TRS CARE
TEACHER RETIREMENT SYSTEM OF TEXAS

BlueCross BlueShield of Texas

Benefits Booklet

TRS-Care Standard Plan for Participants Under 65 Without Medicare

Effective Jan. 1 – Dec. 31, 2023

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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INTRODUCTION

TRS-Care provides coverage for many of your health care needs, including physician office visits, inpatient and outpatient services, behavioral health, prescription drugs and more. This booklet is your guide to your TRS-Care health benefits. Included is detailed information about your TRS-Care Standard plan, tips on how to use the plan effectively, and a comprehensive table of contents to help you locate information you may need.

Coverage under this *plan* is provided regardless of your race, color, national origin, disability, age, sex, gender identity, sexual orientation or preexisting conditions. 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 your health 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 be section headings describing provisions or they may be defined terms.

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

Overview of your plan

- TRS-Care participants who are not eligible for Medicare have a single plan option administered by Blue Cross and Blue Shield of Texas. The TRS-Care Standard Plan is a federally-compliant high deductible health plan (HDHP). This means it is compatible with a health savings account (HSA). TRS does not administer an HSA, but you can open an account at a bank, credit union or other financial institution.
- The TRS-Care Standard plan includes a deductible, coinsurance and out-of-pocket maximum. There are no copays. Once the deductible is met, the plan pays a percentage of your covered expenses, and you pay a percentage of the services; this referred to as a coinsurance.
- Before your coverage begins paying, you will need to meet an annual deductible. If you have individual-only coverage, you will meet the individual-only deductible. If you cover one or more dependents, such as a spouse, you must meet the family deductible before the plan begins to pay for any covered family member. The family deductible can be met by one person or a combination of family members. The deductible applies to all covered expenses EXCEPT in-network preventive care (including certain generic preventive prescription drugs).
- TRS Care Standard plan has an out-of-network deductible and out-of-network out-of-pocket maximum. The in-network and out-of-network deductible and out-of-pocket maximums are separate limits. Only in-network expenses will apply to meet the in-network deductible and apply towards the in-network out-of-pocket maximum. Only out-of-network expenses will apply to meet the out-of-network deductible and apply towards the out-of-network out-of-pocket maximum.
- The TRS-Care Standard plan has a maximum out-of-pocket limit in place to protect you. The maximum out-of-pocket is the most that you will pay for covered medical services and prescription drugs within a calendar year.
- TRS Virtual Health offers telemedicine medical visits through Teladoc. Teladoc is a telemedicine program. This service lets you talk by phone or video chat with board-certified doctors 24/7. They can diagnose, treat and prescribe medications. Effective Sept. 1, 2019, the consultation fee was lowered to $30. This fee will count toward your deductible and will also be applied to your out-of-pocket maximum. It is a convenient and less expensive way to get some types of care.

In absence of any benefit not specifically listed in this booklet TRS-Care Standard defaults to BCBSTX standard claims administration processing guidelines and policy.

- You can receive confidential TRS Virtual Health mental health care through Teladoc. Adults 18 and over can receive care for anxiety, depression, grief, family issues and more. Choose to see a psychiatrist, psychologist, social worker or therapist and establish an ongoing relationship. Appointments must be scheduled online or through the Teladoc app. There is a cost for care:
  a. After the deductible is satisfied, the plan pays 80%, you pay 20%. The fee for the consult is:
     (1) Psychiatrist (initial visit), $185
     (2) Psychiatrist (ongoing visits), $95
     (3) Psychologist, licensed clinical social worker, counselor or therapist, $85
- TRS Virtual Health includes general medical consults through Teladoc for some family members, even if they are not enrolled on your TRS-Care Standard plan. The family member must be age 18 and over and could be your adult child or an elderly parent. You can extend the TRS Virtual Health general medical consult to someone you care for with a two-way or three-way video or phone consult with a board-certified physician for a flat fee of $45.
- With a HDHP like the TRS-Care Standard plan, it's important to be a good consumer and get the most out of your plan. You will save money and reduce your out of pocket costs by:
  a. Choosing in-network providers. To locate in-network providers, log in to Blue Cross and Blue Shield of Texas at www.bcbstx.com/trscarestandard**.**
  b. Taking advantage of preventive services, such as your annual physical, cancer screenings, immunizations, flu shots and certain generic preventive prescription drugs that are available at no cost to you.
  c. Getting care at the right place for the right situation. For example, visit the emergency room for life threatening situations and use urgent care or Teladoc for services to treat an ankle sprain or cold/flu symptoms.
- The TRS-Care Standard plan is not insured, but self-funded through the Texas Public School Retired Employees Group Insurance Fund. To help conserve our shared resources, you can be an informed consumer and spend your benefit dollars wisely. You should contact BCBSTX for medical appeals and CVS for prescription drug appeals.
- This booklet addresses the TRS-Care Standard plan medical and prescription drug benefits for retirees and their dependents under age 65 and not covered by Medicare.
- Do not depend on others to manage your coverage. TRS-Care does not pay for every medical or drug expense you may incur. You may be responsible for a share of or all of the cost, so please be an informed consumer. Read this booklet carefully and consult the website or call TRS-Care Customer Service at 1-866-355-5999 with questions before you make health care decisions.
- You are responsible for the decisions you make and for complying with the TRS-Care rules.

If you have questions, refer to the website www.bcbstx.com/trscarestandard or call your Personal Health Guide at 1-866-355-5999.

If you use an *out-of-network provider*, regardless of the circumstances, you will most likely have to pay more than the *out-of-network deductible* and *coinsurance* amounts. The **"***allowed amount***"** can be significantly less than what the provider bills when using an *out-of-network provider*. You will be responsible for any amount that is not covered under the plan including your *deductible* and *coinsurance* when applicable.

A Claim Information Form (CIF) is required every 12 months for TRS-Care primary *participants* (those without Medicare). This information may be reported by calling your Personal Health Guide at 1-866-355-5999.

Visit www.bcbstx.com/trscarestandard and go to the "Forms" sections.

Medical Claims Address:
Blue Cross and Blue Shield of Texas
Claims Division
P.O. Box 660044
Dallas, TX 75266-0044
1-866-355-5999

Do not assume anything. Refer to this booklet or call your Personal Health Guide at 1-866-355-5999 if you have any questions about your coverage.

What happens when you turn 65?

When you turn 65 or become eligible for Medicare, it is important to notify TRS of your Medicare status.

- If you're eligible for premium-free Medicare Part A (hospitalization), sign up for it through the Social Security Administration. You can apply online at www.ssa.gov/medicare, visit your local Social Security office, or call Social Security at 1-800-772-1213 (TTY: 1-800-325-0778).
- Purchase Medicare Part B through the Social Security Administration as soon as enrollment becomes available to you. You must buy and maintain Medicare Part B to be eligible for TRS-Care benefits. The Social Security Administration can confirm your Part B premium; please note that it will not be deducted from your TRS pension.
- If you're currently enrolled in TRS-Care, when you turn age 65, BCBSTX will send you a packet with form requesting your Medicare number. Please complete the form and return it to TRS.*
- Separately, TRS will send you an enrollment kit. Review the materials inside. If you're adding dependents, complete and submit the application for TRS-Care no later than 31 days from the end of the month in which you retire or turn 65.

If you are eligible for TRS-Care coverage, and once TRS verifies your Medicare information, TRS will enroll you in the TRS-Care Medicare Advantage® and TRS-Care Medicare Rx® plans. If TRS does not receive your Medicare number, TRS will not be able to enroll you, and you risk losing TRS-Care coverage altogether.

*If you're a retiree or surviving spouse who isn't yet 65, and you either terminated TRS-Care or didn't enroll during your Initial Enrollment opportunity, you also can enroll in the TRS-Care when you turn 65. You may add dependents then too. To enroll in TRS-Care at 65, you must request an application and submit it no later than 31 days from the end of the month in which you turn 65. Call TRS Health and Insurance Benefits at 1-888-237-6762 to request an application.

When you are first eligible (usually at age 65 or after you qualify for Social Security Disability Benefits for Medicare Part B), you should purchase it. TRS strongly urges you to enroll in Medicare as soon as you're eligible for it. If you don't sign up early enough to make your effective date the first day of your birthday month, you risking having a gap in TRS-Care coverage.

Keep in mind, the period for enrolling in the TRS-Care program is shorter than the enrollment period for Medicare. The enrollment period for Medicare extends for three months after your 65th birthday, but you must submit an application for enrollment in the TRS-Care program no later than 31 days from the end of the month in which you turn 65.

You must provide your Medicare information to TRS (so it can be sent to BCBSTX) before the first day of your birthday month. If you do not provide TRS with your Medicare information you may be terminated from TRS-Care and will not be able to re-enter the program unless you have a Special Enrollment Event.

Turning age 65 is an enrollment opportunity for retirees and surviving spouses. If you've never enrolled in TRS-Care before but were eligible for the program when you retired, you have an additional opportunity to enroll yourself and your eligible dependents at age 65. TRS will send TRS retirees a postcard prior to your 65th birthday inviting you to contact us for an enrollment packet (TRS 700EO). TRS-Care retirees, including those who are currently enrolled in TRS-Care, may add their eligible dependents to their TRS-Care coverage when the retiree reaches age 65.

NOTE: this enrollment opportunity is not available to dependent spouses or children when they turn 65.

In-Network and Out-of-Network Benefits

In-Network Benefits

To receive *in-network benefits* as indicated on your SCHEDULE OF COVERAGE, **you must** choose *providers* within the *network* for all care **(other than for emergencies**). The *network* has been established by Blue Cross and Blue Shield of Texas (BCBSTX) and consists of *physicians*, *specialty care providers*, *hospitals*, and other health care facilities to serve *participants* throughout the *network plan service area*.

Refer to your *provider* directory or visit the BCBSTX website at www.bcbstx.com/trscarestandard to make your selections. The listing may change occasionally, so make sure the *providers* you select are still *in-network providers*. An updated directory will be available at least annually. You may access our website, www.bcbstx.com/trscarestandard, for the most current listing to assist you in locating a *provider*.

If you choose an *in-network provider*, the *provider* will bill BCBSTX - not you - for services provided.

The provider has agreed to accept as payment in full the least of:

- the billed charges
- the *allowable amount* as determined by BCBSTX
- other contractually determined payment amounts

You are responsible for paying any *deductibles*, *copays*, and *coinsurance*. You may be required to pay for limited or non-covered services. No claim forms are required.

Out-of-Network Benefits

If you choose *out-of-network provider*s, only *out-of-network benefits* will be available. If you go to a *provider* outside the *network*, benefits will be paid at the *out-of-network benefits* level.

If you choose a *health care provider* outside the *network*, you may have to submit claims for the services provided.

You will be responsible for paying:

- billed charges above the *allowable amount* as determined by BCBSTX
- *coinsurance*, *copays* and *deductibles*
- limited or non-covered services
- failure to obtain *prior authorization* penalty

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline (Personal Health Guides)	**1-866-355-5999**	**24 hours a day 7 days a week**
CVS Caremark	**www.info.carmark.com/trscarestandard 1-844-345-4577**	**24 hours a day 7 days a week**
Websites	**www.bcbstx.com/trscarestandard www.trs.texas.gov**	**24 hours a day 7 day a week**

Customer Service Helpline

Personal Health Guides can:

- identify your *plan service area*
- give you information about *in-network* and *ParPlan 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/trscarestandard for information about BCBSTX, access to forms referenced in this benefits booklet, and much more.

Mental Health/Substance Use Disorder Prior Authorization

Prior Authorization 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 **UTILIZATION MANAGEMENT** section for more information. To obtain *prior authorization*, you, your *behavioral health provider*, or authorized representative may call the 24/7 Personal Health Guide number at 1-866-355-5999.

Medical Prior Authorization

To satisfy all medical *prior authorization* 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-Care Standard Plan

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

IMPORTANT NOTE: *Copays* and *coinsurances,* shown below, indicate the amount you are 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.

	In-Network Benefits	Out-of-Network Benefits
Deductibles Per Calendar year		
Per Individual	$1,500	$3,000
Per Family	$3,000	$6,000
Maximum Out-of-Pocket Per Calendar year		
Per Individual	$5,650	$11,300
Per Family	$11,300	$22,600
Professional Services		
Primary Care Provider (PCP) Office or Home Visit **Specialist Physician ("Specialist") Office or Home Visit**	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Inpatient Hospital Services		
Inpatient Hospital Services	20% *coinsurance* after *deductible* No penalty for failure to obtain *prior authorization* for services	40% *coinsurance* after *deductible,* $500 per day maximum allowed amount* $400 penalty for failure to obtain *prior authorization* for services
Outpatient Facility Services		
Outpatient Surgery	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Radiation Therapy and Chemotherapy	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Dialysis	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Outpatient Infusion Therapy Services		
Infusion therapy - Hospital Setting	$500 *copay* after *deductible*	$1,000 *copay* after *deductible*
Infusion therapy - Home, Office, *Infusion Suite* Setting	$30 *copay* after *deductible*	$250 *copay* after *deductible*

*$500 per day maximum applies to all services billed by an *out-of-network inpatient facility*, regardless if allowed amount applies to the *deductible* or *maximum out-of-pocket.*

SCHEDULE OF COVERAGE

TRS-Care Standard Plan

	In-Network Benefits	Out-of-Network Benefits
Outpatient Laboratory and X-Ray Services		
Arteriograms, Computerized Tomography (CT Scan), Magnetic Resonance Imaging (MRI), Electroencephalogram (EEG), Myelogram, Positron Emission Tomography (PET Scan)	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Other X-Ray Services	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Other Outpatient Lab	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Labs – Outpatient Hospital setting	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Diagnostic imaging of the breast (including diagnostic mammograms, ultrasound imaging, or magnetic resonance imaging)	Plan pays 100% after deductible	40% coinsurance after deductible
Rehabilitation Services*		
Rehabilitation Services and Therapies, Physical Therapy and Occupational Therapy limited to a visit maximum of 25*. Chiropractic Services limited to a visit maximum of 20, all services billed by a Chiropractor will apply to the visit maximum. *Additional visits allowed if medically necessary	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Maternity Care and Family Planning Services		
Maternity Care Prenatal Postnatal ***Inpatient Hospital Services*****, for each admission	20% *coinsurance* after *deductible*	40% *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	20% *coinsurance* after *deductible*; unless otherwise covered under *Contraceptive Services* described in ***Preventive Care Services*.**	40% *coinsurance* after *deductible*

* Benefits for *Autism Spectrum Disorder* will not apply towards and are not subject to any Rehabilitation Services and Therapies visit maximum.

** $500 per day maximum applies to all services billed by an *out-of-network inpatient facility*, regardless if allowed amount applies to the *deductible* or *maximum out-of-pocket*.

SCHEDULE OF COVERAGE

TRS-Care Standard Plan

	In-Network Benefits	Out-of-Network Benefits
Infertility Services • treatment of underlying conditions	20% coinsurance after deductible	40% coinsurance after deductible
Behavioral Health Services		
***Outpatient mental health care, serious mental illness* and *treatment of substance use disorder* (SUD) – Office Setting**	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
***Outpatient mental health care, serious mental illness* and *treatment of substance use disorder* (SUD) – Other Outpatient services**	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
***Inpatient mental health care, serious mental illness* and *treatment of substance use disorder* (SUD)- Facility services**	20% *coinsurance* after *deductible*	40% coinsurance after deductible, $500 per day maximum allowed amount*
Inpatient *mental health care, serious mental illness* and *treatment of substance use disorder* (SUD)- Professional services	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Emergency Care Services		
Accidental Injury & Emergency Care		
Facility (If admitted, any charges described in *Inpatient Hospital Services* will apply.)	20% *coinsurance* after *deductible*	
Physician	20% *coinsurance* after *deductible*	
Non-Emergency Care		
Facility	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Physician	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Urgent Care Services		
Urgent Care	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Retail Health Clinics		
Retail Health Clinics	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Ambulance Services		
Ambulance Services, per service	20% *coinsurance* after *deductible*	

*$500 per day maximum applies to all services billed by an *out-of-network inpatient facility*, regardless if allowed amount applies to the *deductible* or *maximum out-of-pocket*.

