FirstCare™
HEALTH PLANS

TRS-ActiveCare Program

2019-2020

Rate Overview and
Description of Plan Benefits

TRS
ACTIVECARE
TEACHER RETIREMENT SYSTEM OF TEXAS

Rate Overview

Coverage Category	2019 – 2020 Premiums
Employee Only	$560.50
Employee and Spouse	$1,416.52
Employee and Child(ren)	$892.16
Family	$1,454.80

FirstCare HEALTH PLANS

For a complete list of plan changes, please refer to your evidence of coverage and schedule of benefits.

Schedule of Benefits
FirstCare Select Plus HMO Network
TRS ActiveCare
TRS2019T

You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage. The following is a summary of the copay amounts you & any dependents must pay when receiving the services listed below. These services must be performed, prescribed, or directed by your Primary Care Physician or designated OB/GYN Physician. Please refer to your Evidence of Coverage for a detailed explanation of covered & non-covered services. If you have any questions, or would like more information about FirstCare's benefits and medical services go to **www.FirstCare.com** or contact our Customer Service Team, Monday through Friday, 8 a.m. – 6 p.m. CT, at 1.800.884.4901, TTY Line 1.800.562.5259.

Note: FirstCare Health Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

PLAN YEAR	Contract Year
PLAN YEAR DEDUCTIBLE	$950 per Member / $2,850 per Family
OUT-OF-POCKET MAXIMUM *Includes medical and Rx deductible and copays.*	$7,450 per Member/ $14,900 per Family
ANNUAL MAXIMUM	Unlimited

COVERED MEDICAL SERVICES	
GENERAL SERVICES *Including Medical & Behavioral Health Services*	*Copay Charges*
• **Adult PCP Office Visit** Include Lab/X-ray services, injectables and supplies. Other services provided in a physician's office are subject to additional copays. *Note: Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	$20 Copay
• **Pediatric PCP Office Visit** (For a covered dependent through age 19). Include Lab/X-ray services, injectables and supplies. Other services provided in a physician's office are subject to additional copays. *Note: Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	No Charge
• **Specialist Office Visit** Include Lab/X-ray services. Other services provided in a physician's office are subject to additional copays. *Note: Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	$70 Copay
• **Behavioral Health Office Visit**	$20 Copay

COVERED MEDICAL SERVICES

GENERAL SERVICES *Including Medical & Behavioral Health Services*	*Copay Charges*
• **Emergency Room**	$500 Copay after Deductible
• **Minor Emergency/Urgent Care**	$50 Copay

OTHER HEALTH CARE SERVICES *All other services, including but not limited to those listed below.*	*Copay Charges*
• **Preventive Service** Prostate and Colorectal Cancer Screening; Routine Immunizations; Routine Physical Exams; Well-Woman Exams; any 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.	No Charge
• **Telemedicine and Telehealth Services**	The amount of the Deductible or Copayment may not exceed the amount of the Deductible or Copayment required for a comparable medical service provided through a face-to-face consultation
• **Inpatient Services** Behavioral Health Facilities; Blood and Blood Products; Coronary Care Units; Facility Charges; Intensive Care Unit (ICU); Labor & Delivery; Laboratory Tests/X-rays; Neonatal Intensive Care Unit (NICU); Operating/Recovery Room; Physician Services; Pre-Admission Testing; Rehabilitation Facility; Skilled Nursing Facility¥; Surgical Procedures.	25% Copay after Deductible
• **Outpatient Services** Behavioral Health Facilities; Facility Charges; Observation Unit; Physician Services; Surgical Procedures.	25% Copay after Deductible
• **Ambulance Services** Air/Ground	25% Copay after Deductible
• **Routine Lab and X-rays**	No Charge
• **MRI; CT Scan; PET Scan** Both Facility/Physician charges	$250 Copay after Deductible
• **Non-Preventive Testing** Cardiac Imaging; EKG; Ultrasound; Genetic Testing; Non-Preventive Colonoscopy (Facility/Physician); Sleep Study; Stress Test.	25% Copay after Deductible

OTHER HEALTH CARE SERVICES *All other services, including but not limited to those listed below.*	*Copay Charges*
• **Other Services** Including, but not limited to: Allergy Testing/Serum/Injections; Amino Acid-Based Elemental Formulas; Diabetes Services; Dialysis Services; Durable Medical Equipment; Family Planning Services; Hearing Aids¥ and Cochlear Implants; Home Health Care¥; Home Infusion Medications; Hospice Care; Internal Implantable Devices; Limited Accidental Dental Care; Medical Supplies; Nutritional Counseling; Organ Transplant Services; Orthotics; Pain Management; Prosthetics; Spinal Manipulation¥; Surgical Procedures in Physician Office; Telemedicine and Telehealth Services; Therapy Services¥.	25% Copay after Deductible
• **All Other Covered Services** *(not specified herein)*	25% Copay after Deductible

Covered Service Limitations¥:

- **Hearing Aids**
  Limited to one device per ear every 3 years
- **Home Health Care**
  Limited to 60 visits per plan year
- **Skilled Nursing Facility**
  Limited to 30 days per plan year
- **Spinal Manipulation**
  Limited to 10 visits per plan year
- **Therapy Services (Rehabilitation/Habilitation/Speech/Occupational/Physical)**
  Limited to 35 visits per plan year for each service

FirstCare™ HEALTH PLANS

If you, or someone you're helping, has questions about FirstCare Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-855-572-7238 (TTY/TDD 1.800.562.5259).

