsurance and any deductible are not required for a newborn child at time of delivery. If a newborn child is discharged and readmitted to a hospital more than five (5) days after the date of birth, a separate hospital admission copay/coinsurance and any deductibles for such readmission will be required.
**Global Billing**

The services normally provided in uncomplicated maternity cases include antepartum care (care provided prior to delivery), delivery, and postpartum care (care provided after delivery).

| Antepartum care | • the initial and subsequent history  
• physical examination  
• recording of weight  
• blood pressure  
• fetal heart tones  
• routine chemical urinalysis  
• monthly visits up to 28 weeks gestation  
• biweekly visits to 36 weeks gestation  
• weekly visits until delivery |
|-----------------|-------------------------------------------------------------|
| Delivery services | • admission to the hospital  
• admission history and physical examination  
• management of uncomplicated labor  
• vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery |
| Postpartum care | Hospital and office visits following a vaginal or cesarean section delivery |

The following services are not included in global maternity:

- initial office visit
- sonograms and ultrasounds related to OB
- labs
- visits not related to pregnancy
- circumcision
- services billed by a physician other than the delivering/OB physician

**Benefits for Emergency Care and Treatment of Accidental Injury**

Benefits are available for emergency care medical emergencies wherever they occur. Examples of medical emergencies include:

- unusual or excessive bleeding
- broken bones
- acute abdominal or chest pain
- unconsciousness
- convulsions
- difficult breathing
- suspected heart attack
- sudden persistent pain
- severe or multiple injuries or burns
- poisonings

PCPs provide coverage for participants 24 hours a day, 365 days a year. You must notify your PCP within twenty-four (24)-forty-eight (48) hours of receiving emergency care, or as soon as possible without being medically harmful or injurious to you.

BCBSTX will pay for a medical screening examination or other evaluation required by Texas or federal law and provided in the emergency department of a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility that is necessary to determine whether an emergency medical condition exists.
You may obtain emergency care, including the treatment and stabilization of an emergency medical condition that originated in a hospital emergency facility or in a comparable facility from an in-network or out-of-networks and the emergency care will be covered, based upon the signs and symptoms presented at the time of treatment as documented by the attending health care personnel, whether the emergency care services were received within the service area or out-of-area.

Emergency care services are subject to the copay/coinsurance and any deductible; unless you are admitted as an inpatient directly from the emergency room, in which case you pay the inpatient hospital amount. You are not responsible for any amounts beyond the copay/coinsurance and any deductibles shown in the SCHEDULE OF COVERAGE(s).

To obtain post stabilization care that originated in a hospital emergency facility or comparable facility where you have been treated and stabilized, your treating physician or provider must request such care by contacting BCBSTX. BCBSTX must approve or deny coverage of the post stabilization care requested within the time appropriate to the circumstances relating to the delivery of the service and your condition, but in no case may approval or denial exceed one hour of receiving the call. For the purposes of this paragraph, “comparable facility” includes the following:

- any stationary or mobile facility, including, but not limited to, Level V Trauma Facilities and Rural Health Clinics that have licensed or certified or both licensed and certified personnel and equipment to provide Advanced Cardiac Life Support consistent with American Heart Association and American Trauma Society standards of care and a free-standing emergency medical care facility as that term is defined in Insurance Code §843.002 (concerning Definitions);
- for purposes of emergency care related to mental illness, a mental health facility that can provide 24-hour residential and psychiatric services and that is:
  a. a facility operated by the Texas Department of State Health Services
  b. a private mental hospital licensed by the Texas Department of State Health Services
  c. a community center as defined by Texas Health and Safety Code §534.001 (concerning Establishment)
  d. a facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services
  e. an identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the Texas Department of State Health Services
  f. a hospital operated by a federal agency

Regardless of other provisions in this plan to the contrary, for emergency care rendered by providers who are not part of the network of participating providers (non-participating provider) or otherwise contracted with BCBSTX, BCBSTX shall fully reimburse such providers at its usual and customary rate or agreed-upon rate not to exceed billed charges.

This amount is calculated excluding any in-network copay/coinsurance and any deductibles imposed with respect to the participant.

Out-of-area services. Only emergency care services as described above are covered. Continuing or follow-up treatment for accidental injury or emergency care is limited to care required before you can return to the service area without medically harmful or injurious consequences. Emergency care services for out-of-area services are subject to the copay/coinsurance and any deductibles as described in the SCHEDULE OF COVERAGE(s).

Benefits for Urgent Care

Benefits for eligible expenses for urgent care will be determined as shown on your SCHEDULE OF COVERAGE.

Urgent care services are covered when rendered by an urgent care provider for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services won’t endanger life or permanent health and doesn’t require emergency care services.
Urgent care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a hospital emergency room/treatment room or physician's office. The necessary medical care is for a condition that isn’t life-threatening.

Note: A PCP referral isn't required.

Benefits for Retail Health Clinics

Benefits for eligible expenses for retail health clinics will be determined as shown on your SCHEDULE OF COVERAGE. Retail Clinics provide diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional primary care office visit, urgent care visit or emergency care visit.

Benefits for Early Detection Tests for Cardiovascular Disease

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

- computed tomography (CT) scanning measuring coronary artery calcifications
- ultrasonography measuring carotid intima-media thickness and plaque

Tests are available to each covered individual who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Benefits are limited as indicated on your SCHEDULE OF COVERAGE.

Benefits for Speech and Hearing Services

Benefits as shown on your SCHEDULE OF COVERAGE are available for the services of a physician or professional other provider to restore loss of or correct an impaired speech or hearing function. Coverage also includes habilitation and rehabilitation services.

Benefits for Autism Spectrum Disorder won’t apply towards and are not subject to any speech services visits maximum indicated on your SCHEDULE OF COVERAGE.

Any benefit payments made by BCBSTX for hearing aids will apply toward the benefit maximum amount indicated on your SCHEDULE OF COVERAGE.

One cochlear implant, which includes an external speech processor and controller, per impaired ear is covered for dependents to age 19, every three years. Coverage also includes related treatments such as habilitation and rehabilitation services, fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids. Implant components may be replaced as medically necessary or audiologically necessary, every three years.

Covered services and equipment may require preauthorization.

Benefits for Certain Therapies for Children with Developmental Delays

Medical-Surgical Expense benefits are available to a covered dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan.

Such therapies include:

- occupational therapy evaluations and services
- physical therapy evaluations and services
- speech therapy evaluations and services
- dietary or nutritional evaluations

The Individualized Family Service Plan must be submitted to BCBSTX prior to the commencement of services and when the Individualized Family Service Plan is altered.
Once the child reaches the age of three, when services under the *Individualized Family Service Plan* are completed, *eligible expenses*, as otherwise covered under this *plan*, will be available. All contractual provisions of this *plan* will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

*Developmental Delay* means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- cognitive development
- physical development
- communication development
- social or emotional development
- adaptive development

*Individualized Family Service Plan* means an initial and ongoing treatment plan developed and issued by the Interagency Council on Early Childhood Intervention under Chapter 73 of the Human Resources Code for a *dependent* child with Developmental Delays.

*Benefits for Treatment of Autism Spectrum Disorder*

Generally recognized services prescribed in relation to *Autism Spectrum Disorder* by the participant's *physician* or *behavioral health provider* in a treatment plan recommended by that *physician* or *behavioral health provider* are available for a covered *participant*.

- a *health care provider*:
  a. who is licensed, certified, or registered by an appropriate agency of the state of Texas
  b. whose professional credential is recognized and accepted by an appropriate agency of the United States
  c. who is certified as a provider under the TRICARE military health system

- an individual acting under the supervision of a *Health Care provider* described in 1 above

  For purposes of this section, generally recognized services may include services such as:

  a. evaluation and assessment services
  b. screening at 18 and 24 months
  c. applied behavior analysis
  d. behavior training and behavior management
  e. speech therapy
  f. occupational therapy
  g. physical therapy
  h. medications or nutritional supplements used to address symptoms of *Autism Spectrum Disorder*

*Benefits for Autism Spectrum Disorder* won't apply towards any maximum indicated on your *SCHEDULE OF COVERAGE*. Please review the *Benefits for Physical Medicine Services* and *Benefits for Speech and Hearing Services* provisions of this benefits booklet for more specific information about how visit maximums for *physical medicine services* and speech services apply to benefits for *Autism Spectrum Disorder*.

*Preauthorization* will assess whether services meet coverage requirements. Review the *PREAUTHORIZATION REQUIREMENTS* section in this benefits booklet for more specific information about *preauthorization*.

Please see the definition of "*qualified ABA provider*" in the *DEFINITIONS* section of this benefits booklet for more information.
Benefits for Screening Tests for Hearing Impairment

Benefits are available for eligible expenses incurred by a covered dependent child:

- for a screening test for hearing loss from birth through the date the child is 30 days old
- necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months

Deductibles indicated on your SCHEDULE OF COVERAGE won’t apply to this provision.

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

The following eligible expenses described below for cosmetic, reconstructive, or plastic surgery will be the same as for treatment of any other sickness as shown on your SCHEDULE OF COVERAGE.

Note: Benefits for cosmetic, reconstructive, or plastic surgery are available when prescribed or arranged by the PCP and any preauthorization requirements are met.

Covered services include:

- treatment provided for the correction of defects incurred in an accidental injury sustained by the participant
- treatment provided for reconstructive surgery following cancer surgery
- surgery performed on a newborn child for the treatment or correction of a congenital defect
- surgery performed on a covered dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast
- services and supplies for reduction mammoplasty when medically necessary and in accordance with the medical policy guidelines of BCBSTX
- reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy
- reconstructive surgery performed on a covered dependent child due to craniofacial abnormalities to improve the function of or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease

Benefits for Dental Services

Benefits for eligible expenses incurred by a participant will be provided on the same basis as for treatment of any other sickness as shown on your SCHEDULE OF COVERAGE only for the following:

- covered oral surgery (please see the definition of “covered oral surgery” in the DEFINITIONS section of this benefits booklet for more information)
- services provided to a newborn child which are necessary for treatment or correction of a congenital defect
- the correction of damage caused solely by accidental injury, and such injury resulting from domestic violence or a medical condition, to healthy, un-restored natural teeth and supporting tissues

Services must be received within 24 months of the date of the accident. An injury sustained as a result of biting or chewing shall not be considered an accidental injury.

Any other dental services, except as excluded in the MEDICAL LIMITATIONS AND EXCLUSIONS section of this benefits booklet, for which a participant incurs inpatient hospital expenses for a medically necessary inpatient hospital admission, will be determined as described in Benefits for inpatient hospital expenses.

Note: Benefits for Dental Services are available when prescribed or arranged by the PCP and performed in an in-network provider’s office or in the inpatient or outpatient setting.
Benefits for Organ and Tissue Transplants

- Subject to the conditions described below, benefits for covered services and supplies provided to a **participant** by a **hospital, physician, or other provider** related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:
  
a. the transplant procedure isn’t **experimental/investigational** in nature  
b. donated human organs or tissue or an FDA-approved artificial device are used  
c. the recipient is a **participant** under your health plan; and  
d. the transplant procedure is **preauthorized** as required under your health plan  
e. the **participant** meets all the criteria established by BCBSTX in pertinent written medical policies  
f. the participant meets all the protocols established by the **hospital** in which the transplant is performed

Covered services and supplies “related to” an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

- Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered **medically necessary** and meets all the conditions cited above.

Benefits will be available for:

  a. a recipient who is covered under this **plan**  
  b. a donor who is a **participant** under this **plan**  
  c. a donor who isn’t a **participant** under this **plan**

- Covered services and supplies include services and supplies provided for the:
  
a. evaluation of organs or tissues including, but not limited to, the determination of tissue matches  
b. donor search and acceptability testing of potential live donors  
c. removal of organs or tissues from living or deceased donors  
d. transportation and short-term storage of donated organs or tissues

- No benefits are available for a **participant** for the following services or supplies:
  
a. expenses related to maintenance of life of a donor for purposes of organ or tissue donation  
b. living and/or travel expenses of the recipient or a live donor  
c. purchase of the organ or tissue  
d. organs or tissue (xenograft) obtained from another species

- **Preauthorization** is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** subsection in this benefits booklet for more specific information about **preauthorization**.
  
a. Such specific **preauthorization** is required even if the patient is already a patient in a **hospital** under another **preauthorization** authorization.  
b. At the time of **preauthorization**, BCBSTX will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if BCBSTX determines that an extension is **medically necessary**.  

- No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which BCBSTX considers to be **experimental/investigational**.
Benefits for Treatment of Acquired Brain Injury

Benefits for eligible expenses incurred for medically necessary treatment of an acquired brain injury will be determined on the same basis as treatment for any other physical condition. Eligible expenses include the following services as a result of and related to an acquired brain injury:

- cognitive communication therapy - services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information
- cognitive rehabilitation therapy - services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits
- community reintegration services - services that facilitate the continuum of care as an affected individual transitions into the community, including outpatient day treatment or other post-acute care treatment
- neurobehavioral testing - an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior; this may include interviews of the individual, family, or others
- neurobehavioral treatment - interventions that focus on behavior and the variables that control behavior
- neurocognitive rehabilitation - services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques
- neurocognitive therapy - services designed to address neurological deficits in informational processing and to facilitate the development of higher-level cognitive abilities
- neurofeedback therapy - services that utilizes operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood
- neurophysiological testing - an evaluation of the functions of the nervous system
- neurophysiological treatment - interventions that focus on the functions of the nervous system
- neuropsychological testing - the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning
- neuropsychological treatment - interventions designed to improve or minimize deficits in behavioral and cognitive processes
- post-acute transition services - services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration, including outpatient day treatment or other post-acute care treatment; this shall include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under this plan who:
  a. has incurred an acquired brain injury
  b. has been unresponsive to treatment
  c. becomes responsive to treatment later
- psychophysiological testing - an evaluation of the interrelationships between the nervous system and other bodily organs and behavior
- psychophysiological treatment - interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors
- remediation - the process(es) of restoring or improving a specific function

Service means the work of testing, treatment, and providing therapies to an individual with an acquired brain injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

Treatment for an acquired brain injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.
Benefits for acquired brain injury won’t be subject to any visit limit indicated on your SCHEDULE OF
COVERAGE.

Note: Benefits for Treatment of acquired brain injury are available when prescribed or arranged by the
PCP or Specialist and any preauthorization requirements are met.