SCHEDULE OF COVERAGE

TRS-Care Standard Plan

	In-Network Benefits	Out-of-Network Benefits
Extended Care Services		
Skilled Nursing Facility Services, for each day, up to 25 days per *calendar year*	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*[*]
Hospice Care, per visit	20% *coinsurance* after *deductible*; unless otherwise covered under *Inpatient Hospital Services*.	40% *coinsurance* after *deductible*[*]
Home Health Care, per visit, up to 120 visits per *calendar year* combined with *Private Duty Nursing*	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Private Duty Nursing, per visit, up to 120 visits per *calendar year* combined with *Home Health Care*	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*

[*]$500 per day maximum applies to all services billed by an *out-of-network inpatient facility*, regardless if allowed amount applies to the *deductible* or *maximum out-of-pocket*.

SCHEDULE OF COVERAGE

TRS-Care Standard Plan

	In-Network Benefits	Out-of-Network Benefits
Preventive Services		
Well child care through age 17	Plan pays 100%	40% *coinsurance* after *deductible*
Periodic health assessments for *participants* age 18 and older	Plan pays 100%	40% *coinsurance* after *deductible*
Immunizations		
• childhood immunizations required by law for *participants* through age 6	Plan pays 100%	40% *coinsurance* after *deductible*
• immunizations for *participants* over age 6	Plan pays 100%	40% coinsurance after deductible
Bone mass measurement for osteoporosis limited to one every two years for female *participants* age 65 and older and male *participants* age 70 and older.	Plan pays 100%	40% *coinsurance* after *deductible*
Well-woman exam, once per *calendar year*, includes, but not limited to, exam for cervical cancer (Pap smear), for female *participants* age 21 and older.	Plan pays 100%	40% *coinsurance* after *deductible*
Screening mammogram for female *participants* age 35 and over and for female *participants* with other risk factors, once per *calendar year.*	Plan pays 100%	40% coinsurance after deductible
• outpatient facility or imaging centers	Plan pays 100%	40% *coinsurance* after *deductible*
Contraceptive Services and Supplies • contraceptive education, • counseling • certain female FDA approved contraceptive methods • female sterilization procedures and devices	Plan pays 100%	40% *coinsurance* after *deductible*
Breastfeeding Support, Counseling and Supplies • lactation counseling limited to six (6) visits per *calendar year* • electric breast pumps limited to one (1) per *36 months* (Hospital grade breast pumps are covered up to purchase price of $150)	Plan pays 100%	40% *coinsurance* after *deductible*

SCHEDULE OF COVERAGE

TRS-Care Standard Plan

	In-Network Benefits	Out-of-Network Benefits
Preventive Services (Cont'd)		
Rectal screening for the detection of colorectal cancer for *participants* age 45 and older:		
• annual fecal occult blood test, once per *calendar year*	Plan pays 100%	40% *coinsurance* after *deductible*
• flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years	Plan pays 100%	40% *coinsurance* after *deductible*
• colonoscopy, limited to 1 every 10 years	Plan pays 100%	40% *coinsurance* after *deductible*
• Cologuard, limited to 1 every 3 years	Plan pays 100%	40% *coinsurance* after *deductible*
Routine eye exams covered for *participants* with diabetes	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
First pair of eyeglasses, frames and lenses, or contact lenses purchased within 12 months after intraocular surgery or accidental injury	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Early detection test for cardiovascular disease, limited to 1 every 5 years • computer tomography (CT) scanning • ultrasonography	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Early detection test for ovarian cancer (CA125 blood test), once per *calendar year*	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Exam for prostate cancer for *participants* age 40 or older, once per *calendar year*	Plan pays 100%	40% *coinsurance* after *deductible*
Dental Surgical Procedures		
Dental Surgical Procedures (limited covered services)	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Cosmetic, Reconstructive or Plastic Surgery		
Cosmetic, Reconstructive or Plastic Surgery (limited covered services)	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*

SCHEDULE OF COVERAGE

TRS-Care Standard Plan

	In-Network Benefits	Out-of-Network Benefits
Allergy Care		
Testing and Evaluation	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Injections	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Serum	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Diabetes Care		
Diabetes Self-Management Training, for each visit **Diabetes Equipment** (Diabetes Supplies covered under pharmacy drug plan)	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Prosthetic Appliances and Orthotic Devices		
Prosthetic appliances **and Orthotic Devices** $1,000 lifetime maximum for wigs needed as a result of hair loss due to injury or treatment of a disease. Two (2) pairs of therapeutic footwear per *calendar year*, for the prevention of complications associated with diabetes.	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Durable Medical Equipment		
Durable Medical Equipment	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Hearing Aids		
Hearing Aids & Cochlear Implants for *participants* to the age of 19. $1,000 maximum per 36 months for hearing aids. Cochlear implant replacement parts covered every 3 years.	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Speech and Hearing Services		
Speech and Hearing Services, hearing therapy is not covered	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*

SCHEDULE OF COVERAGE

TRS-Care Standard Plan

	In-Network Benefits	Out-of-Network Benefits
Telehealth Services through TRS Virtual Health		
Medical –		
• **Teladoc**	20% *coinsurance* after *deductible,* medical consult fee of $42 applies to *deductible*	Not Applicable
• **RediMD**	20% *coinsurance* after *deductible,* medical consult fee of $30 applies to *deductible*	Not Applicable
Behavioral Health – Teladoc	20% *coinsurance* after *deductible*, Behavioral health consult fees apply to *deductible*: • psychiatrist (initial visit) $185.00 • psychiatrist (ongoing visit) $95.00 • psychologist, licensed clinical social worker $85.00	Not Applicable

SCHEDULE OF COVERAGE

TRS-Care Standard Plan

	Blue Distinction Plus Designated Center	Blue Distinction Designated Center	In-Network Benefits	Out-of-Network Benefits
Blue Distinction Centers				
Bariatric Surgery	20% *coinsurance* after *deductible*	Not Covered	Not Covered	Not Covered
Transplants	0% *coinsurance* after *deductible* for Inpatient Hospital & Outpatient Hospital services	0% *coinsurance* after *deductible* for Inpatient Hospital & Outpatient Hospital services	20% *coinsurance* after *deductible* for Inpatient Hospital & Outpatient Hospital services	40% *coinsurance* after *deductible* for Inpatient Hospital* & Outpatient Hospital services

*$500 per day maximum applies to all services billed by *an out-of-network inpatient facility*, regardless if allowed amount applies to the *deductible* or *maximum out-of-pocket*.

Dependent Eligibility

Dependent child age limit to age 26.

Preexisting Conditions

Preexisting conditions are covered immediately.

Eligibility and Enrollment

This section provides an overview of TRS-Care eligibility requirements and enrollment.

Who can enroll in TRS-Care?

Service Retirees

A service retiree must have at least 10 years of service credit in TRS at the time of retirement. This service credit may include up to five years of military service credit, but it may not include any other purchased special or equivalent service credit. In addition to the "10 years of service credit" requirement, you must meet one of the following requirements at retirement:

- the sum of your age and years of service credit in TRS equals or exceeds 80 (with at least 10 years of service credit), regardless of whether you had a reduction in the retirement annuity for early age (years of service credit can include purchased service)
- you have 30 or more years of service credit in the TRS pension (including purchased service)

Note: Combined service credit under the Proportionate Retirement Program may not be used to establish eligibility for TRS-Care or any type of benefits other than service retirement benefits. A service retiree is not eligible to enroll in the TRS-Care Program if they are eligible for ERS, the UT System, or the Texas A&M System health benefit program coverage.

Disability Retirees

Individuals are eligible to participate in TRS-Care when they become a disability retiree under the TRS pension. Once enrolled in TRS-Care as a disability retiree, participation continues as long as the individual is a disability retiree under the TRS pension fund. If you're applying for health coverage because of a disability, you may be contacted to validate your Medicare Social Security Disability status.

Note: Coverage for a disability retiree with fewer than 10 years of service credit in the TRS pension only continues up to the total number of years of service credit. Consequently, coverage for such a disability retiree will end when disability retirement benefits under the TRS pension fund end. A disability retiree is eligible to enroll in TRS-Care even if he or she is eligible for ERS, the UT System, or the A&M System health benefit program coverage.

Dependents

The following dependents are eligible to enroll in TRS-Care:

- a spouse, including a common law spouse (A common law spouse in not 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: a natural child
  a. an adopted child, or one lawfully placed for adoption
  b. a foster child
  c. a stepchild
  d. a grandchild who lives with you and depends on you for at least 50 percent of the child's support
  e. any other child who is in a regular parent-child relationship as determined by TRS*
  ***Any other child who is in a regular parent-child relationship**: a child that is not your grandchild; the child is unmarried; the child's primary residence is your household; you provide at least 50 percent of the child's support; neither of the child's natural parents reside in your household; you have the legal right to make decisions regarding the child's medical care; and you have full legal guardianship (documentation will be required).
- a child (regardless of age) who lives with or has his or her care provided by the retiree or surviving spouse on a regular basis, if the child has a mental disability or physical incapacity to such an extent to be dependent on the retiree or surviving spouse for care and support, as determined by TRS.

  a. any other child under age 26 (unmarried) who is in a regular parent-child relationship with the retiree or surviving spouse
  b. Appropriate documentation will be required to establish that these children meet the TRS-Care eligibility criteria. When the responsible adult is not a grandparent, the normal parent/child relationship means that:

(1) you provide at least 50% of the support for the child
(2) the natural parent of the child does not reside in the same household
(3) you have the legal right to make decisions regarding the child's medical care*
(4) you have full legal guardianship (documentation will be required)

*This requirement does not apply to dependents 18 and over.

Coverage for your dependents will generally become effective on the date your coverage becomes effective if, by then, you have requested dependent coverage.

Children who must be covered due to a qualified medical child support order will become eligible on the date of the court decision if a written request is made within 31 days of the legal event. Coverage will be effective the first day of the following month from the date of the court order is signed. A court order on a spouse (or ex-spouse) does not require the plan to provide dependent coverage.

If you are the non-custodial parent of a child who must be covered due to a qualified medical child support order, you should provide proof of claim to the custodial parent. Benefits for such a claim will be paid to the custodial parent.

Eligible dependents may also be enrolled if they experience a special enrollment event as described on page 71.

Dependent coverage will continue as long as the monthly payment is made and the dependent remains eligible. The monthly contributions are subject to change.

Some types of dependents will require additional documentation to establish they meet eligibility criteria.

Can a disabled dependent child be an eligible dependent even though the child is 26 or older?

A disabled child, regardless of the child's age, can be enrolled only within the initial enrollment period of the retiree or surviving spouse, during a special enrollment event, or when the retiree or surviving spouse reaches age 65 if the retiree or surviving spouse is already enrolled in TRS-Care when he/ she turns 65.

Medical expense benefits for a fully disabled child will not be terminated because the child reaches the maximum age for a dependent child as long as the child continues to be disabled, dependent upon you for support, and unmarried.

However, medical documentation will be required to determine incapacitation.
Children will be considered incapacitated if they are unable to earn their own living because they are mentally or physically disabled, and they depend chiefly on you for support and maintenance.

"Incapacitated child" forms will be mailed to the participant. One is to be completed by the child's physician and the other is to be completed by the participant. Proof that your child is fully disabled must be submitted to TRS no later than 31 days after the date your child reaches age 26 or at the time first enrolled.

BCBSTX may require proof of the continuation of the disability. BCBSTX, at its own expense, also may require an examination of your child as often as needed while the disability continues. An exam will not be required more often than once each year after two years from the date that your child reaches age 26.

Coverage ceases at the earliest occurrence of the following:

- cessation of the disability
- failure to provide proof that the disability continues
- failure to have any required exam
- marriage of the disabled child
- termination of dependent coverage for the child for any reason other than reaching age 26

Other Scenarios

I am already enrolled in TRS-ActiveCare:
TRS-Care (for retirees) is a plan separate and distinct from TRS-ActiveCare (for working school employees). When you retire, you must submit an application form that tells TRS if you'd like to enroll yourself and your dependents in, or defer enrollment in, TRS-Care.

Also, be sure to contact your school official to verify your TRS-ActiveCare termination date.

Both spouses are TRS pension retirees:
If both spouses are TRS pension retirees, and each meet the TRS-Care eligibility requirements individually, each can enroll separately in TRS-Care as individuals, which may be financially advantageous. Call **1-888-237-6762** if you'd like additional information.

A TRS pension retiree can be covered under TRS-ActiveCare as a dependent of an active employee who is enrolled in TRS-ActiveCare.

How to Enroll

After you submit your retirement application (Form TRS 30) to TRS and it is processed, you will receive a TRS-Care enrollment packet that includes an application for TRS-Care (Form TRS 700A). If you want to enroll in TRS-Care, complete the application and send it back to TRS.

If you're applying for disability retirement, TRS will send you a TRS-Care enrollment packet if your disability retirement is approved.

During your Initial Enrollment Period for *TRS-Care*, if you choose not to enroll, you do not need to take any action. You only need to submit an application if you want to enroll in TRS-Care.

When you may enroll

Initial Enrollment Period at Retirement

If you're a service retiree, your Initial Enrollment Period is the later of:

- the period that begins on the effective date of your retirement and expires at the end of the last day of the month that is three consecutive calendar months, but in no event less than 90 days, after your effective retirement date
- the period that begins on the last day of the month in which your election to retire is received by TRS and expires at the end of the last day of the month that is three consecutive calendar months, but in no event less than 90 days, following the last day of the month in which your election to retire is received by TRS.

  Your application for TRS-Care (TRS Form 700A or 700M) is due no later than the last day of your Initial Enrollment Period. Please see the chart "Initial Enrollment Period for TRS-Care" below for more information.

Initial Enrollment Period due to Disability Retirement

If you are a disability retiree, your Initial Enrollment Period begins on the date that your disability retirement is approved by the TRS Medical Board and expires at the end of the last day of the month that is three consecutive calendar months, but in no event less than 90 days, after the date that your disability retirement is approved by the TRS Medical Board.

Initial Enrollment Period due to the Death of a Retiree or Active Member

The initial enrollment period in TRS-Care for an eligible surviving spouse of a deceased retiree and for an eligible surviving dependent child of a deceased retiree expires on the last day of the month that is three consecutive calendar months, but in no event less than 90 days, after the retiree died.

The initial enrollment period in TRS-Care for an eligible surviving spouse of a deceased active member and for an eligible surviving dependent child of a deceased active member expires on the last day of the month that is three consecutive calendar months, but in no event less than 90 days, after the retiree died.

Initial Enrollment Period for TRS-Care Three consecutive months but no less than 90 days	
RETIREMENT DATE	**TRS 700A DUE DATE**
Sept. 30	Dec. 31
Oct. 31	Jan. 31
Nov. 30	Feb. 28 (or 29)
Dec. 31	March 31
Jan. 31	May 1
Feb. 28 (or 29)	May 31
March 31	June 30
April 30	July 31
May 31	Aug. 31
June 30	Sept. 30
July 31	Oct. 31
Aug. 31	Nov. 30

When is My Coverage Effective?

Effective date of coverage

The effective date of coverage will be (1) the first day of the month following your effective date of retirement if TRS receives your TRS-Care Initial Enrollment Application (Form TRS 700A or 700M) on or before your effective retirement date; or (2) the first day of the month following the receipt of the application for coverage by TRS-Care if your form is received after your effective retirement date but within your Initial Enrollment Period.