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de FirstCare Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về FirstCare Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Chinese: 如果您或您正在帮助的人士对第一救护健康计划 (FirstCare Health Plans) 有疑问， 您有权免费获取对应您母语的帮助及信息。联系口译员请拨打 1-855-572-7238 (TTY/TDD 1-800-562-5259)。

Korean: 귀하 또는 귀하가 돕는 있는 사람이 FirstCare Health Plans 에 문의할 사항이 있는 경우, 귀하의 언어도 무료 지원 및 정보를 받을 권리가 있습니다. 통역사와 통화하시려면 1-855-572-7238 (TTY/TDD 1-800-562-5259) 번으로 전화해 주십시오.

Arabic:

لك الحق، أو لدى أي شخص آخر تساعده في الحصول على المساعدة والمعلومات أو أي أسئلة بخصوص FirstCare Health Plans للتحدث مع مترجم بدون أي تكلفة. اتصل بالرقم (TTY/TDD 1-800-562-5259) 1-855-572-7238

Urdu:

اگر آپ یا آپ کسی کی مدد کر رہے ہیں, اور سوالات ہیں" FirstCare Health Plans " کے بارے می, تو یہ آپ کا حق ہے مدد حاصل کرنا اور معلومات حاصل کرنا اپنی زبان میں بغیر کسی قیمت کے. کسی ترجمان سے بات کرنے کے لئے کال کریں. 1-855-572-7238 (TTY/TDD 1-800-562-5259)

Tagalog: Kung mayroon kang, o sinumang tinutulungan mo, mga katanungan tungkol sa FirstCare Health Plans, mayroon kang karapatang humingi ng tulong at impormasyon nang walang bayad. Upang makipag-usap sa isang tagapagsalin, tumawag sa 1-855-572-7238 (TTY/TDD 1-800-562-5259)

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de FirstCare Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Hindi: यदि आपके, या आप जिन्हें सहायता कर रहे हैं उनके पास FirstCare Health Plans से संबंधित कोई प्रश्न हैं तो आपको अपनी भाषा में बिना किसी शुल्क के सहायता और जानकारी पाने का अधिकार है। किसी अनुवादक से बात करने के लिए यहां कॉल करें 1-855-572-7238 (TTY/TDD 1-800-562-5259)

Persian-Farsi:

اگر شما یا شخصی که به او کمک میکنید سوالی درباره FirstCare Health Plans داشته باشید، این حق را دارید که کمک و اطلاعات به زبان خود بدون هیچ هزینه‌ای دریافت کنید. برای صحبت با یک مترجم با شماره (TTY/TDD 1-800-562-5259) 1-855-572-7238 تماس حاصل فرمایید.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zu FirstCare Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-572-7238 (TTY/TDD 1-800-562-5259) an.

Gujarati: જો તમને, અથવા કોઈકને તમે મદદ કરી રહ્યાં છો, તેને FirstCare Health Plans વિશે પ્રશ્નો હોય તો, તમને નિશુલ્ક તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા કોલ કરો: 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Russian: Если вам или лицу, которому вы помогаете, возникнет вопросы по FirstCare Health Plans, то вы имеете право на бесплатную помощь и информацию на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Japanese: FirstCare Health Plan についてご質問の場合は、無料でご自分の言語のサポートと情報を得ることができます。1-855-572-7238 （テレタイプライター/聴覚障害者用通信機器 1-800-562-5259） にお電話いただき、通訳者とお話しください。

Laotian: ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ ມີຄໍາຖາມກ່ຽວກັບ FirstCare Health Plans, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ກະລຸນາໂທ 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Non-Discrimination Notice

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

We provide free communication aids and services to people with disabilities. We also provide language assistance to people whose primary language is not English.

To receive language or communication assistance please call 1-855-572-7238.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, please contact us to file a grievance:

SHA, LLC dba FirstCare
ATTN: Complaints and Appeals
12940 N. HWY 183
Austin, TX 78750
Phone: 1-855-572-7238 *(Mon. - Fri., 8 a.m. - 5 p.m. CT)*
TTY /TDD: 1-800-562-5259

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building, Washington, DC 20201
Phone: 1-800-368-1019
TTY/TDD: 1-800-537-7697

Complaint forms are available at: http://www.hhs.gov/ocr/filing-with-ocr/index.html

FirstCare HEALTH PLANS

HMO Prescription Drug Schedule of Benefits
TRS ActiveCare
TRSRX19T

CONTRACT YEAR DEDUCTIBLE *Does not apply to ACA Preventive Drugs and Preferred Generic Drugs*	$150 per Member
OUT-OF-POCKET MAXIMUM	Integrated with Medical

This Rider is issued to you in connection with and amends your FirstCare Evidence of Coverage. This Rider is effective as of the date of your Evidence of Coverage. Capitalized terms used in this Rider that are not defined herein shall have the meanings ascribed to such terms in your Evidence of Coverage.