Benefits for Treatment of Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those
medically necessary items for Diabetes Equipment and Diabetes Supplies (for which a physician or
professional other provider has written an order) and Diabetic Management Services/Diabetes Self-
Management Training. Such items, when obtained for a Qualified participant, shall include but not be
limited to the following:

• diabetes equipment
  a. blood glucose monitors (including noninvasive glucose monitors and monitors for the blind)
  b. insulin pumps (both external and implantable) and associated appurtenances, which include
     (1) insulin infusion devices
     (2) batteries
     (3) skin preparation items
     (4) adhesive supplies
     (5) infusion sets
     (6) insulin cartridges
     (7) durable and disposable devices to assist in the injection of insulin
     (8) other required disposable supplies
  c. podiatric appliances, including up to two pairs of therapeutic footwear per plan year, for the
     prevention of complications associated with diabetes

• diabetes supplies
  a. test strips specified for use with a corresponding blood glucose monitor
  b. visual reading and urine test strips and tablets for glucose, ketones, and protein
  c. lancets and lancet devices
  d. insulin and insulin analog preparations
  e. injection aids, including devices used to assist with insulin injection and needleless systems
  f. biohazard disposable containers
  g. insulin syringes
  h. prescriptive and non-prescriptive oral agents for controlling blood sugar levels
  i. glucagon emergency kits

Note: Diabetic supplies (test strips, lancets, insulin syringes, blood glucose monitors) are covered
under the prescription drug plan.

• Repairs and necessary maintenance of insulin pumps not otherwise provided for under the
  manufacturer’s warranty or purchase agreement, 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, may be covered.

• As new or improved treatment and monitoring equipment or supplies become available and are
  approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be
  covered if determined to be medically necessary and appropriate by the treating physician or
  professional other provider who issues the written order for the supplies or equipment.

• Medical-surgical expense provided for the nutritional, educational, and psychosocial treatment of
  the Qualified participant may be covered. Such Diabetic Management Services/Diabetes Self-
  Management Training for which a physician or professional other provider has written an order to the
  participant or caretaker of the participant is limited to the following when rendered by or under the
direction of a physician.
Initial and follow-up instruction concerning:

a. the physical cause and process of diabetes
b. nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes
c. prevention and treatment of special health problems for the diabetic patient
d. adjustment to lifestyle modifications
e. family involvement in the care and treatment of the diabetic patient; the family will be included in certain sessions of instruction for the patient

Diabetes Self-Management Training for the Qualified participant will include the development of an individualized management plan that is created for and in collaboration with the Qualified participant (and/or their family) to understand the care and management of diabetes, including nutritional counseling and proper use of Diabetes Equipment and Diabetes Supplies.

A Qualified participant means an individual eligible for coverage under this plan who has been diagnosed with:

• insulin dependent or non-insulin dependent diabetes
• elevated blood glucose levels induced by pregnancy
• another medical condition associated with elevated blood glucose levels

Benefits for Physical Medicine Services

Benefits for medical-surgical expenses incurred for physical medicine services are available and will be determined on the same basis as treatment for any other sickness shown on your SCHEDULE OF COVERAGE.

Benefits for Chiropractic Services

Benefits for medical-surgical expenses incurred for chiropractic services are available as shown on your SCHEDULE OF COVERAGE.

However, chiropractic services benefits for all visits won’t be provided for more than the maximum number of visits (outpatient facility and office combined) shown on your SCHEDULE OF COVERAGE. All services billed by a Chiropractor will apply to the maximum number of visits.

Benefits for Routine Patient Costs for Participants in Approved Clinical Trials

Benefits for eligible expenses for Routine Patient Care Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and recognized under state and/or federal law.

Routine Patient Care Costs means the costs of any medically necessary health care service for which benefits are provided under your health plan, without regard to whether the participant is participating in a clinical trial.

Routine Patient Care Costs don’t include:

• the investigational item, device, or service itself
• items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient
• a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

Note: Benefits for Routine Patient Costs for participants in Approved Clinical Trials are available when provided or arranged by the PCP.
Benefits for Certain Tests for Detection of Prostate Cancer

Benefits are available as shown on the SCHEDULE OF COVERAGE for an annual medically recognized diagnostic physical examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male under your health plan who is at least:

- 45 years of age and asymptomatic
- 40 years of age with a family history of prostate cancer or another prostate cancer risk factor

Benefits for Preventive Care Services

Preventive Care Services will be provided for the following covered services:

- evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”)
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved
- evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents
- with respect to women, such additional preventive care and screenings, not described in item a. above, as provided for in comprehensive guidelines supported by the HRSA

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The Preventive Care Services listed in items a. through d. above may change as USPSTF, CDC and HRSA guidelines are modified and will be implemented by BCBSTX in the quantities and at the times required by applicable law or regulatory guidance. For more information, you may access the website at www.bcbstx.com/trsactivecare or contact your Personal Health Guide at 1-866-355-5999.

Examples of covered services included are:

- routine annual physicals
- immunizations
- well-child care
- breastfeeding support services and supplies
- cancer screening mammograms
- bone density test (for women 65+ and men 70+, every two years)
- screening for colorectal cancer
- smoking cessation counseling services (limited to eight visits per plan year)
- smoking intervention (including a screening for tobacco use, counseling and FDA-approved tobacco cessation medications)
- healthy diet counseling and obesity screening/counseling (limited to 26 visits per plan year for participants 22+, up to 10 visits may be used for healthy diet counseling; ages 0-22 years of age covered at 100% of the allowed amount with no maximum)

Examples of covered immunizations included are:

- Diphtheria
- Haemophilus influenzae type b
- Hepatitis B
- Measles
- Mumps
- Pertussis
- Polio
- Rubella
- Tetanus
- Varicella and any other immunization that is required by law for a child
Allergy injections are not considered immunizations under this benefit provision.

Examples of covered services for women with reproductive capacity are:

- female sterilization procedures
- outpatient contraceptive services
- FDA-approved over-the-counter female contraceptives with a written prescription by a health care provider
- specified FDA-approved contraception methods with a written prescription by a Health Care provider provided in this section from the following categories:
  a. progestin-only contraceptives
  b. combination contraceptives
  c. emergency contraceptives
  d. extended cycle/continuous oral contraceptives
  e. cervical caps
  f. diaphragms
  g. implantable contraceptives
  h. intra-uterine devices
  i. injectables
  j. transdermal contraceptives
  k. vaginal contraceptive devices
  l. spermicide
  m. female condoms

To determine if a specific contraceptive drug or device is included in this benefit, refer to the Women's Preventive Health Services - Contraceptive Information page located on the website at www.bcbstx.com/trsactivecare or contact your Personal Health Guide at 1-866-355-5999. The list may change as FDA guidelines are modified.

Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the Women's Preventive Health Services - Contraceptive Information page. You may, however, have coverage under other sections of this benefits booklet, subject to any applicable coinsurance, deductibles, copays and/or benefit maximums.

Preventive Care Services provided by an in-network provider for the items a. through d. above and/or the Women's Preventive Health Services - Contraceptive Information List won't be subject to coinsurance, deductibles, copays and/or dollar maximums.

Covered services not included in items a. through d. above and/or the Women's Preventive Health Services - Contraceptive Information List will be subject to the applicable coinsurance, copays, deductibles and/or applicable dollar maximums.

**Benefits for Breastfeeding Support, Services and Supplies**

Benefits will be provided for breastfeeding counseling and support services when rendered by a provider, during pregnancy and/or in the post-partum period.

Benefits include the rental (or at your health plan's option, the purchase) of manual or electric breast pumps, accessories and supplies. Benefits for electric breast pumps are limited to two per plan year. Limited benefits are also included for the rental only of hospital grade breast pumps, up to the purchase price of $150.

You may be required to pay the full amount and submit a claim form to BCBSTX with a written prescription and the itemized receipt for the manual, electric or hospital grade breast pump, accessories and supplies. Visit the BCBSTX website at www.bcbstx.com/trsactivecare to obtain a claim form.

Contact your Personal Health Guide at 1-866-355-5999 for additional information.
Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for participants 40 years of age and older, as shown in Preventive Care Services on your SCHEDULE OF COVERAGE, except that benefits won’t be available for more than one routine mammography screening each plan year. Coverage for mammography screening for participants under 40 years of age will be based on medical necessity. Low-dose mammography includes digital mammography or breast tomosynthesis.

Benefits for Detection and Prevention of Osteoporosis

If a participant is a Qualified Individual, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a participant’s risk of osteoporosis and fractures associated with osteoporosis, as shown in Preventive Care Services on your SCHEDULE OF COVERAGE.

Qualified Individual means:
- a postmenopausal woman not receiving estrogen replacement therapy
- an individual with:
  - vertebral abnormalities
  - primary hyperparathyroidism
  - a history of bone fractures
- an individual who is:
  - receiving long-term glucocorticoid therapy
  - being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

Benefits for Tests for Detection of Colorectal Cancer

Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for participants who are 50 years of age or older and who are at normal risk for developing colon cancer, include:
- a fecal occult blood test performed once per plan year, and a flexible sigmoidoscopy performed every five years
- a colonoscopy performed every ten years
- Cologuard performed every three years

Benefits will be provided for physician Services, as shown in Preventive Care Services on your SCHEDULE OF COVERAGE.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits are available for certain tests for detection of Human Papillomavirus and Cervical Cancer for each woman enrolled in your health plan who is 18 years of age or older, for an annual medically recognized diagnostic examination for the early detection of cervical cancer, as shown in Preventive Care Services on your SCHEDULE OF COVERAGE.

Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.
- HPV/Cervical Cancer Testing billed in combination with Pap smears for screening woman aged 30 or older are covered once every 3 years. Services are not covered for participants under the age of 30.
- High-risk HPV testing alone for screening women 30 years of age or older covered once every 5 years. Services are not covered for participants under the age of 30.

You must first obtain a referral from your PCP for follow-up services related to the treatment of a disease or condition that isn’t within the scope of an obstetrician/gynecologist. For help in selecting an obstetrician/gynecologist, refer to the provider directory, contact your PCP or call your Personal Health Guide at 1-866-355-5999.
Benefits for Childhood Immunizations

Benefits for medical-surgical expenses incurred by a dependent child for childhood immunizations will be determined at 100% of the allowable amount. Deductibles, copays and coinsurance won’t be applicable, as shown in Preventive Care Services on your SCHEDULE OF COVERAGE.

Benefits are available for:
- Diphtheria
- Haemophilus influenza type b
- Hepatitis B
- Measles
- Mumps
- Pertussis
- Polio
- Rubella
- Tetanus
- Varicella and any other immunization that is required by law for the child

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Morbid Obesity

Benefits for eligible expenses incurred by a participant for the medically necessary treatment of morbid obesity will be provided on the same basis as for any other sickness. Benefits are available for healthy diet counseling and obesity screening/counseling as shown in Preventive Care Services on your SCHEDULE OF COVERAGE.

Benefits for Other Routine Services

Benefits for other routine services are available for the following as indicated on your SCHEDULE OF COVERAGE:
- routine x-rays, routine EKG, routine diagnostic medical procedures
- annual hearing examinations are limited to one per plan year, except for benefits as provided under Benefits for Screening Tests for Hearing Impairment
- annual vision examinations are limited to one per plan year

Behavioral Health Services

Benefits for Mental Health Care, Treatment of Serious Mental Illness and Treatment of Substance Use Disorder

Benefits for eligible expenses incurred for mental health care, treatment of serious mental illness and treatment of substance use disorder will be the same as for treatment of any other sickness. Refer to the PREAUTHORIZATION REQUIREMENTS subsection to determine what services require preauthorization.

Any eligible expenses incurred for the services of a psychiatric day treatment facility, a crisis stabilization unit or facility, a residential treatment center, or a residential treatment center for children and adolescents for medically necessary mental health care or treatment of serious mental illness in lieu of inpatient hospital services will, for the purpose of this benefit, be considered inpatient hospital expenses.

Inpatient treatment of substance use disorder must be provided in a substance use disorder treatment center or hospital. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a hospital will be available on the same basis as for sickness generally as described under Inpatient Hospital Expense.

Mental health care provided as part of the medically necessary treatment of substance use disorder will be considered for benefit purposes to be treatment of substance use disorder until completion of substance use disorder treatments. (Mental health care treatment after completion of substance use disorder treatments will be considered mental health care.)
MEDICAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this benefits booklet are not available for:

- any services or supplies which are not medically necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction

- any experimental/investigational services and supplies

- any portion of a charge for a service or supply that is in excess of the allowable amount as determined by BCBSTX

- any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and during any employment whether benefits are, or could upon proper claim be, provided under the Workers’ Compensation law

- any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, provided, however, that this exclusion shall not be applicable to any coverage held by the participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy

- any services or supplies for which a participant isn’t required to make payment or for which a participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas

- any services or supplies provided by a person who is related to the participant by blood or marriage

- any services or supplies provided for injuries sustained:
  a. as a result of war, declared or undeclared, or any act of war
  b. while on active or reserve duty in the armed forces of any country or international authority

- any charges:
  a. resulting from the failure to keep a scheduled visit with a physician or professional other provider
  b. for completion of any insurance forms
  c. for acquisition of medical records

- room and board charges incurred during a hospital admission for diagnostic or evaluation procedures that could have been performed on an outpatient basis without adversely affecting the participant's physical condition or the quality of medical care provided

- any services or supplies provided before the patient is covered as a participant hereunder or any services or supplies provided after the termination of the participant's coverage

- any services or supplies provided for dietary and nutritional services, except as may be provided under your health plan for:
  a. Preventive Care Services as shown on your SCHEDULE OF COVERAGE
  b. inpatient nutritional assessment program provided in and by a hospital and approved by BCBSTX
  c. Benefits for Autism Spectrum Disorder as described in Special Provisions Expenses
  d. Benefits for Treatment of Diabetes as described in Special Provisions Expenses
  e. Benefits for Certain Therapies for Children with Developmental Delays as described in Special Provisions Expenses
• any services or supplies provided for custodial care

• any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles

• any items of medical-surgical expenses incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in the Benefits for Dental Services provision in the Special Provisions Expenses portion of this benefits booklet

• any services or supplies provided for cosmetic, reconstructive, or plastic surgery, except as provided for in the Benefits for Cosmetic, Reconstructive, or Plastic Surgery provision in the Special Provisions Expenses portion of this benefits booklet

• any services or supplies provided for:
  a. treatment of myopia and other errors of refraction, including refractive surgery
  b. orthoptics or visual training
  c. eyeglasses or contact lenses, except for intraocular lenses when medically necessary
  d. examinations for the prescription or fitting of eyeglasses or contact lenses
  e. restoration of loss or correction to an impaired speech or hearing function, except as may be provided under the Benefits for Speech and Hearing Services and Benefits for Autism Spectrum Disorder provisions in the Special Provisions Expenses portion of this benefits booklet

• any occupational therapy services which don’t consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the Benefits for Physical Medicine Services and Benefits for Autism Spectrum Disorder provision in the Special Provisions Expenses portion of this benefits booklet

• travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a physician or professional other provider

• any services or supplies provided primarily for:
  a. environmental sensitivity
  b. clinical ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists
  c. inpatient allergy testing or treatment.