If you want your coverage to take effect the first of the month after your retirement date, TRS must receive the application on or before your effective retirement date. This also applies for disability retirees.

During your Initial Enrollment Period, you may still make changes to your coverage elections. The effective date of coverage for any new elections is the first day of the month after TRS receives the new application requesting the retirement coverage.

Deferring coverage

During your Initial Enrollment Period, you may postpone the effective date of your TRS-Care coverage to the first of any of the three months immediately following the month after your retirement date. For example, if your retirement date is May 31, the TRS-Care coverage effective date (normally June 1) may be deferred to July 1, Aug. 1, or Sept. 1. For a deferred effective date, you must write the coverage effective date in the space provided on the Initial Enrollment Application. If you have questions about deferring your effective date, please call **1-888-237-6762**.

Are my children and I eligible for TRS-Care as surviving dependents?

You are eligible to elect coverage as a surviving spouse of a retiree if you were married to a TRS retiree at the time of the retiree's death; and that retiree was eligible for, or would have been eligible for, coverage under this program.

The surviving spouse must elect coverage in order for the dependent children to be covered. If the dependent children of a deceased eligible retiree have survived the retiree and the retiree's spouse, they are then eligible to elect coverage.

You are eligible to continue and/or elect coverage as a surviving spouse of a deceased active member who died on or after Sept. 1, 1986, if the deceased active member had 10 years of service credit in the retirement system for actual service in Texas public schools and had made contributions to TRS-Care at the last place of employment in public education in this state. Surviving spouse and surviving dependent children coverage will continue so long as the monthly payment is made. Surviving dependent children must meet the applicable TRS-Care eligibility criteria.

Eligibility for coverage begins on the first day of the month following the death of the retiree, active member, or surviving spouse. An application to make changes (TRS700C or TRS700D) must be returned to TRS-Care by the later of 31 days after the death of the retiree, active member, or surviving spouse or 31 days following the date the application to make changes is sent by TRS-Care.

A surviving spouse of a deceased retiree or deceased active member who was eligible for TRS-Care may continue his or her own coverage but may not cover a spouse upon remarriage.

Special Enrollment Events

Special enrollment events are opportunities to enroll in TRS-Care outside of your Initial Enrollment Period. You may become eligible for TRS-Care under the special enrollment provisions of the Health Insurance Portability and Accountability Act (HIPAA).

There are two general categories of special enrollment events.

- an individual has an involuntary loss of comprehensive health coverage
- an individual acquires a new dependent

Loss of Eligibility for Other Coverage

If a retiree or surviving spouse loses coverage
If you, as a retiree or surviving spouse, are not enrolled in TRS-Care, and through no fault of your own, you lose comprehensive health coverage with another health plan, you may be able to enroll in TRS-Care under a special enrollment event. However, you must otherwise be eligible for TRS-Care and you must be able to show that you involuntarily lost comprehensive health coverage.

Loss of disability, specified disease, vision, dental, or other coverage that is not comprehensive health coverage does not trigger a special enrollment event.

If you are not already enrolled in TRS-Care at the time you experience an involuntary loss of comprehensive coverage through no fault of your own, you may enroll yourself and your eligible dependents in TRS-Care within 31 days following the loss of coverage under the other comprehensive health plan.

However, if you are already enrolled in TRS-Care at the time you lose other comprehensive health plan coverage, you will not be able to enroll any of your otherwise eligible dependents.
Should you lose coverage with another plan, it will be important to keep your notice of termination letter in order to confirm to TRS that the loss of coverage was involuntary.

Letter of Coverage

TRS may request that you obtain a letter of coverage that states the exact period of time your prior insurer provided comprehensive health coverage to you and the reason you lost coverage. TRS may also request that you provide other letters of coverage for any eligible dependents you desire to enroll in TRS-Care.

If a spouse or other eligible dependent loses coverage
When a spouse or other eligible dependent is not enrolled in TRS-Care, and through no fault of their own, they lose comprehensive health coverage with another health plan, you may enroll your eligible dependents in TRS-Care within 31 days following the dependent's involuntary loss of the other health plan coverage. If you enroll an eligible dependent, you must also become enrolled in TRS-Care (if you are not already enrolled).

Examples of involuntary loss of comprehensive health coverage include:

- divorce or legal separation results in you losing coverage under your spouse's comprehensive health plan
- a dependent is no longer considered a "covered" dependent under a parent's comprehensive health plan
- your spouse's death leaves you without comprehensive health coverage under his or her plan
- your employment ends along with coverage under your employer's comprehensive health plan, or your spouse's employment ends along with your coverage under your spouse's employer's comprehensive health plan
- your employer reduces your work hours to the point where you are no longer covered by the comprehensive health plan
- your plan decides it will no longer offer comprehensive health coverage to a certain group of individuals (for example, those who work part time)
- an individual loses coverage under the state's Children's Health Insurance Program (CHIP) or Medicaid, or becomes eligible to receive premium assistance under those programs for group health plan coverage (HIPP)
- an individual involuntarily loses coverage under a Medicare supplement plan (e.g., Medigap) or an individual Medicare Advantage plan
- you no longer live or work in an HMO's service area and lost comprehensive health coverage

Among other possible events, the following do not qualify for a special enrollment event:

- dropping other coverage because premiums increased
- termination of coverage for failure to pay your premiums
- termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the coverage)

New Dependents

A retiree or surviving spouse (enrolled or otherwise eligible for TRS-Care) who acquires an eligible dependent through marriage, birth, adoption, placement for adoption, or guardianship, must notify TRS in writing within 31 days of the date he/she acquires the eligible dependent, in order for the enrollment to be valid.

For example, if an otherwise eligible retiree is not currently enrolled in TRS-Care at the time he/she gets married, the retiree may enroll himself or herself, along with any eligible dependents, during a special enrollment period. A surviving spouse, however, may not enroll a new spouse if the surviving spouse remarries.

Enrollment is effective:

- in the case of the dependent's birth, the date of the birth
- in the case of the dependent's adoption, the date of such adoption or placement for adoption
- in the case of guardianship, the first day of the month after TRS-Care receives the written request

Documentation is required to establish the eligibility for all new dependents.

A common law marriage is not considered a special enrollment event unless there is a Declaration of Informal Marriage filed with an authorized government agency.

Turning 65: A new enrollment opportunity

If you're a retiree or surviving spouse who isn't yet 65, and you either terminated TRS-Care or didn't enroll during your initial enrollment opportunity, you can enroll in TRS-Care when you turn 65. You may also add eligible dependents at that time.

Prior to your 65th birthday, TRS will send instructions on how to enroll. To enroll in TRS-Care at 65, you must request an application for TRS-Care (Form 700EO) and submit your application for coverage no later than 31 days from the end of the month in which you turn 65. Call TRS Health and Insurance Benefits at **1-888-237-6762** to request an application.

TRS does not always have information about surviving spouses in its records. Surviving spouses are responsible for requesting and submitting their application for coverage no later than 31 days from the end of the month in which they turn 65.

Please note: This enrollment opportunity is not available to dependent spouses or children when they turn 65.

When you become eligible for Medicare, you must purchase and maintain Medicare coverage, including Medicare Part B coverage, to enroll in the TRS-Care Medicare Advantage® medical plan and TRS-Care Medicare Rx® prescription drug plan. You risk losing all TRS-Care coverage if you do not have Medicare Part B coverage when you're eligible to purchase it.

Planning to retire due to a disability?

If you're planning to retire due to a disability, you will pay the premiums listed on page 73, depending on whether you cover yourself only or any dependents.

Already retired due to a disability?

Premiums are determined by the TRS retiree or surviving spouse's Medicare eligibility, regardless of the Medicare status of their dependents. For example, if you are the TRS retiree and you're not yet eligible for Medicare and you cover your spouse who is eligible for Medicare, you would pay $689 per month because you, the retiree, are not yet eligible for Medicare.

What should you know?

When you reach age 65, you may have the opportunity to enroll in TRS-Care and add eligible dependents. In most cases, you will also become eligible for Medicare, which works with the TRS-Care Medicare Advantage® plan and TRS-Care Medicare Rx® plan. Just submit an application and, upon confirmation of your eligibility for TRS-Care and the plan(s) available to you, TRS will enroll you.

When am I eligible for Medicare?

In most cases, you are eligible for Medicare at age 65 or you may be eligible at any age if you have received Social Security disability benefits.

Medicare eligibility at age 65

TRS strongly urges you to enroll in Medicare as soon as you're eligible for it. You can enroll three months prior to the month you turn 65. The earlier you sign up, the sooner TRS can verify your Medicare status and enroll you. Ideally, your Medicare coverage will take effect the first day of your birthday month. If your birthday is on the first of the month, your Medicare coverage will take effect the first of the previous month (the first of the month prior to your birthday month).

Keep in mind, **the period for enrolling in the TRS-Care program is shorter than the enrollment period for Medicare**. The enrollment period for Medicare extends for three months after the month of your 65th birthday, but you must submit an application for enrollment in the TRS-Care program no later than 31 days from the end of the month in which you turn 65.

You must buy and maintain Medicare Part B to be eligible for TRS-Care benefits after you become eligible for Medicare. This is required even if you are not eligible for premium-free Medicare Part A. You don't have to buy Part A if you aren't already getting it for free, but you do need to buy Medicare Part B. If you do not buy and maintain Medicare Part B, you risk losing all TRS-Care coverage.

Medicare eligibility for End Stage Renal Disease (ESRD)

If you're eligible for Medicare due to ESRD, Medicare pays secondary to TRS-Care because federal rules require TRS-Care coverage to be primary for a certain period of time. Once your Medicare Part A becomes your primary coverage, your TRS-Care monthly premium and your TRS-Care deductible will go down. If you're eligible due to ESRD, please let TRS know by phone or in writing.

What steps do I need to take when I turn 65?

You're eligible for Medicare at age 65 and can enroll three months prior to the month you turn 65.

- If you're eligible for premium-free Medicare Part A (hospitalization), sign up for it through the Social Security Administration. You can apply online at www.ssa.gov/medicare, visit your local Social Security office, or call Social Security at 1-800-772-1213 (TTY: 1-800-325-0778).
- Purchase Medicare Part B through the Social Security Administration as soon as enrollment becomes available to you. You must buy and maintain Medicare Part B to be eligible for TRS-Care benefits. The Social Security Administration can confirm your Part B premium; please note that it will not be deducted from your TRS pension.
- If you're currently enrolled in TRS-Care, when you turn age 65, UnitedHealthcare will send you a packet with a form requesting your Medicare number. Please complete the form and return it to TRS.*
- Separately, TRS will send you an enrollment kit. Review the materials inside. If you're adding dependents, complete and submit the application for TRS-Care no later than 31 days from the end of the month in which you retire or turn 65.

If you are eligible for TRS-Care coverage, and once TRS verifies your Medicare information, TRS will enroll you in the TRS-Care Medicare Advantage® and TRS-Care Medicare Rx® plans. **If TRS does not receive your Medicare number, TRS will not be able to enroll you, and you risk losing TRS-Care coverage altogether.**

*If you're a retiree or surviving spouse who isn't yet 65, and you either terminated TRS-Care or didn't enroll during your initial enrollment opportunity, you also can enroll in TRS-Care when you turn 65. You may add dependents then, too. To enroll in TRS-Care at age 65, you must request an application and submit it no later than 31 days from the end of the month in which you turn 65. Call TRS Health and Insurance Benefits at 1-888-237-6762 to request an application.

Adjustment Rule

If, for any reason, a person is enrolled in an inappropriate level of coverage, coverage will be adjusted as provided in this Booklet.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of the plan in effect prior to the date of any adjustment.

Any increase in the level of benefits because of a change in any of the above amounts will not provide additional benefits for covered medical expenses incurred before the date the change took effect.

Under what circumstances can TRS-Care terminate my coverage?

Retiree coverage under *TRS-Care* ceases at the earliest occurrence of the following:

- you are no longer eligible
- a retiree becomes enrolled in a plan offered by TRS-ActiveCare or a plan offered by a Texas public school that is not participating in TRS-ActiveCare a retiree becomes eligible for coverage under a plan provided under a program administered by the Employees Retirement System of Texas, the University of Texas, or Texas A & M
- it is established that fraud was committed by you or your covered dependent
- you fail to make the required contribution
- *TRS-Care* is discontinued

Dependent coverage will cease at the earliest occurrence of any of the following:

- discontinuance of all dependent coverage under TRS-Care
- a dependent enrolls in TRS-Care as a retiree
- the person ceases to meet TRS-Care's definition of a dependent
- the retiree's coverage ceases
- the retiree fails to make any required contributions
- it is established that the dependent committed fraud

Failure to timely pay the full amount of a required contribution for coverage will result in termination of coverage at the end of the month for which the last contribution was made.

If my coverage or my dependent's coverage is terminated, are there ways to continue the coverage?

TRS-Care is required to offer to the TRS-Care retiree's spouse and dependent children who are enrolled in TRS-Care the right to temporarily continue group health coverage if the coverage would cease upon the occurrence of certain qualifying events. The COBRA continuation coverage that a spouse or dependent child elects to obtain, if any, provides benefits that are identical to the coverage's provided to similarly situated retirees, surviving spouses, and their dependents. TRS-Care will notify the spouse or dependent children of any changes in coverage or benefits available.

COBRA continuation coverage is available if a TRS-Care retiree's spouse or dependent children will lose coverage under TRS-Care due to any of the following:

- your death
- your divorce or legal separation
- a dependent child ceasing to be a dependent as defined in the TRS-Care Benefits Booklet

If the spouse or dependent children would lose coverage upon the occurrence of one of these three qualifying events, they must notify TRS-Care of the event within 60 days of the later of (1) the date on which the qualifying event occurs; or (2) the date coverage would be lost as a result of the qualifying event.

For a written notice of a qualifying event to be timely, it must be post marked or otherwise sent to TRS-Care on or before the last day of the 60-day notification period.

There are two ways a TRS-Care participant whose coverage is terminated may continue coverage. Continuation of TRS-Care coverage through COBRA is explained on page 86 in the "Notices" section. (Please note that a surviving spouse of a TRS-Care retiree can continue TRS-Care participation without enrolling through COBRA.)

How does TRS-Care work when there is other coverage?

Some persons have group health coverage in addition to coverage under this Program. When this is the case, the benefits from "other plans," including group plans not purchased by a *plan sponsor*, will be taken into account.

This may mean a reduction in benefits under TRS-Care. The combined benefits will not be more than the expenses recognized under all plans. This is called Coordination of Benefits (COB). At no time will TRS-Care pay more than the covered person is legally obligated to pay.

Under the COB provision, the plan that pays first is called the primary plan. The secondary plan typically makes up the difference between the primary plan's benefit and the covered charge. When one plan does not have a COB provision, that plan is always considered primary and always pays first. COB payments do not always total 100% of charges.

If you currently have TRICARE, *TRS-Care* will always be primary. It is important that you notify *TRS-Care* Customer Service at **1-866-355-5999** when you have other insurance coverage. They will help you determine the order of benefit determination for your claims.

Allowable Amount

The *allowable amount* is the maximum amount of benefits BCBSTX will pay for *eligible expenses* you incur under your health plan. BCBSTX has established an *allowable amount* for *medically necessary* services, supplies, and procedures provided by *providers* that have contracted with BCBSTX or any other Blue Cross and/or Blue Shield Plan, and *providers* that have not contracted with BCBSTX or any other Blue Cross and/or Blue Shield Plan.

When you choose to receive services, supplies, or care from a *provider* that doesn't contract with BCBSTX, you will be responsible for any difference between BCBSTX's *allowable amount* and the amount charged by the non-contracting *provider*. You will also be responsible for charges for services, supplies, and procedures limited or not covered under your health plan, any applicable *deductibles*, *coinsurance*, and *copays*.

However, if you receive services from an *out-of-network provider* when you are in an *in-network hospital* or facility, you may be protected from balance billing in accordance with applicable law.

Review the definition of *allowable amount* in the **DEFINITIONS** section of this benefits booklet to understand the guidelines used by BCBSTX.

Case Management

Under certain circumstances, your health plan allows BCBSTX the flexibility to offer benefits for expenses which are not otherwise *eligible expenses*. BCBSTX, at its sole discretion, may offer such benefits if:

- the *participant*, their family, and the *physician* agree
- benefits are cost effective
- BCBSTX anticipates future expenditures for *eligible expenses* which may be reduced by such benefits

Any decision by BCBSTX to provide such benefits shall be made on a case-by-case basis. The case coordinator for BCBSTX will initiate case management in appropriate situations.

Freedom of Choice

Each time you need medical care, you can choose to:

See an In-Network Provider	***See an Out-of-Network Provider***	
	ParPlan provider (refer to ParPlan, below, for more information)	***Out-of-Network Provider (not a contracting provider)***
• You receive the higher level of benefits (*in-network benefits*). • You are not required to file claim forms. • You are not balance billed; *in-network providers* won't bill for costs exceeding BCBSTX's *allowable amount* for covered services. • Your *provider* will obtain *prior authorization* for necessary services.	• You receive the lower level of benefits (*out-of-network benefits*). • You are not required to file claim forms in most cases; *ParPlan providers* will usually file claims for you. • You are not balance billed; *ParPlan providers* won't bill for costs exceeding the BCBSTX's *allowable amount* for covered services. • In most cases, *ParPlan providers* will obtain *prior authorization for* necessary services.	• You receive *out-of-network benefits* (the lower level of benefits). • You are required to file your own claim forms. • You may be billed for charges exceeding the BCBSTX's *allowable amount* for covered services. • You must obtain *prior authorization for* necessary services.

Identification Card

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

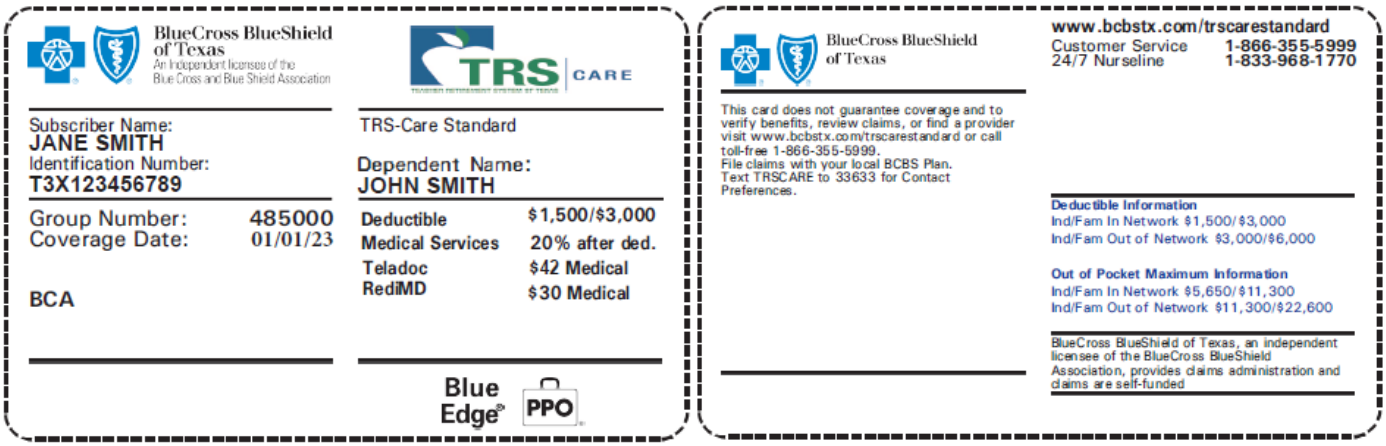
- ***your subscriber identification number***
  This unique identification number is preceded by a three-character alpha prefix that identifies BCBSTX as your Claim Administrator.
- ***your group number***
  This is the number assigned to identify your *plan sponsor's plan* with BCBSTX.
- ***any copays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

Each covered family member will receive an ID card. If you are a spouse or dependent, your card will also include the Retiree's name (also referred to as the subscriber).

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.

Sample 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

Medical Necessity

All services and supplies for which benefits are available under your health plan must be *medically necessary* as determined by BCBSTX. Charges for services and supplies which BCBSTX determines are not *medically necessary* won't be eligible for benefit consideration and may not be used to satisfy *deductibles* or to apply to the *maximum out-of-pocket*.

ParPlan

When you consult a *physician* or *professional other provider* who doesn't participate in the *network*, you should inquire if they participate in BCBSTX's *ParPlan,* a simple direct-payment arrangement (see the definition of *ParPlan* in the **DEFINTIONS** section of this benefits booklet). If the *physician* or *professional other provider* participates in the *ParPlan,* they agree to:

- file all claims for you
- accept BCBSTX's *allowable amount* determination as payment for *medically necessary* services
- not bill you for services over the *allowable amount* determination

When you choose a provider that participates in the ParPlan, you will receive *out-of-network* benefits and be responsible for:

- any *deductibles*
- coinsurance
- services that are limited or not covered under your health plan

NOTE: If you have a question regarding a *physician's* or *professional other provider's* participation in the *ParPlan*, please contact your Personal Health Guide at 1-866-355-5999.

Preexisting Conditions Provision

Benefits for *eligible expenses* incurred for treatment of a preexisting condition will be available immediately with no preexisting condition waiting period.

Specialty Care Providers

A wide range of *specialty care providers* are included in the *network*. When you need a specialist's care, *in-network benefits* will be available, but only if you use an *in-network provider.*

There may be occasions however, when you need the services of an *out-of-network provider*. This could occur if you have a complex medical problem that can't be taken care of by an *in-network provider*.

- If the services you require are not available from *in-network providers*, and BCBSTX preauthorizes your visit to an *out-of-network provider* prior to the visit, *in-network benefits* will be provided.
- If you elect to see an *out-of-network provider* and if the services could have been provided by an *in-network provider*, only *out-of-network benefits* will be available.

Use of Non-Contracting Providers

When you choose to receive services, supplies, or care from a *provider* that doesn't contract with BCBSTX (a non-contracting *provider*), you receive *out-of-network benefits* (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX non-contracting *allowable amount*, which in most cases is less than the *allowable amount* applicable for BCBSTX contracted *providers*. Please see the definition of non-contracting *allowable amount* in the **DEFINITIONS** section of this benefits booklet.

The non-contracted *provider* isn't required to accept the BCBSTX non-contracting *allowable amount* as payment in full and may balance bill you for the difference between the BCBSTX non-contracting *allowable amount* and the non-contracting *provider's* billed charges (except when the *provider* would be prohibited from doing so under law). You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies, and procedures limited or not covered under your health plan, any applicable *deductibles*, *coinsurance*, and *copays*.

UTILIZATION MANAGEMENT

Utilization Management

Utilization management may be referred to as *medical necessity* reviews, utilization review (UR) or medical management reviews. A *medical necessity* review for a procedure/service, inpatient admission, and length of stay is based on BCBSTX medical policy and/or level of care review criteria. *Medical necessity* reviews may occur prior to services rendered, during the course of care, or after care has been completed for a *post-service medical necessity review*. Some services may require a *prior authorization* before the start of services, while other services will be subject to a *post-service medical necessity review*. If requested, services normally subject to a *post-service medical necessity review* may be reviewed for *medical necessity* prior to the service through a *recommended clinical review*.

Refer to the definition of *medical necessity* or *medically necessary* in the **DEFINITIONS** section of this benefits booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

Prior Authorization Requirements

Prior authorization establishes in advance the *medical necessity* or *experimental/investigational* nature of certain care and services covered under this *plan*. It ensures that the care and services described below for which you have obtained *prior authorization* won't be denied based on *medical necessity* or *experimental/investigational*. However, *prior authorization* 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 *prior authorization*:

- all inpatient hospital admissions
- extended care expenses
- home health
- home infusion therapy
- home hospice
- molecular genetic testing
- radiation therapy
- outpatient transplant evaluations
- non-emergency air ambulance: fixed wing (please refer to the *fixed-wing air ambulance* definition in the **DEFINITIONS** section of this benefits booklet)
  a. **Cardiac (heart related):**
     (1) stress testing (myocardial perfusion imaging – single-photon emission computed tomography SPECT and PET)
     (2) implantable device services: pacemakers, implantable cardioverter-defibrillators
     (3) 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) lumbar spinal fusion
   (5) orthopedic applications of stem-cell therapy
   (6) total disc replacement surgery

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)

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-systemic

For specific details about the *prior authorization* 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 *prior authorization* for certain services during the *calendar year*. Updates to the list of services requiring *prior authorization* 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 *prior authorization* for *inpatient hospital admissions*. In order to receive maximum benefits under this benefits booklet, you must get *prior authorization* for emergency and non-emergency admissions for *mental health care*/*serious mental illness*, *residential treatment centers* and partial hospitalization programs. Blue Cross and Blue Shield of Texas 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 *prior authorization*:

- 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:
  a. psychological testing or neuropsychological testing in some cases (BCBSTX will notify your provider if *prior authorization* is required for these testing services)
  b. 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)
  c. outpatient electroconvulsive therapy
  d. intensive outpatient program
  e. 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 obtain *prior authorization* of services for you, when required.

If you elect to use *out-of-network providers* for services and supplies available *in-network*, *out-of-network benefits* will be paid. 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 *in-network provider* is required to obtain *prior authorization* for inpatient *hospital admissions*. You are responsible for satisfying all other *prior authorization* requirements.

This means that you must ensure that you, an authorized representative, your *physician*, *behavioral health provider* or *provider* of services must comply with the guidelines below. Failure to obtain *prior authorization* of services will require additional steps and/or benefit reductions as described in the subsection entitled *Failure to Obtain Prior Authorization*.

Prior Authorization for Inpatient Hospital Admissions

In the case of an elective inpatient *hospital admission*, the call for *prior authorization* 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, *prior authorization* should take place within two working days after admission, or as soon thereafter as reasonably possible.

Your *in-network provider* is required to obtain *prior authorization* for any inpatient admissions. If *prior authorization* 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 participating *provider* of services, or an authorized representative should obtain *prior authorization* by your health plan 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 the number listed on the back of your ID Card. 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 *prior authorization* 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 *in-network specialty care provider*. If you elect to use *out-of-network providers* for services and supplies available *in-network*, *out-of-network benefits* will be paid. *In-network* and *out-of-network providers* may obtain *prior authorization* of services for you, when required, but it is your responsibility to ensure *prior authorization* requirements are satisfied.

However, if care isn't available from *in-network provider*s 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; otherwise, *out-of-network benefits* will be paid.

When *prior authorization* of an inpatient *hospital admission* is obtained, a length-of-stay is assigned. If you require a longer stay, your *provider* may seek an extension for the additional days. Benefits won't be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the ***Length of Stay/Service Review*** subsection of this benefits booklet.

Prior Authorization 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
  a. 48 hours following an uncomplicated vaginal delivery
  b. 96 hours following an uncomplicated delivery by caesarean section
- treatment of breast cancer
  a. 48 hours following a mastectomy
  b. 24 hours following a lymph node dissection

You or your *provider* won't be required to obtain *prior authorization* 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 *prior authorization* from BCBSTX.

Prior Authorization for Extended Care Expenses and Home Infusion Therapy

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

- prior to initiating extended care expenses or home infusion therapy
- when an extension of the 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 *prior authorization* 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.

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

In order to receive maximum benefits, you must obtain *prior authorization* from the *plan* for all inpatient treatment for *mental health care*, *serious mental illness*, and *substance use disorder*. *Prior authorization* is also required for certain outpatient services.

Outpatient services requiring *prior authorization* include:

- psychological testing
- neuropsychological testing
- repetitive transcranial magnetic stimulation
- intensive outpatient programs
- applied behavior analysis
- outpatient electroconvulsive therapy

Prior authorization isn't required for therapy visits to a *physician*, *behavioral health provider* and/or *professional other provider*.

To satisfy *prior authorization* requirements, you, an authorized representative 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 *prior authorization* 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 in-*network specialty care provider*. If you elect to use *out-of-network providers* for services and supplies available *in-network*, *out-of-network benefits* will be paid. *In-network* and *out-of-network providers* may obtain *prior authorization* of services for you, when required, but it is your responsibility to ensure *prior authorization* requirements are satisfied.

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; otherwise, *out-of-network benefits* will be paid.

When you obtain *prior authorization* for a treatment or service, a length of stay or length of service is assigned. If you require a longer stay or length of service, 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.

Length of Stay/Service Review

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under this *plan*.

Upon completion of the preadmission or emergency admission review, BCBSTX will send you a letter confirming that you or your representative called BCBSTX. A letter authorizing a length of service or length of stay will be sent to you, your *physician, provider* of services, and/or the *hospital* or facility.

An extension of the length of stay/service will be based solely on whether continued *inpatient* care or other health care services are *medically necessary*. If the extension is determined not to be *medically necessary*, the coverage for the length of stay/service will not be extended, except as otherwise described in the **CLAIM FILING AND APPEALS PROCEDURES** section of this benefits booklet.

A length of stay/service review, also known as a concurrent *medical necessity* review, is when you, your *provider*, or other authorized representative may submit a request to BCBSTX for continued services. If you, your *provider* or authorized representative requests to extend care beyond the approved time limit and it is a request involving urgent care or an ongoing course of treatment, BCBSTX will make a determination on the request as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

Recommended Clinical Review Option

There are services that do not require a Prior Authorization that may be subject to a *post-service medical necessity review* before the claim is paid. There is an option for your *provider* to request a *recommended clinical review* to determine if the service meets approved medical policy and/or level of care review criteria before services are provided to you. Once a decision has been made on the services reviewed as part of the *recommended clinical review* process, the same services will not be reviewed for *medical necessity* after they have been performed.

To determine if a *recommended clinical review* is available for a specific service, visit our website at www.bcbstx.com/find-care/where-you-go-matters/utilization-management.com for the *recommended clinical review* list, which is updated when new services are added or when services are removed. You can also call your Personal Health Guide at the number on the back of your ID card. This website also includes information on which services require *prior authorization* before services are performed.

In the event a *recommended clinical review* determines the proposed services are not *medically necessary*, you have the right to file an appeal as described in the CLAIM FILING AND APPEALS PROCEDURES section. All appeal and review requirements related to *medical necessity* determinations, including independent review, apply to services where your *provider* requests a *recommended clinical review*.

***Recommended clinical review* is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of the *plan*. Please coordinate with your *provider* to submit a written request for a *recommended clinical review*.**

General Provisions Applicable to All Recommended Clinical Reviews

- **No Guarantee of Payment**
  A *recommended clinical review* is not a guarantee of benefits or payment of benefits by BCBSTX. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Even if the service has been approved *in a recommended clinical review*, coverage or payment can be affected for a variety of reasons. For example, you may have become ineligible as of the date of service or the member's benefits may have changed as of the date of service.
- **Request for Additional Information**
  The *recommended clinical review* process may require additional documentation from your *provider* or pharmacist. In addition to the written request for *recommended clinical review*, the *provider* or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSTX to make a determination of coverage pursuant to the terms and conditions of this *plan*.