• any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning

• any services or supplies provided for, in preparation for, or in conjunction with:
  a. sterilization reversal (male or female)
  b. gender reassignment surgery
  c. sexual dysfunctions
  d. in vitro fertilization
  e. promotion of fertility through extra-coital reproductive technologies including, but not limited to:
    (1) artificial insemination
    (2) intrauterine insemination
    (3) super ovulation uterine capacitation enhancement
    (4) direct intra-peritoneal insemination
    (5) trans-uterine tubal insemination
    (6) gamete intra-fallopian transfer
(8) pronuclear oocyte stage transfer  
(9) zygote intra-fallopian transfer  
(10) tubal embryo transfer

- any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease

- any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain

- any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations

- except for prescription and over-the-counter medications for tobacco cessation and tobacco cessation counseling covered in this plan, supplies for smoking cessation programs and the treatment of nicotine addiction are excluded

- any services or supplies in connection with alternative treatments such as:
  a. acupressure
  b. hypnotism
  c. massage therapy
  d. aroma therapy

- any services or supplies provided for the following treatment modalities:
  a. intersegmental traction
  b. surface EMGs
  c. spinal manipulation under anesthesia
  d. muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron

- any items that include, but are not limited to:
  a. an orthodontic or other dental appliance
  b. splints or bandages provided by a physician in a non-hospital setting or purchased “over-the-counter” for support of strains and sprains
  c. orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes
  d. cast shoes
  e. shoe inserts designed to support the arch or affect changes in the foot or foot alignment
  f. arch supports
  g. elastic stockings
  h. garter belts

**NOTE:** This exclusion doesn’t apply to podiatric appliances when provided as diabetic equipment.

- disposable or consumable outpatient supplies, such as:
  a. syringes
  b. needles
  c. blood or urine testing supplies (except as used in the treatment of diabetes)
  d. sheaths
  e. bags
  f. elastic garments
  g. stockings and bandages
  h. garter belts
  i. ostomy bags

- any benefits in excess of any specified dollar, day/visit, or plan year maximums
• any services and supplies provided to a participant incurred outside the United States if the participant traveled to the location for the purposes of receiving medical services, supplies, or drugs

• replacement prosthetic appliances when it is necessitated by misuse or loss by the participant

• any outpatient prescription or non-prescription drugs (except for contraceptive drugs with a written prescription by a health care provider provided under the COVERED MEDICAL SERVICES portion of this plan as shown in Benefits for Preventive Care Services)

• any non-prescription contraceptive medications or devices for biological male use

• self-administered drugs dispensed or administered by a physician in their office

• any drugs and medicines purchased for use outside a hospital which require a written prescription for purchase other than injectable drugs not approved by the FDA for self-administration that are administered by or under the direct supervision of a physician or professional other provider

• any non-surgical services or supplies provided for reduction of obesity or weight, even if the participant has other health conditions which might be helped by a reduction of obesity or weight

• biofeedback (except for an acquired brain injury diagnosis) or other behavior modification services

• any related services to a non-covered service

  Related services are:
  a. services in preparation for the non-covered service
  b. services in connection with providing the non-covered service
  c. hospitalization required to perform the non-covered service
  d. services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery

• any services or supplies from more than one provider on the same day(s) to the extent benefits were duplicated

• behavioral health services provided at the following:
  a. behavioral modification facilities
  b. boot camps
  c. emotional group academies
  d. military schools
  e. therapeutic boarding schools
  f. wilderness programs
  g. halfway houses and group homes, except for Covered Services provided by appropriate providers as described in this benefits booklet

• any of the following applied behavior analysis (ABA) services:
  a. services with a primary diagnosis that isn’t Autism Spectrum Disorder
  b. services that are facilitated by a provider that isn’t properly credentialed (please see the definition of qualified ABA provider in the DEFINITIONS section of this benefits booklet)
  c. activities primarily of an educational nature
  d. respite, shadow, or companion services
  e. any other services not provided by an appropriately licensed provider in accordance with nationally accepted treatment standards

• special medical reports not directly related to treatment
• examinations, testing, vaccinations or other services required by:
  a. employers
  b. insurers
  c. schools
  d. camps
  e. courts
  f. licensing authorities
  g. other third parties
  h. for personal travel

• benefits for which you are eligible through entitlement programs of the federal, state, or local government, including but not limited to Medicare, Medicaid or their successors

• care for conditions that federal, state or local law requires to be treated in a public facility

• appearances at court hearings and other legal proceedings, and any services relating to judicial or administrative proceedings or conducted as part of medical research

• any services, supplies or drug received by a participant outside of the United States, except for emergency care

• transportation services except as described in ambulance services, or when approved by BCBSTX

• personal or comfort items, including but not limited to televisions, telephones, guest beds, admission kits, maternity kits and newborn kits provided by a hospital or other inpatient facility

• private rooms unless medically necessary and authorized by BCBSTX
  
  If a semi-private room isn’t available, BCBSTX covers a private room until a semi-private room is available.

• services or supplies furnished by an institution that is primarily a place of rest, a place for the aged or any similar institution

• inpatient mental health services that are provided:
  a. by an out-of-network provider or out-of-network mental health treatment facility, crisis stabilization unit or residential treatment center for children and adolescents, although in-network providers may refer participants to providers not in the network for covered services not available from in-network providers as outlined in HOW THE PLAN WORKS
  
  b. for the following diagnosed conditions:
     (1) Alzheimer's disease
     (2) intractable personality disorders
     (3) mental retardation
     (4) educational testing or any other testing required by school system
     (5) psychiatric therapy on court order or as a condition of parole or probation
     (6) chronic organic brain syndrome

• deluxe equipment such as:
  a. motor driven wheelchairs and beds (unless determined to be medically necessary)
  b. comfort items
  c. bed boards
  d. bathtub lifts
  e. over-bed tables
  f. air purifiers
  g. sauna baths
h. exercise equipment
i. stethoscopes and sphygmomanometers
j. experimental and/or research items
k. replacement, repairs or maintenance of the DME

- hearing aid repair and batteries
- any services or supplies not specifically defined as eligible expenses in this plan
DEFINITIONS

The definitions used in this benefits booklet apply to all coverage unless otherwise indicated.

**Accidental Injury** means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a physician or professional other provider.

**Acquired Brain Injury** means a neurological insult to the brain, which isn’t hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

**Advanced Practice Nurse (APN)** means a registered nurse approved by the Texas Board of Nursing to practice as an advanced practice nurse based on completing an advanced educational program acceptable to the Board. The term includes a nurse practitioner, nurse-midwife, nurse anesthetist, and a clinical nurse specialist. An Advance Practice Nurse is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings including but not limited to homes, hospitals, institutions, offices, industry, schools, community agencies, public and private clinics, and private practice. An Advance Practice nurse acts independently and/or in collaboration with other Health Care Professionals in the delivery of health care services.

**Allowable Amount** means the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular service, supply or procedure rendered by an in-network provider. The allowable amount is based on the provisions of the in-network provider contract and the payment methodology in effect on the date of service, whether diagnostic related grouping (DRG), capitation, relative value, fee schedule, per diem or other.

**Annual Enrollment Period** means the designated period by the group preceding the next plan anniversary date during which participants may enroll for coverage.

**Autism Spectrum Disorder (ASD)** means a neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder--not otherwise specified. A neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

**Behavioral Health Provider** means a physician or professional other provider who renders services for mental health care, serious mental illness or substance use disorder, only as listed in this benefits booklet.

**Care Coordination** means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's health care needs across the continuum of care.

**Care Coordinator Fee** means a fixed amount paid by a Blue Cross and/or Blue Shield Plan to providers periodically for Care Coordination under a Value-Based Program.

**Certain Diagnostic Procedures** means:

- bone scan
- cardiac stress test
- CT scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- myelogram
- PET scan (Positron Emission Tomography)
**Chiropractic Services** means any of the following services, supplies or treatment provided by or under the direction of a Doctor of Chiropractic acting within the scope of their license: general office services, general services provided in an outpatient facility setting, x-rays, supplies, and physical treatment. Physical treatment includes functional occupational therapy, physical therapy, mechanotherapy, muscle manipulation therapy and hydrotherapy.

**Claim Administrator** means Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation. BCBSTX assumed only the authority and discretion as given by the employer to interpret the plan provisions and benefit determinations.

**Clinical Ecology** means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:
- cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells)
- urine auto injection (injecting one's own urine into the tissue of the body)
- skin irritation by Rinker method
- subcutaneous provocative and neutralization testing (injecting the patient with allergen)
- sublingual provocative testing (droplets of allergenic extracts are placed in mouth)

**Coinsurance** means the percentage of the participant's share for eligible expenses for services and supplies, after the deductible has been met. It is usually a percentage of the allowable amount.

**Complications of Pregnancy** means:
- conditions (when the pregnancy isn't terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as:
  a. acute nephritis
  b. nephrosis
  c. cardiac decompensation
  d. missed abortion
  e. similar medical and surgical conditions of comparable severity, but *shall not include*:
    1. false labor
    2. occasional spotting
    3. physician-prescribed rest during the period of pregnancy
    4. morning sickness
    5. hyperemesis gravidarum
    6. pre-eclampsia
    7. similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy
- non-elective cesarean section
- termination of ectopic pregnancy
- spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth isn't possible.

**Contracting Facility** means a hospital, a facility other provider, or any other facility or institution with which BCBSTX has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under your health plan.

**Contract Month** means the period of each succeeding month beginning on the Administrative Services Agreement date.

**Controlled Substance** means an abusable volatile chemical as defined in the Texas Health and Safety Code, or a substance designated as a *controlled substance* in the Texas Health and Safety Code.
Copay means the dollar amount required to be paid by or on behalf of a participant for certain services at the time they are provided.

**Cosmetic, Reconstructive, or Plastic Surgery** means surgery that:

- can be expected or is intended to improve the physical appearance of a participant
- is performed for psychological purposes
- restores form but doesn’t correct or materially restore a bodily function

**Covered Oral Surgery** means maxillofacial surgical procedures limited to:

- excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths
- surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology
- incision and drainage of facial abscess
- surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses

**Crisis Stabilization Unit or Facility** means an institution which is appropriately licensed and accredited as a crisis stabilization unit or facility for the provision of mental health care and serious mental illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

**Custodial Care** means any service primarily for personal comfort for convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial care services also means those services which don’t require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed.

These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

**Deductible** means the dollar amount of eligible expenses that must be incurred by a participant before benefits under your health plan will be available.

**Dependent** means your spouse as defined by applicable law or any child covered under your health plan who is:

- under the dependent child limiting age shown on your schedule of coverage
- a child of any age who is medically certified as disabled and dependent on the parent for support and maintenance (provided they were covered prior to reaching the dependent limiting age)

**Child** means:

- your natural child
- your legally adopted child, including a child for whom the participant is a party in a suit in which the adoption of the child is sought
- your stepchild
- an eligible foster child
- a child of your child who is your dependent for federal income tax purposes at the time application of coverage of the child of your child is made
f. a child not listed above:
   (1) whose primary residence is your household
   (2) to whom you are legal guardian or related by blood or marriage
   (3) who is dependent upon you for more than one-half of their support as defined by the Internal Revenue Code of the United States

For purposes of this plan, the term dependent will also include those individuals who no longer meet the definition of a dependent but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Dietary and Nutritional Services means the education, counseling, or training of a participant (including printed material) regarding:

- diet
- regulation or management of diet
- the assessment or management of nutrition

Durable Medical Equipment (DME) means equipment that can withstand repeated use, is primarily and usually used to serve a medical purpose, is generally not useful to a person in absence of illness or injury and is appropriate for use in the home.

Durable Medical Equipment Provider means a provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Health Care Organizations.

Effective Date means the date the coverage for a participant actually begins. It may be different from the eligibility date.

Eligibility Date means the date the participant is eligible for coverage under your health plan as described in the WHO GETS BENEFITS section of this benefits booklet.

Eligible Expenses mean inpatient hospital expenses, medical-surgical expenses, extended care expenses, and Special Provisions Expenses as described in this benefits booklet.

Emergency Care means health care services provided in a hospital emergency facility (emergency room), freestanding emergency medical care facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the patient's health in serious jeopardy
- serious impairment of bodily functions
- serious dysfunction of any bodily organ or part
- serious disfigurement
- in the case of a pregnant woman, serious jeopardy to the health of the fetus

Employer means Texas public school districts that participate in the Teacher Retirement System of Texas (TRS).

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

- controlled environment
- sanitizing the surroundings, removal of toxic materials
- use of special non-organic, non-repetitive diet techniques
**Experimental/Investigational** means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated and any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

*Approval* by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. Approval by a federal agency will be taken into consideration by BCBSTX in assessing *experimental/investigational* status but won’t be determinative.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

*Standard medical treatment* means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated
- are appropriate for the *hospital or facility other provider* in which they were performed
- the *physician or professional other provider* has had the appropriate training and experience to provide the treatment or procedure

BCBSTX for your health plan shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is *experimental/investigational*, and will consider factors such as the guidelines and practices of Medicare, Medicaid, or other government-financed programs and approval by a federal agency in making its determination. BCBSTX may make determinations based upon clinical data that support that the medical procedure or item improves net health outcomes based on peer-reviewed scientific studies.

Although a *physician or professional other provider* may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, BCBSTX may still determine such services or supplies to be *experimental/investigational* within this definition. Treatment provided as part of a clinical trial or a research study is *experimental/investigational*.

**Extended Care Expenses** means the *allowable amount* of charges incurred for those *medically necessary* services and supplies provided by a *skilled nursing facility*, a *home health agency*, or a *hospice* as described in the *Extended Care Expenses* portion of this benefits booklet.

**Fixed-Wing Air Ambulance** means a specially equipped airplane used for ambulance transport.

**Group** means the Teacher Retirement System of Texas (TRS) that has entered into an Administrative Services Agreement with BCBSTX under which BCBSTX will provide for or arrange health services for eligible *participants* of the group who enroll.

**Health Care Provider** means an Advanced Practice Nurse, Doctor of Medicine, Doctor of Dentistry, Physician Assistant, Doctor of Osteopathy, Doctor of Podiatry, or other licensed person with prescription authority.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996.

**Home Health Agency** means a business that provides *home health care* and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of *home health care*.

**Home Health Care** means the health care services for which benefits are provided under your health plan when such services are provided during a visit by a *home health agency* to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.
**Home Infusion Therapy** means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. *Home infusion therapy* shall include:

- drugs and iv solutions
- pharmacy compounding and dispensing services
- all equipment and ancillary supplies necessitated by the defined therapy
- delivery services
- patient and family education
- nursing services

Over-the-counter products which don’t require a physician's or professional other provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

**Home Infusion Therapy Provider** means an entity that is duly licensed by the appropriate state agency to provide *home infusion therapy*.

**Hospice** means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

- licensed in accordance with state law (where the state law provides for such licensing)
- certified by Medicare as a supplier of hospice care

**Hospice Care** means services for which benefits are provided under your health plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

**Hospital** means a short-term acute care facility which:

- is duly licensed as a *hospital* by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Health Care Organizations or is certified as a *hospital provider* under Medicare
- is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons under the supervision of physicians or behavioral health providers for compensation from its patients
- has organized departments of medicine and major surgery, either on its premises or in facilities available to the *hospital* on a contractual prearranged basis, and maintains clinical records on all patients
- provides 24-hour nursing services under the supervision of a Registered Nurse
- has in effect a *hospital* Utilization Review Plan

**Hospital Admission** means the period between the time of a participant's entry into a *hospital* or a *substance use disorder treatment center* as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting physician, behavioral health provider or professional other provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a *hospital admission*.

*Bed patient* means confinement in a bed accommodation of a *substance use disorder treatment center* on a 24-hour basis or in a bed accommodation located in a portion of a *hospital* which is designed, staffed, and operated to provide acute, short-term hospital care on a 24-hour basis; the term doesn’t include confinement in a portion of the *hospital* (other than a *substance use disorder treatment center*) designed, staffed, and operated to provide long-term institutional care on a residential basis.
Identification Card (ID Card) means the card issued to the participant by BCBSTX of your health plan indicating pertinent information applicable to their coverage.

Imaging Center means a provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Department of State Health Services Certificate of Equipment Registration and/or Department of State Health Services Radioactive Materials License.

Independent Laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

Infertility means the condition of a presumably healthy participant who is unable to conceive after a period of one year of frequent, unprotected heterosexual intercourse. This doesn't include conditions for male participants when the cause is a vasectomy or orchiectomy or for female participants when the cause is a tubal ligation or hysterectomy.

Infusion Suite means a place of treatment that is an alternative to hospital and clinic-based infusion settings where specialty medications can be infused.

Infusion Therapy means the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it can't be treated effectively by oral medications. Typically, "infusion therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion therapy in most cases requires health care professional services for the safe and effective administration of the medication.

In-Network Benefits means the benefits available under your health plan for services and supplies that are provided by an in-network provider or, if applicable, an out-of-network provider when acknowledged by BCBSTX.

In-Network Provider means a hospital, physician, behavioral health provider, or other provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care provider.

Inpatient Hospital Expense means the allowable amount incurred for the medically necessary items of service or supply listed below for the care of a participant, provided that such items are:

- at the direction or prescription of a physician, behavioral health provider or professional other provider
- provided by a hospital or a substance use disorder treatment center
- prescribed to and used by the participant during an inpatient hospital admission

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made. Inpatient hospital expense shall include:

- room accommodation charges; if the participant is in a private room, the amount of the room charge in excess of the hospital's average semiprivate room charge isn't an eligible expense
- all other usual hospital services, including drugs and medications, which are medically necessary and consistent with the condition of the participant; personal items are not an eligible expense

Medically necessary mental health care or treatment of serious mental illness in a psychiatric day treatment facility, a crisis stabilization unit or facility, residential treatment center, or a residential treatment center for children and adolescents, in lieu of hospitalization, shall be inpatient hospital expense.

Intensive Outpatient Program means a freestanding or hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or specializes in the treatment of co-occurring mental illness with drug addiction, substance abuse or alcoholism.
These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that the participants will benefit from programs that focus solely on mental illness conditions.

**Life-Threatening Disease or Condition** means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

**Limited Provider Network** means a subnetwork within a delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations and/or physician groups which limit Your access to only the physicians and providers in the subnetwork.

**Marriage and Family Therapy** means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

**Maternity Care** means care and services provided for treatment of the condition of pregnancy, other than complications of pregnancy.

**Maximum Out-of-Pocket** means the cumulative dollar amount of eligible expenses, including the plan year deductible, incurred by the participant during a plan year.

**Medical-Surgical Expenses** means the allowable amount for those charges incurred for the medically necessary items of service or supply listed below for the care of a participant, provided such items are:

- at the direction or prescription of a physician, behavioral health provider or professional other provider
- not included as an item of inpatient hospital expense or Extended Care Expense in your health plan

A service or supply is prescribed at the direction of a physician, behavioral health provider or professional other provider if the listed service or supply is:

- provided by a person employed by the directing physician, behavioral health provider or professional other provider
- provided at the usual place of business of the directing physician, behavioral health provider or professional other provider
- billed to the patient by the directing physician, behavioral health provider or professional other provider

An expense shall have been incurred on the date of provision of the service for which the charge is made.

**Medically Necessary** or **Medical Necessity** means those services or supplies covered under your health plan which are:

- essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction
- provided in accordance with and are consistent with generally accepted standards of medical practice in the United States
- not primarily for the convenience of the participant, their physician, behavioral health provider, the hospital, or the other provider
- the most economical supplies or levels of service that are appropriate for the safe and effective treatment of the participant

When applied to hospitalization, this further means that the participant requires acute care as a bed patient due to the nature of the services provided or the participant's condition, and the participant can't receive safe or adequate care as an outpatient. BCBSTX doesn't determine course of
treatment or whether particular health care services are received. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between the participant, their physician, behavioral health provider, the hospital, or the other provider.

The medical staff of BCBSTX shall determine whether a service or supply is medically necessary under your health plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a physician, behavioral health provider or professional other provider may have prescribed treatment, such treatment may not be medically necessary within this definition.

Medicare means Title XVIII of the Social Security Act and all amendments thereto.

Mental Health Care means any one or more of the following:

- the diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system as used by BCBSTX, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin
- the diagnosis or treatment of any symptom, condition, disease, or disorder by a physician, behavioral health provider or professional other provider (or by any person working under the direction or supervision of a physician, behavioral health provider or professional other provider) when the eligible expense is:
  - a. individual, group, family, or conjoint psychotherapy
  - b. counseling
  - c. psychoanalysis
  - d. psychological testing and assessment
  - e. the administration or monitoring of psychotropic drugs
  - f. hospital visits (if applicable) or consultations in a facility listed in subsection 5, below
- electroconvulsive treatment
- psychotropic drugs
- any of the services listed in subsections 1 through 4, above, performed in or by a hospital, facility other provider, or other licensed facility or unit providing such care

Morbid Obesity means a Body Mass Index (BMI) of greater than or equal to 40 kg/meter$^2$ or a BMI greater than or equal to 35 kg/meters$^2$ with at least two of the following co-morbid conditions which have not responded to a maximum medical management and which are generally expected to be reversed or improved by bariatric treatment:

- hypertension
- dyslipidemia
- type 2 diabetes
- coronary heart disease
- sleep apnea

Negotiated National Account Arrangement means an agreement negotiated between one or more Blue Cross and/or Blue Shield Plans for any national account that isn’t delivered through the BlueCard Program.

Network means identified physicians, behavioral health provider, professional other providers, hospitals, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement.
Neuropsychological Testing means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Non-Contracting Facility means a hospital, a facility other provider, or any other facility or institution which hasn't executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by your health plan. Any hospital, facility other provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a Non-contracting facility.

Other Provider means a person or entity, other than a hospital or physician, that is licensed where required to furnish to a participant an item of service or supply described herein as eligible expenses. Other provider shall include:

- **Facility other provider** - an institution or entity, only as listed:
  a. substance use disorder treatment center
  b. crisis stabilization unit or facility
  c. durable medical equipment provider
  d. home health agency
  e. home infusion therapy provider
  f. hospice
  g. imaging center
  h. independent laboratory
  i. prosthetics/orthotics provider
  j. psychiatric day treatment facility
  k. renal dialysis center
  l. residential treatment center for children and adolescents
  m. skilled nursing facility
  n. therapeutic center

- **Professional other provider** - a person or provider, when acting within the scope of their license and who is appropriately certified, only as listed:
  a. Advanced Practice Nurse (APN)
  b. Christian science practitioner
  c. Doctor of Chiropractic
  d. Doctor of Dentistry
  e. Doctor of Optometry
  f. Doctor of Podiatry
  g. Doctor in Psychology
  h. licensed acupuncturist
  i. Licensed Audiologist
  j. Licensed substance use disorder Counselor
  k. Licensed Dietitian
  l. Licensed Hearing Instrument Fitter and Dispenser
  m. Licensed Marriage and Family Therapist
  n. Licensed Clinical Social Worker
  o. Licensed Occupational Therapist
  p. Licensed Physical Therapist
  q. Licensed Professional Counselor
  r. Licensed Speech-Language Pathologist
  s. Licensed Surgical Assistant
  t. Midwife
  u. Nurse First Assistant
  v. Physician Assistant
  w. Psychological Associates who work under the supervision of a Doctor in Psychology
In states where there is a licensure requirement, other providers must be licensed by the appropriate state administrative agency.

**Out-of-Area** means not within the service area.

**Out-of-Network Benefits** means the benefits available under your health plan for services and supplies that are provided by an out-of-network provider.

**Out-of-Network Provider** means a hospital, physician, behavioral health provider, or other provider who hasn’t entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care provider.

**Outpatient Contraceptive Services** means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

**ParPlan** means a program open to physicians, behavioral health practitioners, professional other providers, hospitals, and other facilities that have entered into agreements with BCBSTX to accept allowable amount (paid directly to them) and won’t bill participants over the allowable amount.

**Participant** means an employee, spouse or dependent whose coverage has become effective under this plan.

**Physical Medicine Services** means those modalities, procedures, tests, and measurements listed in the Physicians’ Current Procedural Terminology, whether the service or supply is provided by a physician or professional other provider, and includes, but isn’t limited to:

- physical therapy
- occupational therapy
- hot or cold packs
- whirlpool
- diathermy
- electrical stimulation
- massage
- ultrasound
- manipulation
- muscle or strength testing
- orthotics or prosthetic training

**Physician** means a person, when acting within the scope of their license, who is a Doctor of Medicine or Doctor of Osteopathy.

**Plan** means the self-insured group health plan established for the benefit of its participants whether the plan is subject to the rules and regulations of the Employee's Retirement and Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

**Plan Anniversary Date** means the day, month, and year of the 12-month period following the plan effective date and corresponding date in each year thereafter for as long as this benefits booklet is in force.

**Plan Effective Date** means the date on which coverage for the employer's plan begins with BCBSTX.

**Plan Month** means each succeeding calendar month period, beginning on the plan effective date.

**Plan Service Area** means the geographical area(s) or areas in which a network of providers is offered and available and is used to determine eligibility for health care plan benefits.
**Plan Sponsor** means the Teacher Retirement System of Texas as trustee of the Texas Public School Employees Group Benefits Program.

**Plan Year** means the period for TRS-ActiveCare that begins Sept. 1 and ends Aug. 31 each year.

**Preauthorization** means the process that determines in advance the medical necessity or experimental/investigational nature of certain care and services under this plan.

**Primary Care Copay** means the payment, as expressed in dollars, that must be made by or on behalf of a participant for each office visit charge you incur when services are rendered by a family provider, an obstetrician/gynecologist, a pediatrician, behavioral health provider, an internist, and a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians.

**Primary Care Provider (PCP)** means the in-network physician, Physician Assistant (PA) or Advanced Practice Nurse (APN) who is primarily responsible for providing, arranging and coordinating all aspects of your health care. You and your dependents must each select a PCP from those listed by BCBSTX to provide primary care services. You may choose a PCP who is a family practitioner, internist, pediatrician and/or obstetrician/gynecologist. The PA or APN must work under the supervision of an in-network family practitioner, internist, pediatrician and/or obstetrician/gynecologist in the same network.

**Proof of Loss** means written evidence of a claim including:

- the form on which the claim is made
- bills and statements reflecting services and items furnished to a participant and amounts charged for those services and items that are covered by the claim
- correct diagnosis code(s) and procedure code(s) for the services and items

**Prosthetic Appliances** means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece isn’t considered a Prosthetic Appliance.

**Prosthetics/Orthotics Provider** means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

**Provider** means a hospital, physician, behavioral health provider, other provider, or any other person, company, or institution furnishing to a participant an item of service or supply listed as eligible expenses.

**Provider Incentive** means an additional amount of compensation paid to a health care provider by a Blue Cross and/or Blue Shield Plan, based on the provider’s compliance with agreed upon procedural and/or outcome measures for a particular population of covered persons.

**Psychiatric Day Treatment Facility** means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Health Care Organizations as a psychiatric day treatment facility for the provision of mental health care and serious mental illness services to participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a psychiatric day treatment facility must be certified in writing by the attending physician or behavioral health provider to be in lieu of hospitalization.

**Qualified ABA Provider** means a provider operating within the scope of their license or certification that has met the following requirements:

For the treatment supervisor/case manager/facilitator:
- health care provider, independently licensed clinician, who is licensed, certified, or registered by an appropriate agency in the state where services are being provided
• health care provider whose professional credential is recognized and accepted by an appropriate agency of the United States, (i.e. Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst - Doctoral (BCBS-D))
• health care provider who is certified as a provider under the TRICARE military health system

For the para-professional/line therapist:
• two years of college educated staff person with a Board Certified Assistant Behavior Analyst (BCaBA) for the para-professional/therapist
• a staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist effective as of January 1, 2019

Reconstructive Surgery for Craniofacial Abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Referral means specific directions or instructions from your PCP, in conformance with BCBSTX policies and procedures that direct you to an in-network provider for medically necessary care.

Renal Dialysis Center means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

Research Institution means an institution or provider (person or entity) conducting a phase I, phase II, phase III, or phase IV clinical trial.

Residential Treatment Center means a facility setting (including a residential treatment center for children and adolescents) offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It doesn’t include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and 24-hour onsite nursing service for mental health care and/or for treatment of substance use disorder. BCBSTX requires that any facility providing mental health care, and/or a substance use disorder treatment center must be licensed in the state where it is located or accredited by a national organization that is recognized by BCBSTX as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Health Care Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of mental health care and serious mental illness services for emotionally disturbed children and adolescents.

Retail Health Clinic means a clinic located in retail stores, typically staffed by Advanced Practice Nurses or Physician Assistants, that provide treatment for uncomplicated minor illnesses.

Serious Mental Illness means the following psychiatric illnesses defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):
• bipolar disorders (hypomanic, manic, depressive, and mixed)
• depression in childhood and adolescence
• major depressive disorders (single episode or recurrent)
• obsessive-compulsive disorders
• paranoid and other psychotic disorders;
• schizo-affective disorders (bipolar or depressive)
• schizophrenia
Service Area means the geographical area served by BCBSTX and approved by state regulatory authorities. The service area includes the statewide network covering all 254 counties.

Skilled Nursing Facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

- licensed in accordance with state law (where the state law provides for licensing of such facility)
- Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care

Specialty Care Provider means a physician or professional other provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care provider of specialty services with the exception of a family practitioner, obstetrician/gynecologist, pediatrician, behavioral health provider, an internist or a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these.