Post-Service Medical Necessity Review

A *post-service medical necessity review*, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has been provided and is based on *medical necessity* guidelines. A *post-service medical necessity review* confirms your eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure the service was *medically necessary*. Providers should submit appropriate documentation at the time of a *post-service medical necessity review* request. A *post-service medical necessity review* may be performed when a *prior authorization* or *recommended clinical review* was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

- **No Guarantee of Payment**
  A *post-service medical necessity review* is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this *plan*. *Post-service medical necessity review* does not guarantee payment of benefits by BCBSTX, for instance you may become ineligible as of the date of service or your benefits may have changed as of the date of service.
- **Request for Additional Information**
  The *post-service medical necessity review* process may require additional documentation from your *provider* or pharmacist. In addition to the written request for *post-service medical necessity review*, the *provider* or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSTX to make a determination of coverage pursuant to the terms and conditions of this *plan*.

Failure to Obtain Prior Authorization

If *prior authorization* 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 *prior authorization* requirements for any inpatient admissions. If *prior authorization* 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 *prior authorization* of any of the following treatment or services isn't obtained 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 *prior authorization* issued by BCBSTX can be requested by a *physician* or *health care provider* up to 60 days prior to the expiration of the existing *prior authorization*.

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 *plan sponsor* for delivery to you, the *hospital*, or your *physician* or *professional other provider*, the claim forms that are usually furnished 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

*Provider*s 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.

Non-Contracting Providers

When you receive treatment or care from a health care provider that doesn't contract with BCBSTX, you may be required to file your own claim forms. Some providers, however, will do this for you. If the provider doesn't submit claims for you, refer to the subsection entitled Participant-Filed Claims below for instruction on how to file your own claim forms.

Participant-Filed 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/trscarestandard, 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 provider, 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/trscarestandard

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 subsection **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.

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 the *plan*.

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 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:

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims	Concurrent Care Claims
What is the general deadline for initial determination?	No later than 72 hours from receipt of the claim	15 calendar days from receipt of the claim	30 calendar days from receipt of the claim	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. **Note**: 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.
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

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims	Concurrent Care Claims
What if additional information is needed?	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.	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.	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.	Not applicable
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 an 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 *plan sponsor'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 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 notify you of the benefit determination in a reasonably prompt time considering the medical exigencies.

  The appeal determination will be made by BCBSTX or, if required by a *physician* associated or contracted with BCBSTX and/or by external advisors, who were not involved in making the initial denial of your claim and the individuals who made the Adverse Benefit Determination won't conduct the appeal. 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

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

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.

  Please note: Diagnosis/treatment codes with their meanings and the standards used are also available upon request.
- 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** subsection below.

If You Need Assistance

If you have any questions about the claims procedures or the review procedures, write or call your Personal Health Guide at 1-866-355-5999.Your Personal Health Guide at 1-866-355-5999 is accessible 24 hours a day, 7 days a week.

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

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** subsection 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 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** subsection above. BCBSTX must immediately send you a notice of its eligibility determination that meets the requirements set forth in **Standard External Review** subsection 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** subsection 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** subsection 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 *Plan Sponsor*'s Plan Provisions

TRS 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.

TRS 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 TRS 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 Schedule(s) in this benefits booklet. Your benefits are calculated on a *calendar year* benefit period basis unless otherwise stated. At the end of a *calendar 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*, if indicated on your **SCHEDULE OF COVERAGE**, 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 *prior authorization*
- 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 *prior authorization*
- *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.

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 *calendar 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 *calendar 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*. *Eligible expenses* applied toward satisfying the "individual" and "family" *out-of-network deductible* will only apply to the *out-of-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 obtain *prior authorization*

Individual Maximum Out-of-Pocket

When the *coinsurance* amount 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 *calendar year*.

Family Maximum Out-of-Pocket

When the *coinsurance* amount 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 *calendar year*. No participant will be required to contribute more than the individual Maximum Out-of-Pocket to the family "Maximum Out-of-Pocket."

The following are exceptions to the *maximum out-of-pocket* described above:

- There are separate maximum out-of-pocket for in-network benefits and out-of-network benefits.
- Eligible expenses applied toward satisfying the "individual" and "family" in-network maximum *out-of-pocket* will only apply to the *in-network maximum out-of-pocket*. *Eligible expenses* applied toward satisfying the "individual" and "family" *out-of-network maximum out-of-pocket* will only apply to the *out-of-network maximum out-of-pocket*.

Changes in Benefits

Changes to covered benefits will apply to all services provided to each *participant* under your health 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.

Inpatient Hospital Expenses

Your health plan provides coverage for *inpatient hospital expenses* for you and your eligible *dependents*. Each inpatient *hospital admission* requires *prior authorization*. Refer to the **UTILIZATION MANAGEMENT** section 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*.

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 obtain *prior authorization* 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 *prior authorization*. Refer to the **UTILIZATION MANAGEMENT** section of this benefits booklet for more information.

Applicable *copays* must be paid to your *in-network physician* 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 expenses 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, air conditioners, air purifiers, humidifiers, physical fitness equipment, and 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*.

- 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/trscarestandard 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
- enteral formula, based on *medical necessity*
- 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*. Certain *extended care expenses* require *prior authorization*. Refer to the **UTILIZATION MANAGEMENT** section of this benefits booklet for more information.

Your benefit obligation as shown on your **SCHEDULE OF COVERAGE** will be:

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

All payments made by your health plan, whether under the *in-network* or out-of-network (if applicable) *benefit* level, will apply toward the benefit visit maximums, if any, under both levels of benefits.

The benefit visit maximums will also include any benefits provided to a *participant* for *extended care expenses* under a health *plan* held by the *plan sponsor* 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:

  a. food or home delivered meals
  b. social case work or homemaker services
  c. services provided primarily for custodial care
  d. transportation services
  e. home infusion therapy
  f. 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 *prior authorization* and that any *copays*, *coinsurance*, and *deductibles* shown on your Schedule(s) of Coverage will also apply. Refer to the **UTILIZATION MANAGEMENT** section of this benefits booklet for more information.

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 *prior authorization*. Dependent *children* will be eligible for treatment of *complications of pregnancy*.

Please see the definition of "*complications of pregnancy*" in the **DEFINITIONS** section for more information.

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.

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 expenses* 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**.

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, and
- poisonings

Services provided in an emergency room, freestanding emergency room, or other comparable facility that are not *emergency care* may be excluded from *emergency care* coverage, although these services may be covered under another benefit, if applicable.

If you disagree with BCBSTX's determination in processing your benefits as non-*emergency care* instead of *emergency care*, you may call your Personal Health Guide at 1-866-355-5999. Please review the *Review of Claim Determinations* provision of this benefits booklet for specific information on your right to seek and obtain a full and fair review of your claim.

Emergency care doesn't require *prior authorization*. However, if reasonably possible, contact your *in-network physician* or *behavioral health provider* before going to the *hospital* emergency room/treatment room. They can help you determine if you need *emergency care* or treatment of an *accidental injury* and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether the facility is in the *network*.

Whether you require hospitalization or not, you should notify your *in-network physician* or *behavioral health provider* within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so they can recommend the continuation of any necessary medical services.

Benefits for *eligible expenses* for *accidental injury* or *emergency care*, including *accidental injury* or *emergency care* for Behavioral Health Services, will be determined as shown on your **SCHEDULE OF COVERAGE**. *copays* will be required for facility charges for each outpatient *hospital* emergency room/treatment room visit as indicated on your **SCHEDULE OF COVERAGE**. If admitted for the emergency condition immediately following the visit, any *copays* will be waived, and *prior authorization* of the *inpatient hospital admission* will be required.

All treatment received following the onset of an *accidental injury* or *emergency care* will be eligible for *in-network benefits*. For a non-emergency, *in-network benefits* will be available only if you use *in-network providers*. For a non-emergency, if you can safely be transferred to the care of an *in-network provider* but are treated by an *out-of-network provider*, only *out-of-network benefits* will be available.

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.

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**.

Durable Medical Equipment

You must obtain services and devices through a participating DME *provider*, which may require *prior authorization* by the *claim administrator*. The *claim administrator* will determine whether DME is rented or purchased, and retains the option to recover the DME upon cancellation or termination of your coverage.

DME is covered at initial placement and when standard replacements are needed due to physical growth of Participants under 18 years of age, and must be consistent with the Medicare DME Manual. For a covered DME item, repair, adjustment, or replacement of components and accessories necessary for effective functioning, and replacement of the entire covered DME item is covered if the covered DME item is determined to be non-functional, non-repairable, stolen, or destroyed in a fire and/or natural disaster.

Examples of DME are:

- standard wheelchairs
- crutches
- walkers
- orthopedic tractions
- Hospital beds
- oxygen
- bedside commodes
- suction machines, etc

Excluded items are listed in **MEDICAL LIMITATIONS AND EXCLUSIONS**.

Ostomy Supplies

Benefits for supplies related to ostomy may include, but are not limited to:

- pouches, face plates and belts
- irrigation sleeves, bags and ostomy irrigation catheters
- skin barriers
- deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive remover

Medical Supplies

Medical or disposable supplies prescribed by a *physician* include, but are not limited to:

- urinary catheters
- wound care or dressing supplies given by a *provider* during treatment for covered health services
- medical-grade compression stockings when considered medically necessary
  The stockings must be prescribed by a *physician*, individually measured and fitted to the patient.

Coverage also includes disposable supplies necessary for the effective use of durable medical equipment and diabetic supplies for which benefits are provided as described under *Benefits for Treatment of Diabetes*.

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, whether under the *in-network* or out-of-network, if applicable, Benefits level, will apply toward the benefit maximum amount indicated on your **SCHEDULE OF COVERAGE** for each level of benefits.

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 *prior authorization*.

Note: Hearing therapy is not a covered benefit.

Benefits for Certain Therapies for Children with Developmental Delays

Medical-surgical expenses 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*.

Individuals providing treatment prescribed under that plan must be:

- 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.

Prior authorization will assess whether services meet coverage requirements. Review the **UTILIZATION MANAGEMENT** section in this benefits booklet for more specific information about *prior authorization*.

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

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**.

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
- 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 Oral Surgery and 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:

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 expense* for a *medically necessary* inpatient *hospital admission,* will be determined as described in **Benefits for Inpatient Hospital Expenses**.

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)
- removal of teeth:
  a. teeth partly or completely impacted in the bone of the jaw
  b. teeth that will not erupt through the gum
  c. other teeth that cannot be removed without cutting the bone
  d. the roots of a tooth or cysts without removing the entire tooth
  e. tumors
- 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 expense* for a *medically necessary* inpatient *hospital admission,* will be determined as described in **Benefits for Inpatient Hospital Expenses**.

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
  d. the transplant procedure obtains *prior authorization* as required under your health plan
  e. the *participant* meets all of the criteria established by BCBSTX in pertinent written medical policies
  f. the *participant* meets all of 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 of 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

- *Prior authorization* is required for any organ or tissue transplant. Review the **UTILIZATION MANAGEMENT** section in this benefits booklet for more specific information about *prior authorization*.
  a. Such specific *prior authorization* is required even if the patient is already a patient in a *hospital* under another *prior authorization*.
  b. At the time of *prior authorization*, 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**.

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 *calendar 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 (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) 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 during which physical treatment is rendered won't be provided for more than the maximum number of visits (outpatient facility and office combined) shown on your **SCHEDULE OF COVERAGE**. Any visits during which no physical treatment is rendered won't count toward the visit maximum.

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

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 40 years of age or older.

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/trscarestandard 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. For women under age 65 and men under 70, coverage will be based on medical necessity)
- screening for colorectal cancer
- smoking cessation counseling services (limited to eight visits per *calendar 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 *calendar 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)
- lung cancer screening for participants ages 55-79 who are smokers or recently quit smoking, once per *calendar year*

Examples of covered immunizations included are:

- Diphtheria
- Haemophilus influenzae type b
- Hepatitis B
- Measles
- Mumps
- Pertussis
- Polio
- Rubella
- Tetanus
- Zostavax (Shingles) vaccine, once per lifetime
- 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/trscarestandard 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.

Preventive Care Services provided by an out-of-network provider for the 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 dollar maximums. Deductibles are not applicable to immunizations covered under Benefits for Childhood Immunizations provision.

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 purchase of manual or electric breast pumps, accessories and supplies. Benefits for electric breast pumps are limited to once every 36 months. Limited benefits are also included *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/trscarestandard to obtain a claim form.

If you use an *out-of-network provider*, the benefits may be subject to any applicable *deductible*, *coinsurance* and/or benefit maximum.

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* 35 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 *calendar year*. Coverage for mammography screening for *participants* under 35 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:
  a. vertebral abnormalities
  b. primary hyperparathyroidism
  c. a history of bone fractures

- an individual who is:
  a. receiving long-term glucocorticoid therapy
  b. 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 45 years of age or older and who are at normal risk for developing colon cancer, include:

- a fecal occult blood test performed once per *calendar year*, and a flexible sigmoidoscopy performed every five years
- a colonoscopy performed every ten years
- Cologuard performed every three years (services are not covered for participants under the age of 50)

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 (HPV) and Cervical Cancer for each woman enrolled in your health plan who is 21 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**. These services are only covered for participants under the age of 21 when there is a diagnosis of:

- cervical dysplasia
- cervical cancer
- Diethylstilbestrol (DES) exposure
- HIV infection
- immuno-compromised women

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.

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 influenzae type b
- Hepatitis B
- Measles
- Mumps
- Pertussis
- Polio
- Rubella
- Tetanus

- Varicella
- 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, limited to once per calendar year, except for benefits as provided under ***Benefits for Screening Tests for Hearing Impairment***
- annual vision examinations, limited to once per *calendar year*

Benefits are available for the first pair of eyeglasses, frames and lenses, or contact lenses purchased within 12 months after intraocular surgery or accidental injury. There is no coverage for the cost of subsequent eyeglasses or contact lenses.

Routine eye exams are only covered for *participants* with a diabetic diagnosis.

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 **UTILIZATION MANAGEMENT** section to determine what services require *prior authorization*.

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*.)

Blue Distinction® and Blue Distinction Specialty Care Program

Blue Distinction® (“Blue Distinction”) is a national designation awarded by Blue Cross and Blue Shield Plans to health care providers. The Blue Distinction Specialty Care program includes two levels of designation: *Blue Distinction Centers (BDC)* and Blue Distinction Centers+ (BDC+). The Blue Distinction Specialty Care program focuses on BDC and BDC+ providers that excel in providing safe, effective treatment for specialty care needs.

Blue Distinction Centers

The Blue Distinction designation uses nationally consistent criteria to designate high- performing *providers* based on objective, evidence- based selection criteria. The Blue Distinction Specialty Care program's purpose is to assist you in finding BDC and BDC+ providers that have met overall quality measures for patient safety and outcomes, fewer medical complications, lower readmission rates, and higher survival rates in the administration of specialty care.

Blue Distinction Centers provide care in the following specialty care areas:

- cardiac care
- cellular immunotherapy (CAR- T)
- fertility care*
- substance use treatment and recovery
- cancer care
- gene therapy
- spine surgery
- bariatric surgery
- knee and hip replacement surgery
- maternity care
- transplants

*BDC and BDC+ Fertility Care programs are currently supported by plans with Fertility Care programs at the professional level.

BDC and BDC+ Benefit Differential

Your plan may offer lower out-of-pocket costs when you receive treatment at a BDC and/or BDC+ Provider. You may choose to receive treatment at a non-BDC and/or non-BDC+ *provider*; however, your out-of-pocket costs will be higher. Please refer to your **SCHEDULE OF COVERAGE** section to review the payment levels for procedures performed at a BDC or a BDC+ designated Provider, and procedures performed at other facilities. Blue Distinction benefit levels apply to Blue Distinction facility benefits only, except for fertility, which offers *professional provider* services, and cancer care, which offers facility and *professional providers*.

Mandatory Blue Distinction Centers and Blue Distinction Centers+ Specialty Care Product

The Mandatory BDC and BDC+ Specialty Care product requires you to obtain transplants and bariatric services at a *Blue Distinction Center* or *Blue Distinction Center+* in order to obtain maximum benefits. If you choose to utilize a non-*Blue Distinction Center* or non-*Blue Distinction Center+* you will be responsible for 100% of costs associated with any specialty care received at such facility.