Specialty Copay means the payment, as expressed in dollars, that must be made by or on behalf of a participant for each office visit charge you incur when services are rendered by a specialty care provider.

Subscriber means a person who meets all applicable eligibility and enrollment requirements of this plan, and whose enrollment application and contributions have been received by BCBSTX.

Substance Use Disorder means the abuse of or psychological or physical dependence on or addiction to alcohol or a Controlled Substance.

Substance Use Disorder Treatment Center means a facility which provides a program for the treatment of substance use disorder pursuant to a written treatment plan approved and monitored by a behavioral health provider and which facility is also:

- affiliated with a hospital under a contractual agreement with an established system for patient referral
- accredited as such a facility by the Joint Commission on Accreditation of Health Care Organizations
- licensed as a substance use disorder treatment program by the Texas Commission on Alcohol and Drug Abuse
- licensed, certified, or approved as a substance use disorder treatment program or center by any other state agency having legal authority to so license, certify, or approve

Telehealth Service means a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health care professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Service means a health service delivered by a physician licensed in Texas, or a health professional acting under the delegation and supervision of a physician licensed in Texas and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located, and which is:

- an ambulatory (day) surgery facility
- a freestanding radiation therapy center
- a freestanding birthing center

Urgent Care means medical or health care services provided in a situation other than an emergency that are typically provided in a setting such as an urgent care provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, illness, or injury is of
such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of the person's health.

**Value-Based Program** means an outcome based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

**Waiting Period** means a period established by an *employer* that must pass before an individual who is a potential enrollee in a *plan* is eligible to be covered for benefits.
GENERAL PROVISION

Agent

The *employer* isn't the agent of BCBSTX.

Amendments

The *plan* may be amended or changed at any time by agreement between the *group (TRS)* and BCBSTX.

The Claim Administrator's Ownership Interests

BCBSTX or its subsidiaries or affiliates may have ownership interests in certain *providers* who provide covered services to *participants*, and/or vendors or other third parties who provide covered services related to the benefits and requirements of this *plan* or provide services to certain *providers*.

Anti-Assignment and Payment of Benefits

None of the benefits under this *plan* that are payable to or on behalf of any beneficiary or *participant* are ever assignable or transferable to any other person or entity, including any health care *provider*, health care facility, health care supplier or any other health care person or entity. Nor are benefits under this *plan* subject to any lien by any person or entity, including any health care *provider*, health care facility, health care supplier or any other health care person or entity either before or after benefits, services, or supplies are provided to you. BCBSTX reserves the sole right and discretion to make any benefit payments under the *plan* directly to: (a) you, (b) any contracting facility or *in-network provider*, (c) any *out-of-network provider*, or (d) another designated person or entity including any health care *provider*, health care facility, health care supplier or any other health care person or entity. In such case, the benefit payment will be made on your and not on behalf of the recipient and won’t constitute a waiver of this anti-assignment provision. The *plan* isn’t liable for, or subject to, any obligation or liability (e.g., through garnishment, attachment, pledge or bankruptcy), of yours or a third-party that you, the third-party or anyone else may be liable to for medical care, treatment or services. However, BCBSTX may choose, in its sole discretion, to comply with such requests. In addition, neither you nor anyone acting on your behalf may assign to any other person or entity, including any health care *provider*, health care facility, health care supplier or any other health care person or entity your right to request and/or to receive *plan* documents or demand and recover any penalty related to any delay or failure to provide *plan* documents. Further, neither you nor anyone else acting on your behalf may assign to any other person or entity, including any health care *provider*, health care facility, health care supplier or any other health care person or entity any claim or the right to pursue any lawsuit including any claim related to a breach of fiduciary duty or to otherwise enforce any other state or federal law.

Claims Liability

BCBSTX, in its role as Claim Administrator, provides administrative claims payment services only and doesn’t assume any financial risk or obligation with respect to claims.

Identity Theft Protection

As a *participant*, BCBSTX makes available at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBSTX’s designated outside vendor and acceptance or declination of these services is optional to the *participant*. *Participants* who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbstx.com/trsactivecare or by calling your Personal Health Guide at 1-866-355-5999. Services may automatically end when the person is no longer an eligible *participant*. Services may change or be discontinued at any time with reasonable notice. BCBSTX doesn’t guarantee that a particular vendor or service will be available at any given time.
Medicare

Special rules apply when you are covered by this plan and by Medicare. Generally, this plan is a Primary plan if you are an active employee, and Medicare is a Primary plan if you are a retired employee.

Participant/Provider Relationship

The choice of a health care provider should be made solely by you or your dependents. BCBSTX doesn't furnish services or supplies but only makes payment for eligible expenses incurred by participants. BCBSTX isn't liable for any act or omission by any health care provider. BCBSTX doesn't have any responsibility for a health care provider's failure or refusal to provide services or supplies to you or your dependents. Care and treatment received are subject to the rules and regulations of the health care provider selected and are available only for sickness or injury treatment acceptable to the health care provider.

BCBSTX, TRS, in-network providers, and/or other contracting providers are independent contractors with respect to each other. BCBSTX and TRS in no way controls, influences, or participates in the health care treatment decisions entered into by said providers. BCBSTX doesn't furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The providers, their employees, their agents, their ostensible agents, and/or their representatives don't act on behalf of BCBSTX nor are they employees of BCBSTX.

In-network providers maintain a provider-patient relationship with participants and are solely responsible to you for all health services. If an in-network provider can't establish a satisfactory provider-patient relationship, the in-network provider may send a written request to BCBSTX to terminate the provider-patient relationship, and this request may be applicable to other providers in the same group practice, if applicable.

Overpayment

If the plan or BCBSTX pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error (“Overpayment”), the plan or BCBSTX has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to in-network providers or out-of-network providers.

If no refund is received, the plan and/or BCBSTX (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

- any future benefit payment made to any person or entity under this benefits booklet, whether for the same or a different participant
- any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered self-funded benefit program and/or Blue Cross and Blue Shield administered insured benefit program or policy, if the future benefit payment owed is to an in-network provider
- any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy, if the future benefit payment owed is to an in-network provider
- any future benefit payment, or other payment, made to any person or entity
- any future payment owed to one or more in-network providers

Further, BCBSTX has the right to reduce the plan’s payment to an in-network provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy Overpayment to the same in-network provider and to remit the recovered amount to the other Blue Cross and Blue Shield plan or policy.
**Rescission**

Rescission is the cancellation or discontinuance of coverage that has retroactive effect. Your coverage may not be rescinded unless you or a person seeking coverage on your behalf performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. A cancellation or discontinuance of coverage that has only prospective effect isn’t a rescission. A retroactive cancellation or discontinuance of coverage based on a failure to timely pay required premiums or contributions toward the cost of coverage (including COBRA premiums) isn’t a rescission. You will be given 30 days advance notice of rescission. A rescission is considered an Adverse Benefit Determination for which you may seek internal review and external review.

**Subrogation**

If the *plan* pays or provides benefits for you or your *dependents*, the *plan* is subrogated to all rights of recovery which you or your *dependent* have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the *plan* has paid or provided. That means the *plan* may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the *plan*) in the place of another (you or your *dependent*) with reference to a lawful claim, demand or right, so that they who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

**Right of Reimbursement**

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the *plan* will have a right of reimbursement.

If you or your *dependent* recover money from any person, organization, or insurer for an injury or condition for which the *plan* paid benefits, you or your *dependent* agree to reimburse the *plan* from the recovered money for the amount of benefits paid or provided by the *plan*. That means you or your *dependent* will pay to the *plan* the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the *plan*.

**Right to Recovery by Subrogation or Reimbursement**

You or your *dependent* agree to promptly furnish to the *plan* all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the *plan* in protecting and obtaining its reimbursement and subrogation rights. You, your *dependent* or your attorney will notify the *plan* before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your *dependent* further agree not to allow the reimbursement and subrogation rights of the *plan* to be limited or harmed by any acts or failure to act on your part.

**Coordination of Benefits**

The availability of benefits specified in this *plan* is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This *plan* when a *participant* has health care coverage under more than one *plan*.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this *plan* are determined before or after those of another *plan*. The benefits of this *plan* shall not be reduced when This *plan* determines its benefits before another *plan*; but may be reduced when another *plan* determines its benefits first.
Coordination of Benefits – Definitions

- **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:
  a. group or blanket insurance
  b. franchise insurance that terminates upon cessation of employment
  c. group hospital or medical service plans and other group prepayment coverage
  d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements
  e. governmental plans, or coverage required or provided by law

*Plan* doesn’t include:

a. any coverage held by the *participant* for hospitalization and/or *medical-surgical expenses* which is written as a part of or in conjunction with any automobile casualty insurance policy
b. school accident type coverage
c. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended)

Each contract or other arrangement for coverage is a separate *plan*. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate *plan*.

- **This Plan** means the part of this benefits booklet that provides benefits for health care expenses.

- **Primary Plan/Secondary Plan**
  The order of benefit determination rules state whether *this plan* is a Primary Plan or Secondary Plan covering the *participant*. A Primary Plan is a *plan* whose benefits are determined before those of the other *plan* and without considering the other *plan*'s benefit. A Secondary Plan is a *plan* whose benefits are determined after those of a Primary Plan and may be reduced because of the other *plan*'s benefits.

  When there are more than two plans covering the *participant*, this *plan* may be a Primary Plan as to one or more other plans and may be a Secondary Plan as to a different plan or plans.

- **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the *participant* for whom the claim is made.

- **Claim Determination Period** means a *plan year*. However, it doesn’t include any part of a year during which a *participant* has no coverage under *this plan*, or any part of a year before the date this COB provision or a similar provision takes effect.

- **We** or **Us** means TRS.

Order of Benefit Determination Rules

- **General Information**
  a. When there is a basis for a claim under *this plan* and another *plan*, *this plan* is a Secondary Plan which has its benefits determined after those of the other *plan*, unless (a) the other *plan* has rules coordinating its benefits with those of *this plan*, and (b) both those rules and *this plan*'s rules require that *this plan*'s benefits be determined before those of the other *plan*.
  b. If this benefits booklet contains any dental or vision benefits, the benefits provided by the health portion of *this plan* will be the Secondary Plan.
• Rules
This plan determines its order of benefits using the first of the following rules which applies:

a. Non-Dependent/Dependent. The benefits of the plan which covers the participant as an employee, member or subscriber are determined before those of the plan which covers the participant as a dependent. However, if the participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(1) secondary to the plan covering the participant as a dependent
(2) primary to the plan covering the participant as other than a dependent (e.g., a retired employee), then the benefits of the plan covering the participant as a dependent are determined before those of the plan covering that participant other than a dependent.

b. Dependent Child/Parents Not Separated or Divorced. Except as stated in Paragraph c below, when this plan and another plan cover the same child as a dependent of different parents:

(1) The benefits of the plan of the parent whose birthday falls earlier in a plan year are determined before those of the plan of the parent whose birthday falls later in that plan year.
(2) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan doesn’t have the rule described in this Paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the plans don’t agree on the order of benefits, the rule in the other plan will determine the order of benefits.

c. Dependent Child/Parents Separated or Divorced. If two or more plans cover a participant as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the plan of the parent with custody of the child
(2) then, the plan of the spouse of the parent with custody, if applicable
(3) finally, the plan of the parent not having custody of the child

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph doesn’t apply with respect to any plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph ‘b’.

e. Active/Inactive Employee. The benefits of a plan which covers a participant as an employee who is neither laid off nor retired are determined before those of a plan which covers that participant as a laid off or retired employee. The same would hold true if a participant is a dependent of a person covered as a retired employee and an employee. If the other plan doesn’t have this rule, and if, as a result, the plans don’t agree on the order of benefits, this Paragraph ‘e’ doesn’t apply.

f. Continuation Coverage. If a participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the following shall be the order of benefit determination:

(1) first, the benefits of a plan covering the participant as an employee, member or subscriber (or as that participant’s dependent)
(2) second, the benefits under the continuation coverage
If the other plan doesn’t have this rule, and if, as a result, the plans don’t agree on the order of benefits this Paragraph f doesn’t apply.

g. **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that participant for the shorter period of time.

### Effect on the Benefits of This Plan

- **When This Section Applies**
  This section applies when this plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of this plan may be reduced under this section.

- **Reduction in this Plan’s Benefits**
  The benefits of this plan will be reduced when the sum of:
  
a. the benefits that would be payable for the Allowable Expense under this plan in the absence of this COB provision
b. the benefits that would be payable for the Allowable Expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether the claim that is made exceeds those Allowable Expenses in a Claim Determination Period

  In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans don’t total more than those Allowable Expenses.

  When the benefits of this plan are reduced as previously described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

### Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another plan, or the benefits available under the other plan, if discovered. We have the right to decide what information we need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under this plan must give us any information concerning the existence of other plans, the benefits thereof, and any other information needed to pay the claim.

### Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We won’t have to pay that amount again.

### Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

- the persons We have paid or for whom We have paid
- insurance companies
- hospitals, physicians, or other providers
- any other person or organization
**Termination of Coverage**

**Termination of Individual Coverage**

Coverage under the plan for you and/or your dependents will automatically terminate when:

- your contribution for coverage under the plan isn’t received timely by the plan administrator
- you no longer satisfy the description of an employee as described in this benefits booklet, including termination of employment
- the plan is terminated, or the plan is amended, at the direction of the plan administrator, to terminate the coverage of the class of employees to which you belong
- a dependent ceases to be a dependent as defined in the plan

However, when any of these events occur, you and/or your dependents may be eligible for continued coverage. See Continuation of Group Coverage - Federal in the GENERAL PROVISIONS section of this benefits booklet.

BCBSTX may refuse to renew the coverage of an eligible participant for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as Disabled and dependent on the parent won’t terminate upon reaching the limiting age shown in your SCHEDULE OF COVERAGE if the child continues to be both:

- disabled
- dependent upon you for more than one-half of their support as defined by the Internal Revenue Code of the United States

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your plan administrator to BCBSTX within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a Disabled Dependent beyond the limiting age, BCBSTX may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

**Termination of the Group**

The coverage of all participants will terminate if the group is terminated in accordance with the terms of the plan.

**Continuation of Group Coverage - Federal**

**COBRA Continuation - Federal**

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), participants may have the right to continue coverage after the date coverage ends. Participants won’t be eligible for COBRA continuation if the employer is exempt from the provisions of COBRA.

**Minimum Size of Group**

The group must have normally employed more than twenty (20) employees on a typical business day during the preceding plan year. This refers to the number of full-time and part-time employees employed, not the number of employees covered by a health plan.

**Loss of Coverage**

If coverage terminates (other than for non-payment of premiums) as the result of termination (other than for gross misconduct) or reduction of employment hours, then the participant may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cease.
A covered dependent may elect to continue coverage for thirty-six (36) months from the date coverage would otherwise cease if coverage terminates as the result of:

- divorce from the covered employee
- death of the covered employee
- the covered employee becomes eligible for Medicare
- a covered dependent child no longer meets the dependent eligibility requirements.

COBRA continuation under the plan ends at the earliest of the following events:

- the last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months
- the last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months
- the first day for which timely payment of contribution isn’t made to the plan with respect to the qualified beneficiary
- the group health plan is canceled
- the date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan, in the event you have a preexisting condition and would be denied coverage under the new health plan for a preexisting condition, continuation coverage won’t be terminated until the last day of the continuation period, or the date upon which the preexisting condition becomes covered under the new health plan, whichever occurs first
- the date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits

Extension of Coverage Period

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a participant for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the initial qualifying event.

If a participant is determined to be disabled as defined under the Social Security Act and the participant notifies the employer before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours. You may be charged a higher rate for the extended period.

Notice of COBRA Continuation Rights

The employer is responsible for providing the necessary notification to participants as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the NOTICES section of this benefits booklet.

Cancellation

Except as otherwise provided herein, BCBSTX shall not have the right to cancel or terminate any plan issued to any subscriber while the Administrative Services Agreement remains in force and effect, and while said subscriber remains in the eligible class of employees of group, and their contributions are paid in accordance with the terms of this plan.

Gender

The use of any gender herein shall be deemed to include the other gender and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).
Alternate Service Area Access

An “Alternate Service Area” means the service area(s) covered by health maintenance organizations participating in the Blue Cross and Blue Shield Association Away From Home Care Program outside the state of Texas. For the names of those health maintenance organizations and their service areas or for a list of participating providers in an Alternate Service Area, please contact your Personal Health Guide at 1-866-355-5999.

If you are temporarily residing in an Alternate Service Area, you may obtain Covered Services in the Alternate Service Area as described in this section. For a participant, coverage is available if you are, or will be, residing in the Alternate Service Area at least ninety (90) days, limited to a maximum of one hundred eighty (180) days. Participants may renew qualification within the Alternate Service Area by submitting a request for Alternate Service Area access and receiving approval from BCBSTX.

This plan remains in full force and effect while you are in the Alternate Service Area, and you may avail yourself of covered services under this plan by returning to the service area. Emergency care in the Alternate Service Area will be covered in accordance with the terms and conditions of this plan. Coverage for services other than emergency care in the Alternate service area will be provided in accordance with the terms and conditions of your health plan in the Alternate Service Area (the “Alternate Plan”) which BCBSTX will provide to you at the time of request for Alternate service area access. The terms and conditions of the Alternate Plan, including the benefits thereunder, may differ from this plan and will determine the Covered Services, other than emergency care, that you may receive while in the Alternate Service Area.

To qualify for coverage in an Alternate Service Area, you must submit a request for Alternate Service Area access prior to relocating in an Alternate Service Area. You must select a PCP from a list of participating providers for the Alternate Service Area. BCBSTX will determine the date coverage begins for the Alternate Service Area (either the effective date of participant's eligibility or the first day of the month following BCBSTX’s receipt of the request for Alternate Service Area access). If approved, BCBSTX will issue written notification.

Alternate Service Area Access for Dependents

If you enroll in TRS-ActiveCare Primary or TRS-ActiveCare Primary+ and have dependents who live out-of-state, they may be able to still receive coverage outside of Texas. You’ll have to complete an Out-of-State Dependent/Attestation Form, which you can get from your district benefits administrator or a Personal Health Guide. Once you complete the form and BCBSTX approves it, your dependent will receive a Coverage Exception Letter stating they can receive out-of-state coverage through the Participating Provider (PAR) nationwide network. They will need to provide a copy of this letter when accessing services through the PAR nationwide network. Everyone else on your plan will still need to see in-network providers and get referrals for specialists and other providers within Texas. Out-of-state dependents can search for a participating provider at www.bcbstx.com. They can find a doctor or hospital and choose the ParPlan Network.

Clerical Error

Clerical error, whether of group or BCBSTX, in keeping any records pertaining to the coverage hereunder won’t invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Entire Plan

This plan, any attachments, amendments, the Administrative Services Agreement, and the individual applications, if any, of subscribers constitute the entire contract between the parties and as of the effective date hereof, supersede all other contracts between the parties.
Force Majeure

In the event that due to circumstances not within the commercially reasonable control of BCBSTX, the rendering of professional or hospital services provided under this plan is delayed or rendered impractical, BCBSTX shall make a good faith effort to arrange for an alternative method of providing coverage. These circumstances may include, but are not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the in-network providers' personnel or similar causes. In such event, in-network providers shall render the hospital and Professional Services provided for under your health plan in so far as practical, and according to their best judgment; but BCBSTX and in-network providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Form or Content of Plan

No agent or employee of BCBSTX is authorized to change the form or content of this plan except to make necessary and proper insertions in blank spaces. Changes can be made only through endorsement authorized and signed by an officer of BCBSTX. No agent or other person, except an authorized officer of BCBSTX, has authority to waive any conditions or restrictions of this plan, to extend the time for making a payment, or to bind BCBSTX by making any promise or representation or by giving or receiving any information.

Incontestability

All statements made by you are considered representations and not warranties. A statement may not be used to void, cancel or non-renew your coverage or reduce benefits unless it is in a written enrollment application signed by subscriber and a signed copy of the enrollment application has been provided to the subscriber or to the subscriber's personal representative. Coverage may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application.

Limitation of Liability

Liability for any errors or omissions by BCBSTX (or its officers, directors, employees, agents, or independent contractors) in the administration of this plan, or in the performance of any duty of responsibility contemplated by this plan, shall be limited to the maximum benefits which should have been paid under your health plan had the errors or omissions not occurred, unless any such errors or omissions are adjudged to be the result of willful misconduct or gross negligence of BCBSTX.

Modifications

This plan shall be subject to amendment, modification, and termination in accordance with any provision hereof or by mutual agreement between BCBSTX and group without the consent or concurrence of participants. By electing medical and hospital coverage under BCBSTX or accepting BCBSTX benefits, all participants legally capable of contracting, and the legal representatives of all participants incapable of contracting, agree to all terms, conditions, and provisions hereof.

Notice

You may send a notice to BCBSTX via first-class mail, postage prepaid through the United States Postal Service to the address on the face page of this plan.

BCBSTX, or group by agreement between BCBSTX and group, may send you notices under this plan. These notices may be delivered:

- through the United States Postal Service at the last address known to BCBSTX
- electronically, if permitted by applicable law

Participant Data Sharing

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation, or, if you don’t reside in the Blue Cross and Blue Shield of Texas service area, by the Host Blues whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in
various circumstances, such as from involuntary termination of your health coverage sponsored by the group/employer. As part of the overall plan of benefits that Blue Cross and Blue Shield of Texas offers to you, if you don’t reside in the Blue Cross and Blue Shield of Texas service area, Blue Cross and Blue Shield of Texas may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under your health plan the group/employer has with Blue Cross and Blue Shield of Texas to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

Relationship of Parties
The relationship between BCBSTX and in-network providers is that of an independent contractor relationship. In-network providers are not agents or employees of BCBSTX; BCBSTX or any employee of BCBSTX isn’t an employee or agent of in-network providers. BCBSTX shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any in-network provider. BCBSTX makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any physician, hospital or other in-network provider.

Reports and Records
BCBSTX is entitled to receive from any provider of services to participants, information reasonably necessary to administer this plan subject to all applicable confidentiality requirements described below. By accepting coverage under this plan, the subscriber, for themselves, and for all dependents covered hereunder, authorizes each provider who renders services to you hereunder to:

• disclose all facts pertaining to your care, treatment and physical condition to BCBSTX, or a medical, dental, or mental health professional that BCBSTX may engage to assist it in reviewing a treatment or claim
• render reports pertaining to your care, treatment and physical condition to BCBSTX, or a medical, dental, or mental health professional that BCBSTX may engage to assist it in reviewing a treatment or claim
• permit copying of your records by BCBSTX

Information contained in your medical records and information received from physicians, surgeons, hospitals or other Health Care Professionals relating to the physician-patient relationship or hospital-patient relationship shall be kept confidential in accordance with applicable law.

Subtitles
The subtitles included within this plan are provided for the purpose of identification and convenience and are not part of the complete plan as described in Entire Plan.
AMENDMENTS
NOTICE

Inter-Plan Arrangements Out-of-Area Services

BCBSTX (the claim administrator) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." Whenever you obtain health care services outside of our Service Area, the claims for those services may be processed through one of these Inter-Plan Arrangements.

Typically, when accessing care outside of our Service Area, you will obtain care from health care providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating providers. Our payment practices in both instances are described below.

We cover only limited health care services received outside of our Service Area. As used in this section, “Covered Services” include emergency care, urgent care and, with follow-up care obtained outside the geographic area that we serve. Any other services won’t be covered when processed through any Inter-Plan Arrangements unless such services are authorized by BCBSTX (claim administrator).

A. BlueCard® Program

Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care providers.

The BlueCard Program enables you to obtain Covered Services, as defined above, from a health care provider participating with a Host Blue, where available. The participating health care provider will automatically file a claim for you, so there are no claim forms for you to fill out. You will be responsible for the copay indicated in the benefits booklet.

Emergency Care Services: If you experience a Medical Emergency while traveling outside our Service Area, go to the nearest emergency or urgent care facility.

Whenever you access Covered Services and the claim is processed through the BlueCard Program, the amount you pay for such services, if not a flat dollar copay, is calculated based on the lower of:

- the billed charges for covered services
- the negotiated price that the Host Blue makes available to us

Often, this “negotiated price” is a simple discount that reflects the actual price the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with an individual provider or a provider group that may include settlements, incentive payments, and/or other credit or charges. Occasionally, it may be an average price based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments won’t affect the price we use for your claim because they won’t be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, BCBSTX (claim administrator) would then calculate your liability for any Covered Services according to the applicable law in effect when care is received.
NOTICE

B. Non-Participating Health Care Providers outside our Service Area Liability Calculation

Except for emergency care and urgent care with follow-up care services received from a non-participating provider outside of our Service Area won’t be covered.

For emergency care and urgent care with follow-up care services received from non-participating providers within the state of Texas, please refer to the “Emergency Services” section of the benefits booklet.

For emergency care and, urgent care with follow-up care services that are provided outside of the state of Texas by a non-participating provider, the amount(s) you pay for such services will be calculated using the methodology described in the “Emergency Services” section for non-participating providers located inside our Service Area. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

C. Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands you may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network isn’t served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- Inpatient Services

In most cases, if you contact the service center for assistance, hospitals won’t require you to pay for covered inpatient services, except for your copays/deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services.

You must contact BCBSTX (the claim administrator) to obtain preauthorization for non-emergency inpatient services.

- Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.
NOTICE

• Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for Covered Services outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Plan, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.
NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

• Your hours of employment are reduced; or
• Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

• Your spouse dies;
• Your spouse's hours of employment are reduced;
• Your spouse's employment ends for any reason other than his or her gross misconduct;
• Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
• You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

• The parent-employee dies;
• The parent-employee's hours of employment are reduced;
• The parent-employee's employment ends for any reason other than their gross misconduct;
• The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.
YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.
Information Provided by Your Employer
Your Prescription Drug Plan

TRS-ActiveCare Primary Plan

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Deductible (per person, per plan year)</th>
<th>Subject to plan year deductible for all medical and prescription benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retail Short-Term (up to a 31-day supply) and Retail Maintenance (after 1st fill up to 31-day supply)</td>
<td>Subject to plan year deductible for all medical and prescription benefits</td>
</tr>
<tr>
<td></td>
<td>- Generic</td>
<td>-$15 copay (Deductible does not apply)</td>
</tr>
<tr>
<td></td>
<td>- Preferred brand</td>
<td>-30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>- Non-Preferred brand</td>
<td>-50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Retail Maintenance (after first fill of a maintenance, up to a 31-day supply)</td>
<td>Subject to plan year deductible for all medical and prescription benefits</td>
</tr>
<tr>
<td></td>
<td>- Generic</td>
<td>-$30 copay (Deductible does not apply)</td>
</tr>
<tr>
<td></td>
<td>- Preferred brand</td>
<td>-30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>- Non-Preferred brand</td>
<td>-50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Mail Order Pharmacy (60-90-day supply) and Retail-Plus Network (60-90-day supply at Retail-Plus participating pharmacies)</td>
<td>Subject to plan year deductible for all medical and prescription benefits</td>
</tr>
<tr>
<td></td>
<td>- Generic</td>
<td>-$45 copay (Deductible does not apply)</td>
</tr>
<tr>
<td></td>
<td>- Preferred brand</td>
<td>-30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>- Non-Preferred brand</td>
<td>-50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialty prescription medications (limited to a 31-day supply)</td>
<td>Subject to plan year deductible for all medical and prescription benefits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-$30 coinsurance</td>
</tr>
</tbody>
</table>

*If you obtain a brand-name drug when a generic is available, you will pay the difference between the brand discount and the generic discount.

**Deductible and coinsurance waived for certain generic preventive drugs. Go to info.caremark.com/trsactivecare to view the list.

***When you use third-party copayment assistance for any specialty medication, you will not receive credit toward your out-of-pocket maximum or deductible for any copayment or coinsurance amounts that are applied by a manufacturer coupon or rebate. Only the amount you pay out of pocket will apply toward your deductible and out-of-pocket maximum.
TRS-ActiveCare Primary+ Plan

<table>
<thead>
<tr>
<th>Prescription Drugs*</th>
<th>Deductible (per person, per plan year)</th>
<th>$0 for generic, $200 per person for brand-name drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Short-Term (up to a 31-day supply)</td>
<td>- Generic</td>
<td>-$15 <strong>copay</strong></td>
</tr>
<tr>
<td></td>
<td>- Preferred brand</td>
<td>-25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>- Non-Preferred brand</td>
<td>-50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>You will be reimbursed the allowable amount as determined by CVS Caremark for the amount that would have been charged by a network pharmacy less the required copay after the drug deductible is met (Must submit claim to CVS Caremark within 12 months of service date to be reimbursed)</td>
<td></td>
</tr>
<tr>
<td>Retail Maintenance (after first fill of a maintenance, up to a 31-day supply)</td>
<td>- Generic</td>
<td>-$30 <strong>copay</strong></td>
</tr>
<tr>
<td></td>
<td>- Preferred brand</td>
<td>-25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>- Non-Preferred brand</td>
<td>-50% coinsurance</td>
</tr>
<tr>
<td>Mail Order Pharmacy (up to a 90-day supply) and Retail-Plus Network (up to a 90-day supply at Retail-Plus participating pharmacies)</td>
<td>- Generic</td>
<td>-$45 <strong>copay</strong></td>
</tr>
<tr>
<td></td>
<td>- Preferred brand</td>
<td>-25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>- Non-Preferred brand</td>
<td>-50% coinsurance</td>
</tr>
<tr>
<td>Specialty prescription medications (limited to a 31-day supply)</td>
<td></td>
<td>-20% coinsurance</td>
</tr>
</tbody>
</table>

* If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug. This amount does not count toward the $200 drug deductible for brand-name drugs.