For additional information regarding Blue Distinction Centers for specialty care, please contact your Personal Health Guide at the telephone number indicated in this benefits booklet or shown on your ID Card or visit the following website: www.bcbs.com/why-bcbs/blue-distinction.

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 reduction mammoplasty, except services covered 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
(7) pronuclear oocyte stage transfer
(8) zygote intra-fallopian transfer
(9) 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. bandages
h. garter belts

- excluded supplies include, but are not limited, compression stockings, ace bandages, wound care or dressing supplies, prescribed or non-prescribed medical and disposable supplies that can be purchased over the counter

  This exclusion does not apply to:

  a. ostomy bags and related supplies for which benefits are provided as descried under *Ostomy Supplies* subsection
  b. disposable supplies necessary for the effective use of durable medical equipment for which benefits are provided as described under *Durable Medical Equipment* subsection
  c. urinary catheters, wound care or dressing supplies given by a *provider* during treatment for *covered services*
  d. medical grade compression stockings when considered *medically necessary*
     The stockings must be prescribed by a *physician*, individually measured and fitted to the patient.
  e. diabetic supplies for which benefits are provided as described under *Benefits for Treatment of Diabetes* subsection
  f. batteries, tubing, nasal cannulas, connectors and masks when used with approved durable medical equipment

  Not all medical supplies are covered services, and all are subject to medical review.

- any benefits in excess of any specified dollar, day/visit, or *calendar 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 nonprescription 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

- as it applies to *TRS-Care HD*, any services or supplies provided for bariatric surgery. (Please see your applicable **SCHEDULE OF COVERAGE**)

- 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 *plan sponsors*, insurers, schools, camps, courts, licensing authorities, other third parties or 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:
  a. televisions
  b. telephones
  c. guest beds
  d. admission kits
  e. 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.

- 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
- hearing therapy
- dental implants
- marriage and family therapy
- any services or supplies not specifically defined as *eligible expenses* in this *plan*
- elective abortions - coverage is limited to abortions performed because a serious medical complication would put the health or life of the mother in danger if the fetus was carried to term

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. "*Usual and customary rate*", for purposes of this benefits booklet, means the relevant *allowable amounts* as expressly defined and set forth in this definition.

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan*** – The *allowable amount* is based on the terms of the *provider* contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- ***For Hospitals and Facility Other Providers, Physicians, Professional Other Providers, and any other provider not contracting with BCBSTX in Texas*** – The *allowable amount* will be the lesser of: (i) the *provider's* billed charges, or; (ii) the BCBSTX non-contracting *allowable amount*. Except as otherwise provided in this section, the non-contracting *allowable amount* is developed from base *Medicare* Participating reimbursements adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and will exclude any *Medicare* adjustment(s) which is/are based on information on the claim.

  Notwithstanding the preceding sentence, the non-contracting *allowable amount* for *home health care* is developed from base *Medicare* national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for duration and adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and shall be updated on a periodic basis.

  When a *Medicare* reimbursement rate isn't available or is unable to be determined based on the information submitted on the claim, the *allowable amount* for non-contracting *providers* will represent an average contract rate in aggregate for *in-network providers* adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and shall be updated not less than every two years.

  BCBSTX will utilize the same claim processing rules and/or edits that it utilizes in processing *in-network provider* claims for processing claims submitted by non-contracted *providers* which may also alter the *allowable amount* for a particular service. In the event BCBSTX doesn't have any claim edits or rules, BCBSTX may utilize the *Medicare* claim rules or edits that are used by *Medicare* in processing the claims. The *allowable amount* won't include any additional payments that may be permitted under the *Medicare* laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the *Medicare* reimbursement amount will be implemented by BCBSTX within ninety (90) days after the *effective date* that such change is implemented by the Centers for Medicaid and *Medicare* Services, or its successor.

The non-contracting *allowable amount* doesn't equate to the *provider's* billed charges and *participants* receiving services from a non-contracted *provider* will be responsible for the difference between the non-contracting *allowable amount* and the non-contracted *provider's* billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting *allowable amount* for a particular service, *participants* may call their Personal Health Guide at 1-866-355-5999.

- ***For multiple surgeries*** - The allowable amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest allowable amount plus a determined percentage of the allowable amount for each of the other covered procedures performed.
- ***For procedures, services, or supplies provided to Medicare recipients*** – The *allowable amount* won't exceed *Medicare*'s limiting charge.

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.

Blue Distinction Centers (BDC) means a health care Provider, Hospital or medical facility recognized for their expertise in delivering specialty care. Please see the subsection entitled Blue Distinction Centers for more information.

Blue Distinction Centers+ (BDC+) means a health care Provider, Hospital or medical facility recognized for their expertise and efficiency in delivering specialty care. Please see the subsection entitled Blue Distinction Centers for more information.

Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+) Benefit Differential Product means your employer has chosen to provide a lower out-of-pocket cost when you utilize a BDC or BDC+ designated provider for certain specialty care procedures and treatment.

Calendar year means the period for TRS-Care that begins Jan.1 and ends Dec. 31 each year.

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 *plan sponsor* 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 Rinkel 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, and
- 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.

A *contracting facility* shall also include a *hospital* or *facility other provider* located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in your health plan shall be deemed a *non-contracting facility* regardless of the existence of a written contract with another Blue Cross 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:

a. your natural *child*
b. 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
c. your stepchild
d. an eligible foster *child*
e. 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

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; and
- 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 to support the medical efficacy of a procedure or an item which hasn't been proven as a medical device.

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 expenses 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 *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.

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 *calendar year deductible*, incurred by the *participant* during a *calendar 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 expenses* 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 provider*s, *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. Doctor of Chiropractic
  c. Doctor of Dentistry
  d. Doctor of Optometry
  e. Doctor of Podiatry
  f. Doctor in Psychology
  g. Licensed Acupuncturist
  h. Licensed Audiologist
  i. Licensed Substance Use Disorder Counselor
  j. Licensed Dietitian
  k. Licensed Hearing Instrument Fitter and Dispenser
  l. Licensed Marriage and Family Therapist
  m. Licensed Clinical Social Worker
  n. Licensed Occupational Therapist
  o. Licensed Physical Therapist
  p. Licensed Professional Counselor
  q. Licensed Speech-Language Pathologist
  r. Licensed Surgical Assistant
  s. Midwife
  t. Nurse First Assistant
  u. Physician Assistant
  v. 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 the *allowable amount* (paid directly to them) and won't bill *participants* over the *allowable amount*.

Participant means a retiree, 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 Manual,* 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 *plan sponsor'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 Retired Employees Group Benefits Program.

Post-Service Medical Necessity Review means the process of determining coverage after treatment has already occurred and is based on *medical necessity* guidelines. Can also be referred to as a retrospective review or post-service claims request.

Primary Care Provider (Primary Care Physician/Provider or PCP) 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 a family *provider*, obstetrician/gynecologist, pediatrician, *behavioral health provider*, an internist or a Physician Assistant (PA) or Advanced Practice Nurse (APN) who works under the supervision of one of these.

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

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

Recommended Clinical Review means an optional voluntary review of a *provider's* recommended medical procedure, treatment, or test, that does not require *prior authorization*, to make sure it meets approved Blue Cross and Blue Shield medical policy guidelines and *medical necessity* requirements.

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.

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.

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 provider, 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.

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.

GENERAL PROVISIONS

Agent

TRS isn't the agent of BCBSTX.

Amendments

Your health 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.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any *health care provider*, insurance carrier, or other entity to provide BCBSTX all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your *dependents* will be considered to have waived all requirements forbidding the disclosure of this information and records.

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/trscarestandard 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 provide 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 your *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, your *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 your *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

Coordination of Benefits ("COB") applies when you have health care coverage through more than one *health care plan*. The order of benefit determination rules govern the order in which each *health care plan* will pay a claim for benefits. The *health care plan* that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The *health care plan* that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total Allowable Expense.

For purposes of this section only, the following words and phrases have the following meanings:

Allowable Expense means a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any *health care plan* covering the person for whom claim is made. When a *health care plan* (including this *health care plan*) provides benefits in the form of services, the reasonable cash value of each service rendered is considered to be both an Allowable Expense and a benefit paid. In addition, any expense that a health care provider or Physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

Health Care Plan means any of the following (including this *health care plan*) that provide benefits or services for, or by reason of, medical care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts:

Group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

Health Care Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

BCBSTX has the right to coordinate benefits between this *health care plan* and any other *health care plan* covering you.

The rules establishing the order of benefit determination between this Plan and any other *health care plan* covering you on whose behalf a claim is made are as follows:

1. The benefits of a *health care plan* that does not have a coordination of benefits provision shall in all cases be determined before the benefits of this Plan.

2. If according to the rules set forth below in this section the benefits of another *health care plan* that contains a provision coordinating its benefits with this *health care plan* would be determined before the benefits of this *health care plan* have been determined, the benefits of the other *health care plan* will be considered before the determination of benefits under this *health care plan*.

The order of benefits for your claim relating to paragraphs 1 and 2 above, is determined using the first of the following rules that applies:

1. **Nondependent or Dependent**. The *health care plan* that covers the person other than as a Dependent, for example as a member, policyholder, subscriber, or retiree, is the primary plan, and the *health care plan* that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *health care plan* covering the person as a dependent and primary to the *health care plan* covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the *health care plan* covering the person as a member, policyholder, subscriber, or retiree is the secondary plan and the other *health care plan* is the primary plan. An example includes a retired employee.

2. **Dependent Child Covered Under More Than One Health Care Plan**. Unless there is a court order stating otherwise, *health care plan*s covering a Dependent child must determine the order of benefits using the following rules that apply.

    a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
        (i) The *health care plan* of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or
        (ii) If both parents have the same birthday, the *health care plan* that has covered the parent the longest is the primary plan.

    b. For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
        (i) if a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the *health care plan* of that parent has actual knowledge of those terms, that *health care plan* is primary. This rule applies to plan years commencing after the *health care plan* is given notice of the court decree.
        (ii) if a court order states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 2.a. must determine the order of benefits.
        (iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 2.a. must determine the order of benefits.
        (iv) if there is no court order allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            (I) the *health care plan* covering the custodial parent;
            (II) the *health care plan* covering the spouse of the custodial parent;
            (III) the *health care plan* covering the noncustodial parent; then
            (IV) the *health care plan* covering the spouse of the noncustodial parent.

    c. For a Dependent child covered under more than one health care plan of individuals who are not the parents of the child, the provisions of 2.a or 2.b. must determine the order of benefits as if those individuals were the parents of the child.

    d. For a Dependent child who has coverage under either or both parents' *health care plan*s and has his or her own coverage as a Dependent under a spouse's *health care plan*, paragraph 5. below applies.

e. In the event the Dependent child's coverage under the spouse's *health care plan* began on the same date as the Dependent child's coverage under either or both parents' *health care plan*s, the order of benefits must be determined by applying the birthday rule in 2.a. to the Dependent child's parent(s) and the Dependent's spouse.

3. **Active, Retired, or Laid-off Employee.** The *health care plan* that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The *health care plan* that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the *health care plan* that covers the same person as a retired or laid-off employee or as a Dependent of a retired or laid-off employee does not have this rule, and as a result, the *health care plan*s do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another *health care plan*, the *health care plan* covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other *health care plan* does not have this rule, and as a result, the *health care plan*s do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The *health care plan* that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the *health care plan* that has covered the person the shorter period is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the *health care plan*s meeting the definition of *health care plan*. In addition, this *health care plan* will not pay more than it would have paid had it been the primary plan.

When this *health care plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *health care plans* are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its *health care plan* that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all *health care plans* for the claim equal 100 percent of the total Allowable Expense for that claim. In addition, the secondary plan must credit to its plan deductible (if applicable) any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more closed panel *health care plan*s and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel *health care plan*, COB must not apply between that *health care plan* and other closed panel Health Care Plan*s*.

When benefits are available to you as primary benefits under Medicare, those benefits will be determined first and benefits under this Plan may be reduced accordingly. You must complete and submit consents, releases, assignments and other documents requested by BCBSTX to obtain or assure reimbursement by Medicare. If you fail to cooperate or enroll in Part B of the Medicare program, you will be liable for the amount of money that Medicare would have normally paid if you had cooperated or enrolled.

For purposes of this provision, BCBSTX may, subject to applicable confidentiality requirements set forth in this Plan, release to or obtain from any insurance company or other organization necessary information under this provision. If you claim benefits under this Plan, you must furnish all information deemed necessary by Us to implement this provision.

None of the above rules as to coordination of benefits shall delay your health services covered under this Plan.

Whenever payments have been made by BCBSTX with respect to Allowable Expenses in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this Part, We shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as We shall determine: any person or persons to, or for, or with respect to whom, such payments were made; any insurance company or companies; or any other organization or organizations to which such payments were made.

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 a retiree as described in this benefits booklet
- the *plan* is terminated, or the *plan* is amended, at the direction of the plan administrator, to terminate the coverage of the class of retirees 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 child must be covered under the *plan* and the disability must begin 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 Coverage Under COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) created a right to COBRA continuation coverage, which is a temporary extension of coverage under the plan to your spouse or your dependent children who are covered under the plan when they would otherwise lose the group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to your family and what you need to do to protect the right to receive it.

You and your covered dependents should read this information carefully for a generalized understanding of your spouse's or dependent children's rights and obligation under COBRA. This notice provides only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the plan and under federal law, contact TRS-Care at the Teacher Retirement System of Texas, Group Health Benefits Division.

Either the plan administrator or a third party named by the plan administrator is responsible for administering COBRA continuation coverage. Contact your plan administrator for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage.

Individual entitled to COBRA coverage are called "qualified beneficiaries". Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered retiree who experience a loss of coverage under the plan solely as a result of a "qualifying event" under COBRA. In order to be a qualified beneficiary, an individual must have been enrolled in the plan the day before the date of the qualifying event that causes the loss of coverage for that individual. Dependents not previously enrolled in the plan cannot elect to begin coverage under COBRA. Your spouse may elect to continue plan coverage for himself or herself and/or dependents, or each dependent child may elect individually. Any election made on behalf of a dependent will be binding on that dependent.

A child who is born to or placed for adoption with a covered retiree or surviving spouse during the period of COBRA continuation coverage may be eligible for enrollment in COBRA coverage as a qualified beneficiary. Such child would need to be added to the plan within 31 days of the date of birth or the date the child is placed for adoption.

The maximum coverage period for a child added to COBRA continuation coverage is measured from the same date as for qualified benefits with respect to the same qualifying event and not from the date of the child's birth or placement for adoption.

A summary of the COBRA provisions is as follows:

- The plan is required to offer your spouse and your dependent children who are enrolled under the plan the right to temporarily continue group health coverage if the coverage would cease upon the occurrence of certain qualifying events. The COBRA continuation coverage that your spouse or dependent children elect to obtain, if any, provides benefits that are identical to the coverage's provided to similarly situated retirees and their dependents. The plan will notify your spouse or dependent children of any changes in coverage or benefits available. COBRA continued coverage is available if your spouse or dependent children will lose coverage under the plan due to any of the following:
  a. your death
  b. your divorce or legal separation
  c. a dependent child ceasing to be a dependent as defined in this booklet

If your spouse or dependent children would lose coverage upon the occurrence of one of these qualifying events, your spouse or dependent children must notify TRS-Care at the Teacher Retirement System of Texas Group Health Benefits Division of the event within 60 days of the later of (1) the date on which the qualifying event occurs; or (2) the date coverage would be lost as a result of the qualifying event. For a written notice of a qualifying event to be timely, it must be post marked or otherwise sent to TRS-Care on or before the last day of the 60-day notification period.