**When you use third-party copayment assistance for any specialty medication, you will not receive credit toward your out-of-pocket maximum or deductible for any copayment or coinsurance amounts that are applied by a manufacturer coupon or rebate. Only the amount you pay out of pocket will apply toward your deductible and out-of-pocket maximum.
How Your Prescription Drug Plan Works

About CVS Caremark
CVS Caremark is one of the largest pharmacy health care providers in the United States. CVS Caremark’s network includes more than 64,000 pharmacies nationwide, including chain pharmacies and 20,000 independent pharmacies.

Through CVS Caremark pharmacy services, you can order maintenance and specialty medications online or by phone and have them delivered directly to you. The CVS Caremark website offers these and other services, including Ask-a-Pharmacist, for answers and information about your medications. To start using these and other features and services, register at www.Caremark.com

CVS Caremark ID Cards
Your prescription benefit plan is designed to bring you quality pharmacy care that will help you save money. If you enroll in one of the TRS-ActiveCare plan options, you will receive a new CVS Caremark prescription drug ID card in the mail. Included with the ID card will be CVS Caremark Welcome Kit reflecting your elected prescription benefit plan. If you need to obtain a temporary ID card or order additional cards, you can call 1-866-355-5999 to speak to a CVS Caremark representative, or you can go online at www.Caremark.com

Be sure to take your prescription ID card to your pharmacy when you get a prescription filled for the first time. You can also access a digital copy of your ID cards in the CVS Caremark App.

Sample ID Cards

TRS-ActiveCare Primary
Drug Exclusions
CVS Caremark and TRS regularly review formulary options to look for ways to control costs while preserving individual choice and access to clinically effective drugs. Updates to the tier status of individual medications happen on an ongoing basis.

Drug exclusions from the formulary will occur once per year and will typically go into effect on January 1st. During the four months preceding January 1st, patients utilizing drugs that are to be excluded will receive notification prior to the changes to assist with identifying potential substitute therapies. For a complete list of this year's formulary exclusions, visit CVS Caremark's website at info.caremark.com/trsactivecare

CVS Caremark Preferred Drug list
TRS-ActiveCare Primary and TRS-ActiveCare Primary+ include a formulary, which is a list of drugs indicating preferred and non-preferred status. Each covered drug is Food and Drug Administration (FDA) approved and is also reviewed by an independent group of doctors and pharmacists for safety and efficacy. TRS-ActiveCare encourages the use of the preferred drugs on this list to help control rising prescription drug costs. You will usually pay a lower copayment for generic drugs (Tier 1) and brand-name medications that are on the formulary (Tier 2).
Save Money on Prescriptions
You will pay:

- the lowest copayment for Tier 1 generic drugs
- a higher copayment for Tier 2 preferred brand-name drugs
- the highest copayment for Tier 3 non-preferred brand-name drugs

Your doctor may be able to help you save money by prescribing Tier 1 and Tier 2 drugs if appropriate. Visit CVS Caremark’s website to check the price and coverage of medications under your plan.

Generic Medications
FDA approved generics are safe and effective. Generic drugs may have unfamiliar names, but they are safe and effective. Generic drugs and their brand-name counterparts:

- have the same active ingredients
- are manufactured according to the same strict federal regulations

Generic drugs may differ in color, size, or shape, but the U.S. Food and Drug Administration requires that the active ingredients have the same strength, purity, and quality as the brand-name alternatives. Prescriptions filled with generic drugs have lower copayments under TRS-ActiveCare’s prescription drug program. For more information about your plan’s formulary, visit info.caremark.com/trsactivecare or contact CVS Caremark Customer Care at 1-866-355-5999.

Drugs on the Generics Only Preventive Drug Therapy List maintained by the IRS are covered at no cost to participants on the TRS-ActiveCare Primary plan. The list of eligible generic drugs is posted on the Aetna member website and CVS Caremark website.

Education and Safety
The prescription drugs that you get through the CVS Caremark Pharmacy, as well as those purchased from a participating retail pharmacy are checked for potential drug interactions. If CVS Caremark ever has a question about your prescription, a CVS Caremark pharmacist will contact your doctor prior to dispensing the medication. If your doctor decides to change the prescription, CVS Caremark will send a notification letter to you and to your doctor.
State and federal laws limit the length of time a prescription is valid, regardless of the number of refills remaining. Please verify the expiration date on your refill slip before refilling your medicine.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>TRS-ActiveCare Primary</th>
<th>TRS-ActiveCare Primary +</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Deductible (per plan year)</td>
<td>$2,500 Individual</td>
<td>$0 for generic drugs</td>
<td>Same as Network</td>
</tr>
<tr>
<td></td>
<td>$5,000 Family</td>
<td>$200 per individual for brand-name drugs</td>
<td></td>
</tr>
<tr>
<td>Maximum Out-of-pocket Per plan year</td>
<td>$8,150 Individual</td>
<td>$6,900 Individual</td>
<td>Same as Network</td>
</tr>
<tr>
<td></td>
<td>$16,300 Family</td>
<td>$13,800 Family</td>
<td></td>
</tr>
<tr>
<td>Retail Short Term (up to 31-day supply)</td>
<td>$15 copay</td>
<td>$15 copay</td>
<td>You will be reimbursed the amount that would have been charged by a network pharmacy less the required deductible and coinsurance</td>
</tr>
<tr>
<td>Generic</td>
<td>(deductible does not apply)</td>
<td>25% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Maintenance (after first fill; up to 31-day supply)</td>
<td>$30 copay</td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>(deductible does not apply)</td>
<td>25% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mail Order and Retail-Plus Network (up to 90-day supply)</td>
<td>$45 copay</td>
<td>$45 copay</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>(deductible does not apply)</td>
<td>25% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Medications (31 Day Supply Limit)</td>
<td>30% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>TRS-ActiveCare Primary Network</td>
<td>TRS-ActiveCare Primary+ Network</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------</td>
<td>--------------------------------</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand glucose meter</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Short term 31-day retail supply</td>
<td>Formulary: $0 for needles and syringes only if purchased same day as insulin. Non-Formulary: Deductible and copays/coinsurance applies</td>
<td>Formulary: $0 for needles and syringes only if purchased same day as insulin. Non-Formulary: Deductible and copays/coinsurance applies</td>
<td></td>
</tr>
<tr>
<td>90-day supply at Retail-Plus or mail-order service</td>
<td>Formulary: $0 needles, lancets, and syringes regardless of whether processed on same day as insulin and regardless of brand. Test strips must be the preferred brand. Non-Formulary: Deductible and coinsurance apply</td>
<td>Formulary: $0 needles, lancets, and syringes regardless of whether processed on same day as insulin and regardless of brand. Test strips must be the preferred brand. Non-Formulary: Deductible and coinsurance apply</td>
<td></td>
</tr>
</tbody>
</table>

*Dispense as written penalty does not apply to $0 copays.

**Network Retail Pharmacy Program**

Participating network retail pharmacies will accept your TRS-ActiveCare ID card and charge you the lesser of the negotiated CVS Caremark price or the usual and customary cost for up to a 31-day supply of your prescription at a traditional retail network pharmacy, or a 60-day to 90-day supply at a Retail-Plus network pharmacy. For the TRS-ActiveCare Primary Plan, after your plan year deductible is met, you will pay the applicable coinsurance percentage based on the cost of the prescription until your out-of-pocket maximum is satisfied. For the TRS-ActiveCare Primary+ Plan, after your prescription brand-name drug deductible is met, you will pay any applicable copay or coinsurance percentage based on the cost of the prescription.

Your traditional retail pharmacy service is most convenient when you need a medication for a short period. For example, if you need an antibiotic to treat an infection, you can go to one of the many pharmacies that participate in the TRS-ActiveCare program and get your medication on the same day. For your short-term prescriptions, you may save money by using pharmacies that participate in the CVS Caremark network.
Mail Order through the CVS Caremark Pharmacy
The CVS Caremark Mail Order Pharmacy offers you convenience and potential cost savings. If you need medication on an ongoing or long-term basis, such as medication to treat asthma or diabetes, you can ask your doctor to prescribe up to a 90-day supply for home delivery, plus refills for up to one year.

How to Fill a Mail Order Prescription
For new long-term or maintenance medications, ask your doctor to write two prescriptions:

- the first for up to a 90-day supply, plus any appropriate refills, to fill through the CVS Caremark Mail-Service Pharmacy
- the second for up to a 31-day supply, which you can fill at a participating retail network pharmacy for use until your mail-service prescription arrives

Complete a Mail-Service Order Form and send it to CVS Caremark, along with your original prescription(s) and the appropriate copayment for each prescription. Be sure to include your original prescription. Photocopies are not accepted.

Please note: You must mail in a CVS Caremark Mail Order Form the first time you request a new prescription through mail service. You can also request for you doctor to submit your prescription directly to CVS Caremark Mail Order Pharmacy electronically or contact CVS Caremark Customer Care for assistance. CVS Caremark’s automated refill service is only available after your first prescription order has been processed. You can download a Mail-Service Order Form by visiting www.Caremark.com

A credit card is the preferred payment method, but you can also pay by check or money order. For credit card payments, include your VISA®, Discover®, MasterCard® or American Express® number and expiration date in the space provided on the order form. Through CVS Caremark Mail Order Pharmacy, you can split payments for a 90-day supply into 3 payments over the 3 months.

You can expect to get your mail order prescription 7 to 10 days from the time your order is placed.

Retail-Plus Pharmacy Network
Retail pharmacies that choose to participate in the Retail-Plus network are able to dispense a 60-day to 90-day supply of medication. You may visit info.caremark.com/trsactivecare or contact CVS Caremark Customer Care for more information on which pharmacies have chosen to participate in the Retail-Plus network.

At a Non-Participating Pharmacy
If you utilize a non-participating pharmacy or a network pharmacy that will not file an electronic claim, you must file a direct claim with CVS Caremark. You will be responsible for any cost differences between the pharmacy charge and the plan reimbursement.

If you obtain a prescription outside of the United States, mail a copy of your prescription and purchase receipts along with the claim form. The mailing address is on the back of the form.

Clinical programs — Dispense as Written Prescriptions, Prior Authorization, Step Therapy, and Quantity limits

Dispense-as-Written Prescriptions
If you fill a prescription for a brand-name drug that has a generic version (or equivalent) available, the pharmacist can substitute the generic version unless you or your doctor have indicated on the prescription that you should only receive the brand-name drug.

For instance, the doctor may indicate “Brand Medically Necessary” on the prescription.

Generic equivalents approved by the U.S. Food and Drug Administration (FDA) contain the same active ingredients—and are the same in safety, strength, performance, quality, and dosage form—as their brand counterparts. Generally, generics cost much less than brand-name drugs, for both you and TRS-ActiveCare.
**Step Therapy**  
Under the Step Therapy program, you may be required to try a prerequisite or “first-line” drug before a step therapy or “second-line” drug is approved. Prerequisite drugs and their corresponding step-therapy drugs are FDA approved and are used to treat the same conditions.

If it is Medically Necessary, you can obtain coverage for a step-therapy drug without trying a prerequisite drug first. In this case, your doctor must request coverage for a step-therapy drug as a medical exception. If coverage is approved, your physician will be notified. Your doctor can request a coverage review by calling CVS Caremark Customer Care at 1-866-355-5999.

**Supply Limits**  
Some prescription drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a prescription drug has been assigned a maximum quantity level for dispensing, call CVS Caremark Customer Care at 1-866-355-5999.

**Drugs Requiring Prior Authorization**  
Under TRS-ActiveCare, CVS Caremark may review prescriptions for certain medications with your doctor before they can be covered. This is done under a coverage management program. A prior authorization review follows clinical guidelines that are reviewed and approved by an independent group of doctors and pharmacists.

**Coverage Management Programs**  
Below is a list of each of the three coverage management programs. To find out more information about coverage reviews and prior authorization, please call CVS Caremark Customer Care at 1-866-355-5999.

**Prior Authorization**  
For some medications, you must obtain approval through a coverage review before the medication can be covered under your plan. The coverage review process will allow CVS Caremark to obtain more information about your specific course of treatment (information that isn’t available on your original prescription) in determining whether a given medication qualifies for coverage under TRS-ActiveCare.

**Qualification by History**  
Certain medications may also require a coverage review based on:

- whether certain criteria are met, such as age, sex, or condition
- whether an alternate therapy or course of treatment has failed or is not appropriate

In either of these instances, pharmacists will review the prescription to ensure that all criteria required for a certain medication are met. If the criteria are not met, a coverage review will be required.

**Quantity Management**  
To promote safe and effective drug therapy, certain covered medications may have quantity restrictions. These quantity restrictions are based on manufacturer or clinically approved guidelines and are subject to periodic review and change.

**Coverage Review Process**  
You can check to see if your medication requires prior authorization (coverage review) by calling CVS Caremark Customer Care at 1-866-355-5999.

If your medication requires a coverage review, you or your doctor may start the process by calling CVS Caremark.

**At a Retail Pharmacy in Your Plan’s Network**  
If you are filling a prescription at a retail pharmacy and a coverage review is necessary, CVS Caremark will automatically notify the pharmacist, who in turn will tell you that the prescription needs to be reviewed for prior authorization.
You or your doctor may start the process by calling CVS Caremark.

- CVS Caremark will contact your doctor to request more information than appears on the prescription. After receiving the necessary information, CVS Caremark will notify you and your doctor to confirm whether or not coverage has been authorized.
- If coverage is authorized, you simply pay your normal copayment or coinsurance for the medication. If coverage is not authorized, you may be responsible for the full cost. If appropriate, you can talk to your doctor about alternatives that may be covered.

**Through the CVS Caremark Pharmacy**

If you are filling a prescription through the CVS Caremark Pharmacy and a coverage review is required, CVS Caremark will contact your doctor to request more information than appears on the prescription. After receiving the necessary information, CVS Caremark will notify you and your doctor to confirm whether or not coverage has been authorized.

If coverage is authorized, you will receive your medication and simply pay your normal copayment or coinsurance for it. If coverage is not authorized, CVS Caremark will send you a notification in the mail, along with your original prescription if it was mailed to the CVS Caremark Pharmacy.

**Specialty Pharmacy Program**

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they're administered by a health care professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

CVS Caremark Specialty Pharmacy, (a Designated Dispensing Entity), is the preferred specialty pharmacy provider for TRS-ActiveCare. A list of medications that must be dispensed by CVS Caremark Specialty Pharmacy can be obtained by calling CVS Caremark Specialty Pharmacy at 1-888-265-7790. Specialty medications on this list are subject to change.