Once TRS-Care received notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. COBRA continuation coverage will begin for each qualified beneficiary who timely elects that coverage on the date the plan coverage would otherwise have been lost.

To elect COBRA continuation coverage, a qualified beneficiary must elect that coverage within 60 days after the later of the date coverage would be lost under the plan by reason of a qualifying event or the date a qualified beneficiary receives the COBRA notice. To be timely, the COBRA election form must be postmarked or otherwise sent to Blue Cross Blue Shield of Texas on or before the last day of the 60-day election period.

If TRS-Care is not timely notified of a qualifying event or a qualified beneficiary does not timely elect COBRA continuation coverage, your spouse's and or dependent children's group health benefit coverage under the plan will end and cannot be reinstated under COBRA.

Your spouse or dependent children may be eligible to elect to continue coverage under another provision of the plan in lieu of this COBRA continuation.

- If a qualified beneficiary elects COBRA continuation coverage, the maximum period that COBRA coverage will continue for that qualified beneficiary is 36 months from the date of the qualifying event that triggered loss of coverage. COBRA continuation coverage for your spouse or dependent children will automatically terminate before the end of this 36-month period only when any of the following events occurs:
  a. The plan terminates.
  b. Your spouse or dependent children fail to make timely payment of a required premium.
  c. Your spouse or dependent children covered under another group health plan that does not contain any exclusion or limitation applicable to the individual, or contains a preexisting limitation or exclusion, but it does not apply to the individual because he or she has been credited with prior creditable coverage for the duration of the exclusion or limitation period.
  d. Your spouse or dependent children are no longer eligible for COBRA continuation coverage because of any other reason permitted by law.

The law permits TRS-Care to charge any person who elects COBRA continuation coverage 102% of the full cost to the plan for the period of coverage for a similarly situated beneficiary for whom an event triggering loss of coverage has not occurred. If your spouse or dependent children elect to continue coverage, their initial payment must be submitted to Blue Cross and Blue Shield of Texas within 45 days of their election date. This initial payment must cover the period from the termination date of coverage to the date of the COBRA election.

Once the initial COBRA payment is made, COBRA contributions are due on the first day of the month and must be paid before the last day of each month for which a COBRA contribution is required.

The plan sponsor determines the amount of the COBRA contribution and may change that amount annually. Notification of any change in contribution amounts will be given. COBRA continuation coverage is contingent upon the timely election of COBRA continuation coverage and the receipt of any required contribution that is due. If the COBRA election is untimely or the COBRA payments are not received when due, the elected COBRA continuation coverage will terminate permanently, retroactive to the first day of the period for which the missed payment applies. Your spouse or dependent children COBRA coverage may not be reinstated in such an event.

A qualified beneficiary does not have to show that he or she is insurable to choose COBRA continuation coverage. However, COBRA continuation coverage under the law is provided subject to the individuals eligibility for coverage under the plan. TRS-Care reserves the right to terminate an individual's COBRA continuation coverage retroactively if you are determined to be ineligible. Once COBRA continuation coverage terminates for any reason, it cannot be reinstated.

If you have any questions, contact TRS-Care at the Teacher Retirement System of Texas, Group Health Benefits Division.

Notice of COBRA Continuation Rights

The *plan sponsor* 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 retirees of the *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).

AMENDMENTS

BENEFIT BOOKLET
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of Your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Benefit Booklet to which this Amendment is attached and becomes a part of the Benefit Booklet. Unless otherwise required by Federal or Texas law, in the event of a conflict between the terms on this Amendment and the terms of the Benefit Booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any member, including Participant and Dependents.

The Benefit Booklet is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of a Participating Provider as defined in the Benefit Booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's covered services at the in-network benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.

You have the right to appeal any decision made for a request for benefits under this provision, as explained in the Benefit Booklet.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section IV. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the Benefit Booklet and this Amendment, those terms will apply only to their use in the Benefit Booklet or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or an Independent Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or an Independent Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- covered services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSTX for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an Independent Freestanding Emergency Department that does not have a contractual relationship with BCBSTX for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a covered service, a physician or other health care provider who has a contractual relationship with BCBSTX setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to covered service, a hospital or ambulatory surgical center that has a contractual relationship with BCBSTX setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. Federal No Surprises Act Surprise Billing Protections

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayment Amounts, and Co-Share Amount.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayment Amounts, and Co-Share Amount, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your in-network Deductible and/or Out-of-Pocket Maximum, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a covered service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

NOTICES

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

Out-of-Area Services

Blue Cross and Blue Shield of Texas (BCBSTX) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain health care services outside of BCBSTX service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program, and may include negotiated National Account arrangements available between BCBSTX and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside 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 health care providers. Our payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered health care 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.

For inpatient facility services received in a hospital, the Host Blue's participating provider is required to obtain *prior authorization*. If *prior authorization* isn’t obtained, the participating provider will be sanctioned based on the Host Blue's contractual agreement with the provider, and the participant will be held harmless for the provider sanction.

Whenever you access covered health care services outside BCBSTX's service area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

- the billed covered charges for your covered services
- the negotiated price that the Host Blue makes available to us

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits 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, we would then calculate your liability for any covered health care services according to applicable law.

B. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered health care services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for covered health care services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to us by the Host Blue.

C. Non-Participating Health Care Providers Outside BCBSTX Service Area

1. In General

   When Covered Services are provided outside of the *plan*'s service area by non-participating health care providers, the amount(s) you pay for such services will be calculated using the methodology described in the benefits booklet for non-participating health care providers located inside our service area. You may be responsible for the difference between the amount that the non-participating health care provider bills and the payment the *plan* will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

   In some exception cases, the *plan* may, but isn't required to, in its sole and absolute discretion, negotiate a payment with such non-participating health care providers on an exception basis. If a negotiated payment isn't available, then the *plan* may make a payment based on the lesser of:

   a. the amount calculated using the methodology described in the benefits booklet for non-participating health care providers located inside your service area (and described in Section C(a)(1) above); or
   b. The following:

      1. for professional providers, an amount equal to the greater of the minimum amount required in the methodology described in the benefits booklet for non-participating health care providers located inside your service area; or an amount based on publicly available provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable, or

      2. for hospital or facility providers, an amount equal to the greater of the minimum amount required in the methodology described in the benefits booklet for non-participating health care providers located inside your service area; or an amount based on publicly available data reflecting the approximate costs that hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating health care provider bills and the payment Blue Cross and Blue Shield of Texas will make for the Covered Services as set forth in this paragraph.

D. Value-Based Programs BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you won't bear any portion of the provider incentives, risk-sharing, and/or care coordinator fees of such arrangement, except when a Host Blue passes these fees to Blue Cross and Blue Shield of Texas through average pricing or fee schedule incentive adjustments.

Under the Agreement the *plan sponsor* has with Blue Cross and Blue Shield of Texas, Blue Cross and Blue Shield of Texas and the *plan sponsor* won't impose cost sharing for care coordinator fees.

E. Blue Cross Blue Shield Global Core Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program 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 BlueCard service area, 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 BlueCard service area, 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 the *plan* to obtain Preauthorization for non-emergency inpatient services.**

- **Outpatient Services**

Outpatient Services are available for emergency care. 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.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for Covered Services outside the BlueCard service area, 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

Notice about Waived Payments

When a *participant* has an encounter or use the services of an *out-of-network provider*, and that results in a claim against the *plan*, TRS presumes that the *provider* will collect from the *participant* the corresponding *deductible, copayment*, or *coinsurance*. Based on this presumption, the *participant's deductible*, *maximum out-of-pocket* accumulators, and any other accumulators applicable under the *participant's* coverage are determined. When *providers* waive or fail to collect *deductibles*, *copayments*, and *coinsurance amounts* from *participants*, this *plan* is defrauded and abused as such practices threaten the stability of the funds that TRS administers. It is the responsibility of plan *participants* and *out-of-network providers* to report when a *provider* waives or fails to collect *deductibles, copayments*, and *coinsurance amounts*, as such waivers or failures to collect must not count towards the *participant's* accumulators, and may suggest that an *out-of-network provider* is engaging in practices intended to induce higher expenditures to this *plan*. If a concern is raised, TRS may refuse to pay a claim, or may reduce the payment of a claim, until it receives reasonable evidence that the *participant* has paid any applicable *deductible*, *copayment* or *coinsurance amount*.

NOTICE

The Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance
- prostheses
- treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please refer to your **SCHEDULE OF COVERAGE**. If you would like more information on WHCRA benefits, call your Personal Health Guide at 1-866-355-5999.

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PROVIDERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH PLAN.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain *groups* may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your *retiree'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 the spouse of a retiree, 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; 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-retiree dies;
- 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 *group (plan sponsor)*, 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 death of the employee, or in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the *group (plan sponsor)*, the *group (plan sponsor)* 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 retiree 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 *plan sponsor* 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 retirees 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 retiree, 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.

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 *group/plan sponsor* for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Information Provided by Your Group

How Your Prescription Plan Works Through CVS Caremark

About CVS Caremark

CVS Caremark administers the prescription drug portion of your TRS-Care benefit.

CVS Caremark provides you access to:

- **Local pharmacies.** A network of nearly 60,000 participating retail pharmacies throughout the United States and its territories.
- **The CVS Caremark Pharmacy mail-order service.** For your long-term medications, such as those used to treat high blood pressure or high cholesterol, you can access convenient mail-order service and possible savings through the CVS Caremark retail Pharmacy.
- **Retail-*Plus* pharmacies.** You can also receive your long-term medications at select retail pharmacies.
- **CVS Caremark Network Pharmacists.** CVS Caremark Network Pharmacists are trained and have expertise in specific conditions. One can help you service the long- term medications used to treat your chronic condition.
- **Online resources.** Go to **info.caremark.com/trscarestandard** for useful health and benefit information, along with online pharmacy services.
- **TRS-Care Customer Service**. Representatives will be available to you 24 hours a day, seven days a week. Pharmacists are also available around the clock for consultation.

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 happens on an ongoing basis.

Drug exclusions from the formulary will occur once per year and will typically go into effect on Jan. 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, please click on the link below: **info.caremark.com/trscarestandard**

Preferred Drug List

The TRS-Care Standard Plan includes 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-Care encourages the use of the preferred drugs on this list to help control rising prescription drug costs. You will usually pay a lower coinsurance amount for genetic drugs (Tier 1) and brand-name medications that are on the formulary (Tier 2).

Generic Preventive Drugs

Take advantage of no-cost generic preventive medications. If you take certain generic medications classified as "preventive", such as a prescription drug used for hypertension, a heart condition or depression, you may be able to receive your medication at no cost to you.

Find the list of no-cost drugs under this benefit by visiting i**nfo.caremark.com/trscarestandard** or call CVS Caremark toll-free at **1-844-345-4577**.

Save Money on Prescriptions

You will pay:

- the lowest coinsurance amount for Tier 1 generic drugs
- a higher coinsurance amount for Tier 2 preferred brand-name drugs
- the highest coinsurance 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 **info.caremark.com/trscarestandard** to check the price and coverage of medications under your plan.

Simply select “Price a medication” from the left-hand menu and search for your medication to see its pricing. Click “View coverage notes” on the pricing results page to see any coverage details. If you are a first-time visitor to **www.caremark.com**, please take a moment to register. (Be sure to have your CVS Caremark ID number and a recent prescription number handy.)

Generic Medications

FDA-approved generics may have unfamiliar names, but they are considered 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 FDA requires that the active ingredients have the same strength, purity, and quality as the brand-name alternatives. Prescriptions filled with generic drugs lower your coinsurance under TRS-Care’s prescription drug program. For more information about your plan’s formulary, visit **info.caremark.com/trscarestandard** or contact CVS Caremark at **1-844-345-4577**.

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 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.

Prescription Drug Synchronization

Prescription drug synchronization is a pharmacy capability that aligns a patient’s maintenance medication fill schedules, making it easier for them to stay on the therapies they need to effectively manage their conditions. Prescription drug synchronization offers members the convenience to pick up multiple maintenance 31-day prescriptions in a single visit to their preferred pharmacy. By aligning prescription fill schedules for participants, CVS Caremark aims to make it easier and more convenient for patients to take their medications as prescribed.

Retail Pharmacy Program

Prescriptions and refills dispensed at a retail pharmacy are filled for up to a 31-day supply. The amount that pay for each purchase or refill depends on whether you obtain generic or brand-name drugs and whether you use a drug store that participates in the retail pharmacy network.

The CVS Caremark retail pharmacy network is a national network comprised of over 60,000 retail pharmacies. The network includes most major chains, discount, grocery, and independent pharmacies. To find a local participating pharmacy, visit **info.caremark.com/trscarestandard** and click “Locate a National pharmacy” or contact TRS-Care Customer Service at **1-844-345-4577**.

How to Purchase Retail Prescriptions

At a Participating Retail Pharmacy

When you purchase your medications at a participating retail pharmacy, simply present your prescription drug ID card and pay the applicable amount. Participating network retail pharmacies will 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.

Your standard 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 participates in the TRS-Care program and get your medication on the same day.

Retail-Plus Pharmacies

Retail pharmacies that participate in the Retail-*Plus* network are able to dispense a 60- to 90-day supply of medication. To find a local participating pharmacy, visit **info.caremark.com/trscarestandard** and click "Locate a Retail-*Plus* pharmacy" or contact TRS-Care Customer Service.

At a Non-Participating Pharmacy

If you utilize a non-participating or a network pharmacy that will not file the 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.

Diabetic Management Services

The TRS-Care Standard Plan covers expenses associated with the treatment of diabetes for individual diagnosed with insulin-dependent or non-insulin-dependent diabetes, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels.

If you have diabetes, you may qualify for a preferred blood glucose meter at no cost to you. Your prescription benefit plan is offering a value-added program through which meters are available at no cost to eligible participants. For more details, please contact the CVS Caremark® Member Services Diabetic Meter Team at **1-800-588-4456**.

Diabetic Supplies

Certain diabetic supplies (e.g. lancets, test strips, and syringes) are covered at 100% even before your deductible is met as long as the services are rendered by a network provider. Please be advised this benefit is available only on prescriptions filled for 90-days through Mail Order Delivery or at a participating Retail-*Plus* pharmacy.

- test strips for blood glucose monitors
- lancets and lancet devices
- visual reading and urine test strips and tablets which test for glucose, ketones and protein
- insulin and insulin analog preparations
- incretins and amylin analogs
- injection aids, including devices used to assist with insulin injection and needleless systems
- insulin syringes
- biohazard disposable containers
- prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- glucagon emergency kits or GlucaGen HypoKits

Note: All diabetic supplies listed above, along with blood glucose monitors (including noninvasive glucose monitors and monitors for the blind), will be covered under the prescription drug program, administered by Caremark.

Diabetic Supplies	
Preferred brand glucose meter	$0 copay
31-day (short term) retail supply	**Formulary (list of covered drugs):** $0 copay for needles and syringes. **Non-Formulary:** Deductible and coinsurance apply
60-90-day supply at Retail-*Plus* or mail-order service	**Formulary:** $0 copay for needles, lancets. and syringes regardless of brand. To receive test strips at no cost, you must use the preferred brand. **Non-Formulary:** Deductible and coinsurance apply

You must have a prescription for diabetic supplies from your doctor for supplies to be covered at 100% by the TRS-Care Standard Plan.

The formulary is the list of covered drugs. To determine if the brand of diabetic supplies you are using is on the formulary and is a preferred brand, you can call CVS Caremark at **1-844-345-4577**, or visit **info.caremark.com/trscarestandard**.