In general, specialty medications will not be covered by any pharmacy except for CVS Caremark Specialty Pharmacy, regardless of their medical necessity, their approval, or if the member has a prescription by a physician or other provider. In limited circumstances, however, coverage may be allowed through an alternate provider. Those circumstances include:

- specialty medications billed by a facility as part of an inpatient hospital stay*
- specialty medications billed as part of an emergency room visit*
- situations where medicare is the primary carrier*
- limited distribution Specialty Medications where CVS Caremark does not have access to the drug*
- circumstances where homecare is not clinically appropriate (either due to the member’s clinical history or due to characteristics of the drug which require special handling) and an alternative infusion site (that is qualified to administer the drug) is not available for coordination of services within a reasonable proximity (30 miles or less)**

*Prior approval by CVS Caremark is not required.
**Situation will be evaluated by CVS Caremark clinical staff.

Prior authorization and specialty preferred drug plan design management may be required regardless of the benefit under which the drug is covered or the identity of the provider who is administering the drug.

In addition, for designated Specialty Medications where coverage is still allowed under the medical benefit, the drug, drug dosage(s) and site(s) of care for infusion therapy may require prior authorization for medical necessity, appropriateness of therapy and patient safety.
Specialty Copay Assistance Benefit
Some specialty medications may qualify for third party copayment assistance programs which could lower your out-of-pocket costs for those products. If you use third-party copayment assistance for any such specialty medication, you will not receive credit toward your maximum out-of-pocket or deductible for any copayment or coinsurance amounts that apply to a manufacturer coupon or rebate.

CVS Caremark Infusion Nursing and Site of Care Management for Specialty Medications
Infusion nursing services for select Specialty Medications that are administered in the home and/or in an ambulatory infusion center are covered through the pharmacy benefit and are coordinated through and dispensed by the CVS Caremark Specialty Pharmacy. For non-oncology infused Specialty Medications that require administration by a medical professional, a CVS Caremark Care Team nurse will work with you and your provider to assess your clinical history and determine clinically appropriate options (location for your infusion) for clinician-infused Specialty Medications. Options may include homecare, an ambulatory infusion center, physician office, etc. CVS Caremark Care Team nurses will contact all impacted members to provide assistance and guidance. Whether they’re administered by a health care professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service. By ordering your specialty medications through CVS Caremark, you can receive:

- toll-free access to specialty-trained pharmacists and nurses 24 hours a day, seven days a week
- delivery of your medications within the United States, on a scheduled day, Monday through Friday, at no additional charge
- most supplies, such as needles and syringes, provided with your medications
- safety checks to help prevent potential drug interactions
- refill reminders
- health and safety monitoring
- up to a 90-day supply of your specialty medication subject to applicable copay/deductible/coinsurance

Coordination of Benefits (COB)
TRS-ActiveCare/CVS Caremark offers Coordination of Benefits (COB) as part of your plan. There are two options for payment of claims.

Paper Claim Submission
Under this program, you may submit a paper claim to CVS Caremark along with an Explanation of Benefits (EOB) from the primary payer or a receipt for out-of-pocket costs. CVS Caremark then reimburses you up to the amount that TRS-ActiveCare would have paid if there were no other coverage.

Electronic Claim Submission (Retail Only)
At the time of purchase, the pharmacy submits a secondary claim electronically to CVS Caremark’s real-time claims processing system for the balance unpaid by the primary payer. CVS Caremark then reimburses the pharmacy up to the amount that TRS-ActiveCare would have paid if there were no other coverage. You are then responsible for payment of the unpaid balance.

The secondary benefit will not be more than your benefit under TRS-ActiveCare if there were no other coverage. For example: If you paid $30 under the primary plan, but your TRS-ActiveCare copayment (copay) would have been $20, CVS Caremark will reimburse you $10 as the secondary benefit. If your primary copayment (copay) is $15, CVS Caremark would not pay any secondary benefit because you would have paid $20 in the absence of any other coverage. Claims are either paid or rejected based on plan rules.
Prescription Drug Plan Exclusions

Expenses Not Covered
If any expense not covered is contrary to a law to which the plan is subject, the provision is hereby automatically changed to meet the law’s minimum requirement. No payment will be made under any portion of the plan for:

- a drug that can be purchased without a prescription order; these are commonly called over-the-counter (OTC) drugs (contact CVS Caremark for a list of exceptions)
- therapeutic devices or appliances, support garments, and other non-medical devices
- medication that is to be taken by or administered to a plan participant, in whole or in part, while the plan participant is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution that operates on its premises a facility for dispensing pharmaceuticals
- investigational or experimental drugs; including compounded medications for non-FDA approved use
- prescriptions that a plan participant is entitled to receive without charge under any workers’ compensation law or any municipal, state, or federal program
- hair growth stimulants
- drugs prescribed to remove or reduce wrinkles in the skin
- fertility medications
- ostomy supplies
- topical fluoride products
- growth hormones, unless pre-authorized
- injectables (contact CVS Caremark for a list of exceptions)
- charges for the administration or injection of any drug; some vaccine exceptions
- plasma/blood products (except hemophilia factors)
- any prescription filled in excess of the number specified by the doctor or any refill dispensed after one year from the doctor’s original order
- drugs with cosmetic implications

Claim Denials and Appeals
Under TRS-ActiveCare, you have the option of appealing adverse coverage determinations.

Initial Review

Non-urgent Claims (Pre-service and Post-service)
If you submit a prescription for a drug that is subject to any limitations—such as prior authorization, preferred drug step therapy, or quantity limitations—your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use the CVS Caremark Pharmacy, your doctor will be contacted directly. CVS Caremark will need the following information:

- patient name
- employee ID
- phone number
- the prescription drug for which benefit coverage has been denied
- the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes)
- any additional information that may be relevant to your appeal

You will be notified of the decision no later than 15 days after receipt of a pre-service claim that is not an urgent care claim if CVS Caremark has sufficient information to decide your claim. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim. If you receive an adverse determination on your claim, you will be provided with a written statement that explains the denial and includes instructions on how to appeal that decision.
If CVS Caremark does not have the necessary information needed to complete the review, we will notify you to request the missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information.

If all the needed information is received within the 45-day time frame, you will be notified of the decision no later than 15 days after the receipt of the information or the end of that additional time period. If you don’t provide the needed information within the 45-day period, your claim is considered denied and you have the right to appeal as described below.

**Urgent Claims (Expedited Reviews)**

In the case of an urgent care claim, CVS Caremark will notify you of its decision as soon as possible, but no later than 72 hours after receipt of the claim, unless there is insufficient information to decide the claim. If further information is needed, CVS Caremark will notify you within 24 hours of receipt of your claim that further information is needed and that you have 48 hours to submit the additional information. Additional information must be submitted within 48 hours of the request. CVS Caremark will then notify you of its decision within 48 hours of receipt of the information. If the missing information is not received within that 48 hours, the claim is deemed denied and you have the right to appeal the claim.

An urgent care claim is defined as a request for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, or health, or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that can’t be adequately managed without the care or treatment that is the subject of your claim.

**Appeal of Adverse Benefit Determination**

**Non-urgent Appeal**

If you are not satisfied with the decision regarding your benefit coverage or if you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered denied because missing information was not promptly submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing:

- your name
- CVS Caremark ID number
- phone number
- the prescription drug for which benefit coverage has been denied
- the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes)
- any additional information that may be relevant to your appeal

This information should be mailed to:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-443-1172

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by CVS Caremark in relation to your appeal; the plan provisions on which the decision is based; a description of applicable internal and external review processes, and contact information
for an office of consumer assistance or ombudsman, if any, that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file; the right to receive, upon request and at no charge, the information used to review your second level appeal, and to present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you, together with an opportunity to respond prior to issuance to any final adverse determination of this appeal.

The decision made on your second-level appeal is final and binding.

If your second-level appeal is denied and you are not satisfied with the decision of the second-level appeal (i.e., your “final adverse benefit determination”), you can initiate an external review. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

**Urgent Appeal (Expedited Review)**

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not promptly submitted) if your situation is urgent. An urgent situation is one in which the time period for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your appeal. Urgent appeal requests may be oral or written. You or your physician may call 1-866-443-1183 or send a written request to:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-443-1172

Physicians may submit urgent appeals requests by calling the physician-only toll-free number at 1-866-443-1183.

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination no later than 72 hours after receipt of your appeal request. The notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by CVS Caremark in relation to your appeal; the plan provisions on which the decision is based; a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman, if any, that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your appeal. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you, together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

In addition, in urgent situations, you also have the right to immediately request an urgent (expedited) external review, rather than wait until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time that you request the independent external review. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.
Independent External Review

External Appeals Review
Generally, to be eligible for an independent external review, you must exhaust the internal claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal to both CVS Caremark and request an independent external review at the same time, or alternatively you can submit your urgent appeal for the independent external review after you have completed the internal appeal process.

To file for an independent external review, CVS Caremark must receive your external review request within 4 months of the date of the adverse benefit determination (if the date that is 4 months from that date is a Saturday, Sunday, or holiday, the deadline is the next business day) at:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-443-1172

Non-urgent External Review
Once you have submitted your external review request, CVS Caremark will review, within 5 business days, your claim to determine if you are eligible for external review, and within 1 business day of its decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, CVS Caremark will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to CVS Caremark for reconsideration.

The IRO will review your claim within 45 calendar days and send you and CVS Caremark written notice of its decision. If you are not satisfied with or you do not agree with the decision, your determination letter will contain contact information for the applicable office of health insurance consumer assistance or an ombudsman.

Generic alternative vs. Generic equivalent drugs

Generic Drug
A medication that is generally sold under the name of its active ingredients—the chemicals that make it work—rather than under a brand name. A generic is typically much less expensive than its brand-name counterpart. There are two classifications of generic drugs: Generic equivalent drugs are approved by the U.S. Food and Drug Administration and contain the same active ingredients—and are the same in safety, strength, performance, quality, and dosage form—as their brand-name counterparts. Generic alternative drugs are U.S. Food and Drug Administration (FDA)–approved generic medications whose active ingredients are different from those in another brand-name drug.

You may be taking a brand-name drug that does not have a generic equivalent. However, there may be a different generic that can sometimes be used to treat the same condition as your current brand-name drug. Generic alternatives are not the same as generic equivalents.
Preventive Medications

The plan covers the following preventative medications- both prescription (Rx) and over-the-counter (OTC) at a $0 copayment/coinsurance. To receive these medications at a $0 copayment/coinsurance, you must have an authorized prescription for the product and it must be dispensed by a retail network pharmacy or by mail through CVS Caremark Pharmacy. See chart below for the list of covered preventative medications.

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Covered</th>
<th>Generic only</th>
<th>Age Limit</th>
<th>Quantity Limit</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin - OTC</td>
<td>Y</td>
<td>Y</td>
<td>≥ 45</td>
<td>100 units per fill</td>
<td>N/A</td>
</tr>
<tr>
<td>Aspirin (81mg only)- OTC</td>
<td>Y</td>
<td>Y</td>
<td>≥ 12</td>
<td>100 units per fill</td>
<td>Female Only</td>
</tr>
<tr>
<td>Fluoride Supplements- Rx only</td>
<td>Y</td>
<td>N</td>
<td>≤ 5</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Folic Acid- OTC</td>
<td>Y</td>
<td>Y</td>
<td>≤ 55</td>
<td>100 units per fill</td>
<td>Female Only</td>
</tr>
<tr>
<td>Tobacco Cessation- Rx or OTC</td>
<td>Y</td>
<td>Y</td>
<td>N/A</td>
<td>168 Day Supply per calendar year for replacement products &amp; Rx</td>
<td>N/A</td>
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<tr>
<td>Contraceptives (Oral)- Rx only</td>
<td>Y</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>Female Only</td>
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<tr>
<td>Contraceptives (Emergency)- Rx or OTC</td>
<td>Y</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>Female Only</td>
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<tr>
<td>Contraceptives (Injectables)- Rx only</td>
<td>Y</td>
<td>N</td>
<td>N/A</td>
<td>1 inj. per 75 days or 4 inj. Per 300 days</td>
<td>Female Only</td>
</tr>
<tr>
<td>Contraceptives (Implantable Devices &amp; Vaginal Rings)- Rx only</td>
<td>Y*</td>
<td>N</td>
<td>N/A</td>
<td>1 IUD/Device per 300 days; 13 rings per 300 days</td>
<td>Female Only</td>
</tr>
<tr>
<td>Contraceptives (Transdermal Patch)- Rx only</td>
<td>Y</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>Female Only</td>
</tr>
<tr>
<td>Contraceptives (Barrier Methods: Diaphragms &amp; Cervical Caps)- Rx only</td>
<td>Y</td>
<td>N</td>
<td>N/A</td>
<td>1 per 300 days</td>
<td>Female Only</td>
</tr>
</tbody>
</table>
**Contraceptives (OTC Spermicides, Female Condoms)**- OTC

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>Y</th>
<th>N/A</th>
<th>N/A</th>
<th>Female Only</th>
</tr>
</thead>
</table>

**Bowel Prep Medication**- Rx only. Brands payable until Generic available

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>50-74</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>

**Primary Prevention of Breast Cancer**

<table>
<thead>
<tr>
<th></th>
<th>Y**</th>
<th>Y</th>
<th>≥ 35</th>
<th>N/A</th>
<th>Female Only</th>
</tr>
</thead>
</table>

* = May be covered under medical
** = Requires ‘Preventive Service Zero Copay Primary Prevention of Breast Cancer Diagnosis Exception’. This is a request to allow a member to receive Raloxifene or Tamoxifen Citrate (Generic products only) for a $0 copayment if using for diagnosis of ‘Primary Prevention of Breast Cancer’.

For more specific information regarding coverage options and limitations, please contact CVS Caremark customer service.

**CVS Caremark Online Resources and Tools**

**Your Secure CVS Caremark Member Website**
The main CVS Caremark website is available at [www.Caremark.com](http://www.Caremark.com). You can get:

- refill reminders
- view and print temporary ID card
- Rx information
- cost information
- prescription history
- track your Rx spend
- locate local pharmacies

CVS Caremark also hosts a website specifically for TRS-ActiveCare plans: [info.caremark.com/trsactivecare](http://info.caremark.com/trsactivecare)

From this site, you can check drug costs for the different TRS-ActiveCare plan options, access the Generics Only Preventive Therapy Drug List for TRS-ActiveCare Primary, and see if a pharmacy is in the Retail-Plus Pharmacy Network.

**CVS Caremark Mobile Apps**

Download the CVS Caremark® mobile app and manage your prescription medications from wherever you are. You can order refills, check drug costs, view your prescription ID card and locate a network pharmacy – anytime, anywhere. You can use the app on your iPhone or Android phone.