The 87th Texas Legislature passed State Bill (SB) 827, which makes insulin less expensive for those on TRS-Care Standard plan. Formulary insulins will be capped at $25 for a 31-day supply and $75 for a 60- to 90-day supply. Beginning in the new plan year, you won't have to first meet your deductible and you won't pay the full cost of the insulin. You will only pay a copay for covered insulin, which will not apply toward your deductible, but it will apply towards your maximum out-of-pocket costs. For a list of the covered formulary insulins, visit info.caremark.com/trscarestandard and view the CVS Caremark® Formulary. If your insulin is not listed on the formulary, please contact CVS Caremark Customer Care and our representatives will assist you with a formulary exception process

CVS Caremark Mail Order Program

Mail-Order Service through the CVS Caremark Pharmacy

Filling prescriptions via mail order is a cost-effective option for participants taking long-term medications (such as those used to treat high blood pressure or high cholesterol) on a regular basis. The CVS Caremark Pharmacy provides up to a 90-day supply of medication, delivered directly to your home or other requested location, postage paid for standard delivery. Retail-Plus network pharmacies can also dispense up to a 90-day supply of maintenance medications at the same cost as the mail-order service.

To fill your prescription through the CVS Caremark Pharmacy, mail your prescription order form and payment to the address on the order form. If there is a balance due, an invoice will be included with your prescription order. If you overpaid, your account will be credited.

Or, you may also ask your doctor to call or fax your prescription to the CVS Caremark Pharmacy FastStart.

Prescriber Phone Number: **1-800-378-5697**
Prescriber Fax Number: **1-800-378-0323**

Your medication will usually be delivered within seven days after CVS Caremark receives your order.

To order refills, call the automated refill system at **1-844-345-4577** or visit **www.caremark.com.** Refills are normally delivered more quickly. If you are a first-time visitor to the site, please take a moment to register, and have your ID number and a recent prescription number available.

To ensure timely delivery, please place your orders at least 2 weeks in advance of your anticipated need. If you have any questions concerning your order, or if you do not receive your medication within the designated timeframe, please contact CVS Caremark at **1-844-345-4577**.

If a new medication has been prescribed for you to take immediately, please ask your doctor to issue two prescriptions. One should be written for a 14-day supply and filled at a local participating retail pharmacy, and the second should be written for up to a 90-day supply and sent to the CVS Caremark Pharmacy.

When using the CVS Caremark Pharmacy to fill a prescription for less than a 90-day supply, the full mail order coinsurance still applies.

You can pay by e-check, check, money order, or credit card. Make checks and money orders payable to CVS Caremark and write your CVS Caremark ID number on the front. Call CVS Customer Care at **1-844-345-4577** if you have questions.

Split Payments at Caremark Mail Order Pharmacy

You can split payments for your 90-day supply prescription into 3 separate payments only at Caremark Mail Order Pharmacy. For more information contact CVS Caremark Customer Care at **1-844-345-4577**.

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 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-Care.

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 at **1-844-345-4577**.

Supply Limits

Some prescription drugs are subject to supply limits that restrict the amount dispensed per prescription order or refill. To determine if a prescription drug has been assigned a maximum quantity level for dispensing, visit **info.caremark.com/trscarestandard** or call CVS Caremark at **1-844-345-4577**.

Drugs Requiring Prior Authorization

Under TRS-Care, 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 at **1-844-345-4577**.

Prior Authorization

For some medications, you must obtain approval through a coverage review process 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 is not available on your original prescription) in determining whether a given medication qualifies for coverage under TRS-Care.

Qualification by History

Certain medications may also require a coverage review based on:

- whether certain criteria are met, such as age, sex, or condition; and/or
- 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's or clinically-approved guidelines and are subject to periodic review and change.

For example, if you or your covered dependent is taking a sleep aid, you may not receive more than a 60-day supply within a 90-day period without a coverage review from CVS Caremark and your doctor.

Example: Participant fills a 30-day supply of Ambien on May 1
Participant refills a 30-day supply of Ambien on June 1
The participant has exhausted the quantity allowed for this 90-day period and would not be eligible to receive an additional quantity until Aug. 1

If you plan to take an extended vacation or travel outside the U.S., call CVS Caremark at **1-844-345-4577** to request approval for an additional supply of medicine. Please call in your request to CVS Caremark at least four weeks in advance of your trip.

Coverage review process

You can check to see if your medication requires prior authorization (coverage review) by calling CVS Caremark at **1-844-345-4577**.

If your medication requires a coverage review, you or your doctor may start the process by calling CVS Caremark toll-free at **1-844-345-4577**.

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 toll-free at **1-844-345-4577**.
- 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 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. 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

To get started using Caremark Specialty Pharmacy, call the number on the back of your prescription drug ID card or log in to your account at **www.caremark.com**. If you are a first-time visitor to the CVS Caremark website, take a minute to register, and have your ID number and a recent prescription number handy. If you would like to learn more about specialty medications and services, visit **www.cvsspecialty.com**

Starting Sept.1, 2017, you will need to use CVS Specialty to get your specialty medications.

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 healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

Caremark Specialty Pharmacy is the exclusive provider for specialty medications under the TRS-Care prescription drug plan. Participants also achieve better adherence and health outcomes as a result of the additional care provided through Caremark Specialty Pharmacy. When a participant attempts to fill a specialty medication at a retail pharmacy, the claim will reject and the pharmacy receives a notice that the medication must be filled through Caremark Specialty Pharmacy. Please contact Caremark Specialty Pharmacy at 1-800-237-2767 for assistance in transferring your specialty medications

Our Complete Services

With CVS Specialty, you get more than just specialty medication. You can count on personalized specialty pharmacy services like:

- Access to a pharmacist and nurse specially trained in your condition. You can call them with questions anytime, any day of the year.
- Option to pick up your medication at your local CVS Pharmacy®, or have it delivered to your home, doctor's office or location of your choice.*
- Digital tools available on **CVSspecialty.com** and our mobile app to help you stay on track with your prescriptions, order refills, get reminders and more.
- Help finding financial assistance to pay for your medications.

Questions?

Call us at **1-800-237-2767** from 6:30 a.m. to 8 p.m. (CT) Monday through Friday.

Some specialty medications may qualify for third-party copayment assistance programs that can lower your out-of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, you will not receive credit toward your out-of-pocket maximum or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

PrudentRx

Beginning 1/1/23 CVS Caremark® has collaborated with PrudentRx exclusively for a program that may help save you money when you fill eligible specialty medications. Once enrolled in the PrudentRx program and, if available, the manufacturer's copay assistance program, participating members will have a $0 out-of-pocket (OOP) cost. Participating members enrolled in high-deductible health plans (HDHPs) with health savings accounts (HSAs) must fully satisfy their deductible before they are eligible for a $0 OOP, unless the member has been prescribed medication that qualifies as "preventive care" under the Internal Revenue Code (IRC) which is administered and enforced by the Internal Revenue Service (IRS). Members will also have a $0 OOP cost if they are enrolled in the PrudentRx program, but not enrolled in a manufacturer copay assistance program when there is no manufacturer copay assistance program available. All eligible members' enrollment will begin automatically in the PrudentRx solution, but you can choose to opt out of the program by calling **1-800-578-4403**.

Please note: your plan's specialty drug list may be updated periodically. Amounts paid for your benefit for an eligible medication, including amounts paid by a manufacturer copayment assistance program, shall not be counted toward any member deductible or any member OOP maximum (MOOP)† obligation, unless otherwise required by law.

Coordination of Benefits (COB)

TRS-Care/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-Care 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 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-Care 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-Care if there were no 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.
- If a patient is confined to a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution and they obtain their drugs through the facility's pharmacy, those claims can be reimbursed through pharmacy rather than medical.
- 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, unless pre-authorized
- 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
- Respiratory Therapy Supplies
- drugs prescribed and dispensed for the treatment of obesity, with an FDA Indication for weight loss or for use in any program of weight reduction, weight loss, or dietary control, even if the Participant has medical conditions which might be helped by a reduction of obesity or weight and even though prescribed by a Physician or Other Provider. Examples: Saxenda, Wegovy.
- drugs used for purposes other than those approved by the Food & Drug Administration (FDA) or consistent with the applicable clinical criteria within the Plan's formulary

Claim Denials and Appeals

Under TRS-Care, 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
- 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 (and the corresponding explanation for those codes) and
- 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 documentation 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, they 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 will be deemed denied and you have the right to appeal as described below.

Urgent Claims (Expedited Reviews)

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 cannot be adequately managed without the care or treatment that is the subject of your claim.

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 review the claim. If further information is needed, CVS Caremark will notify you within 24 hours of receipt of your claim and advise 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.

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 Attn: Appeals
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. Your physician may call 1-866-443-1183 or send a written request to:

Caremark Appeals Department

MC109

P.O. Box 52084
Phoenix, AZ 85072-2084

Fax Number: 1-866-443-1172

Physicians may submit urgent appeal 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 which is 4 months from that date is a Saturday, Sunday or holiday, the deadline is the next business day) at:

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 ERO and compile your appeal information and send it to the ERO within 5 business days. The ERO will notify you in writing that they received the request for an external review. The letter will describe your right to submit additional information for consideration to the ERO. Any additional information you submit to the ERO will also be sent back to CVS Caremark for reconsideration.

The ERO 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.

Therapeutic Resource Centers

Get the reassurance of expertise. Talk to a Specialist Pharmacist.

If you need a medication used to treat certain long-term conditions, take advantage of the personalized care and medication expertise of an CVS Caremark Specialist Pharmacist. These pharmacists have received specialized training in the medications used to treat various conditions, including:

- high cholesterol
- asthma
- high blood pressure
- osteoporosis
- depression
- cancer
- diabetes
- migraine headaches

This enhanced level of care is at no cost to you and is already part of your prescription drug benefits.

- CVS Caremark Specialist Pharmacists at the CVS Caremark Specialty Pharmacy are available by phone 24 hours a day, seven days a week to help you understand and manage the medications used to treat conditions such as those listed.
- These pharmacists can help identify potential health risks, such as side effects and unsafe drug interactions.
- They also know your plan, so they can talk with you or your doctor about lower-cost alternatives, such as generics and preferred brand-name medications.
- Conversations with CVS Caremark Specialist Pharmacists are private, which means that you can feel comfortable asking even personal and sensitive questions about your medications.
- A CVS Caremark Specialist Pharmacist may even call you or your doctor to help make sure your medications will work safely together.

TRS-Care Standard Prescription Drug Coverage	
	In-network
Tier 1 Generic drugs	20% after deductible
Tier 2 Preferred brand-name drugs	20% after deductible*
Tier 3 Non-preferred brand-name drugs	20% after deductible*

Under the TRS-Care Standard Plan, before benefits begin to pay, you must meet the plan deductible Your plan deductible includes both your medical and prescription drug expenses. In-network deductible: $1,500 for retiree-only coverage; $3,000 for family coverage.

*Starting Jan. 1, 2020, if you obtain a brand-name drug when a generic equivalent is available, you are responsible for the difference in cost between the brand-name drug and the generic drug, in addition to the generic coinsurance. This cost difference will not apply to your accumulations (deductible or maximum out of pocket).

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 (FDA) 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 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

Take Advantage of No-Cost Prescription Drugs to Protect Your Health

Your TRS-Care health plan includes full coverage for certain generic drugs classified as “preventive medications.” These are drugs that are used to prevent a chronic condition, not treat an existing one. If you are prescribed a medication in one of the classes below, your medication may be on the list and you may be eligible to receive the drug at no cost to you. Be sure and check the list of drugs classified as “preventive” at **info.caremark.com/trscarestandard** to see if your drug is on the list and make the most of this valuable benefit. This list is subject to change.

TYPES OF GENERIC PREVENTIVE MEDICATIONS THAT MAY BE OFFERED AT NO COST TO YOU

Cardiovascular
Antiarrhythmic agents
Antianginal agents
Coronary artery disease
Antihyperlipidemics and combinations

Diabetes
Antidiabetics
Diabetic diagnostic products and supplies
Hematologic agents
Coagulation factors

Hypertension
ACE inhibitors,ARBs, CCBs Beta blockers
Diuretics
Antihypertensives and combinations

Immunizing Agents
Vaccines, toxoids, passive Immunizing agents and biologicals

Mental Health
Antidepressants
Antipsychotics
Osteoporosis
Calcium regulators
Hormone receptor modulators

Preventive Care
Anti-obesity agents
Smoking deterrents
Agents for chemical dependency
Bowel preparations

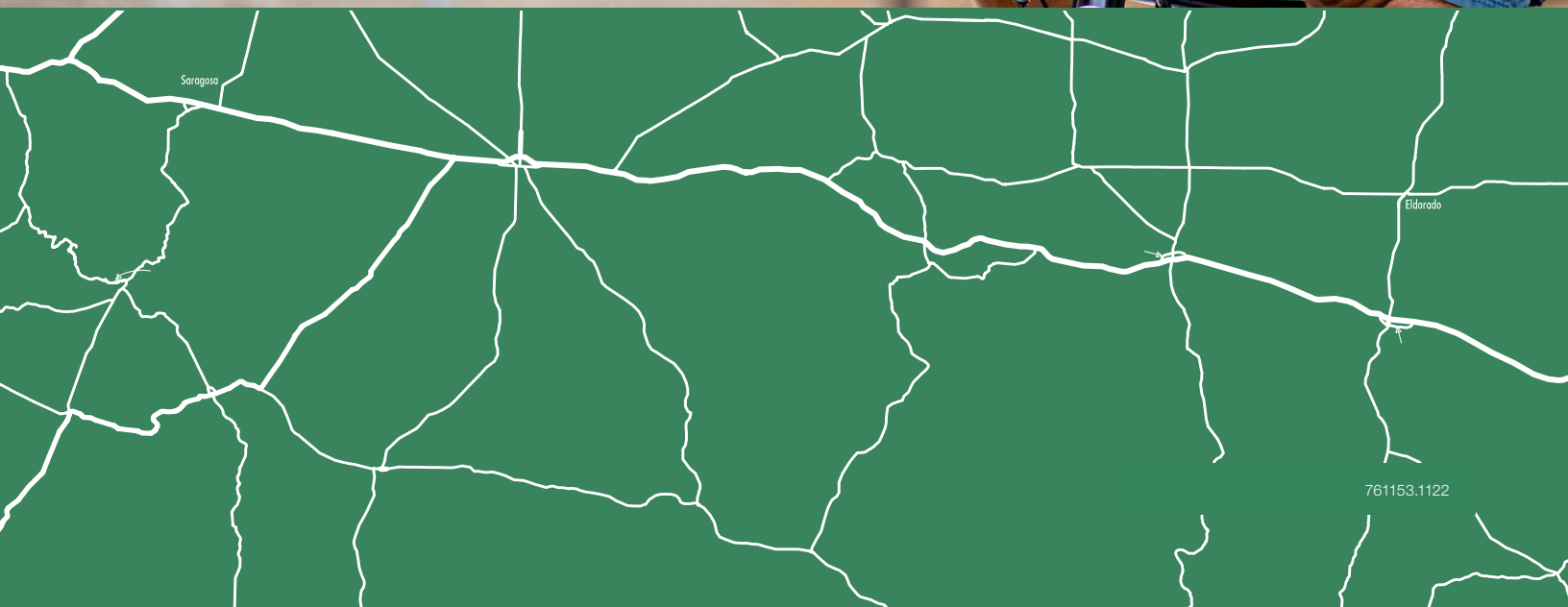
Respiratory Disorders
Antiasthmatics

Seizure Disorders
Anticonvulsants

Stroke
Anticoagulants
Platelet aggregation inhibitors

Women’s Health
Aromatase inhibitors and antiestrogens Contraceptives
Prenatal vitamins

Various Conditions
Anti-malarial agents
Dental caries prevention
Hereditary angioedema (HAE) agents
Immunosuppressive
MS agents
Antiretroviral agents



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