FirstCare is pleased to offer you an additional benefit for the following Copayments per prescription or refill:

	30-Day Standard	90-Day Maintenance*
ACA Preventive Drugs	$0 Copayment per Prescription	$0 Copayment per Prescription
Tier 1 *Preferred Generic Drugs*	$5 Copayment per Prescription	$12.50 Copayment per Prescription
Tier 2 *Preferred Brand Name Drugs*	30% Copayment per Prescription after Deductible	30% Copayment per Prescription after Deductible
Tier 3 *Non-Preferred Generic Drugs and Non-Preferred Brand Name Drugs*	50% Copayment per Prescription after Deductible	50% Copayment per Prescription after Deductible
Specialty Tier 1 *Specialty Preferred Generic Drugs*	15% Copayment per Prescription after Deductible	Not Covered
Specialty Tier 2 *Specialty Preferred Brand Name Drugs*	15% Copayment per Prescription after Deductible	Not Covered
Specialty Tier 3 *Specialty Non-Preferred Brand Name Drugs*	25% Copayment per Prescription after Deductible	Not Covered
Preferred Diabetic test strips for blood glucose monitors	$5 Copayment per Prescription	$12.50 Copayment per Prescription
Non-Preferred Diabetic test strips for blood glucose monitors	30% Copayment per Prescription after Deductible	30% Copayment per Prescription after Deductible

*Available when maintenance-eligible drugs are obtained through a Baylor Scott & White Pharmacy or participating 90-day retail or mail order pharmacy provider.

Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum.

You and Your Covered Dependents shall be eligible to receive prescription drugs on the following basis:

Covered Drugs, Pharmaceuticals and Other Medications

The only covered drugs, pharmaceuticals or other medications (herein collectively referred to as "drug" or "drugs") covered hereunder are those which, under Federal or State law, may be dispensed only pursuant to an order from a licensed Health Professional with appropriate law enforcement agency registrations; which are prescribed by:

a. a Network Health Professional, or
b. in connection with emergency Treatment, a Health Professional in attendance on You or Your Covered Dependent at an emergency facility, or
c. by a Referral Health Professional to whom You or Your Covered Dependent has been referred by a Network Health Professional; which are used for the Treatment of an illness or injury covered under this Agreement;
d. filled through a Health Plan Network Pharmacy in accordance with this Agreement.

As medically appropriate, the Medical Director may require the substitution of any drug for another drug or form of Treatment which, based upon the recommendations of the Pharmacy and Therapeutics Committee or the Pharmacy and Therapeutics subcommittee, and the Medical Director's professional judgment provides equal or better results at a lower cost. Special dietary formulas for individuals with phenylketonuria or other heritable diseases are also covered under this prescription drug benefit. Heritable diseases are inherited diseases that may result in mental or physical retardation or death. Phenylketonuria is an inherited condition that may cause severe mental retardation if not treated.

Coverage for Off-Label Use of Drugs

Drugs prescribed to treat You, or Your Covered Dependent's, covered chronic, disabling or life-threatening illness are potentially coverable, under this prescription drug benefit if the drug has been approved by the Food and Drug Administration for at least one indication and is recognized for treatment of the indication for which the drug is prescribed in either a prescription drug reference compendium or substantially accepted peer reviewed medical literature. If the indication for which the drug is prescribed is not a FDA approved indication of the drug being prescribed, the health plan reserves the right to exempt the drug from coverage for that off label use within the prescription benefit plan. Coverage of the drug includes coverage of medically necessary services associated with the administration of the drug, but does not include coverage for experimental drugs not otherwise approved for any indication by the Food and Drug Administration or coverage for a drug that the Food and Drug Administration has not approved, or prescription drug reference compendia or peer reviewed medical literature has not deemed as a medically-accepted use for the proposed indication.

Evidence Based Formulary Development

Health Plan provides coverage for prescription drugs in accordance with an evidence based formulary developed by physicians and pharmacists comprising the Pharmacy and Therapeutics Committee. A formulary is a list of drugs for which Health Plan provides coverage. The Pharmacy and Therapeutics Committee meets at least quarterly to review the scientific evidence, economic data, and a wide range of other information about drugs for potential formulary placement and coverage. Based upon that review, the committee selects the drugs it believes to be the safest and most efficacious of those drugs which meet the desired goals of providing appropriate therapy at the most reasonable cost. Once such determination is made, the Health Plan may obtain or access contracts with the manufacturer of the drugs for rebates. The committee will not select a drug for the formulary until enough clinical evidence is available to allow the committee to determine the drug's comparable safety and efficacy. The committee defines this timeframe as 180 days of availability. The committee determines which drugs to add or delete, supply and dosage limitations, sequence of use, and all other aspects about the Health Plan formulary. Health plan will provide written notice of the modification to the drug formulary to the commissioner and each affected individual health benefit plan holder, not later than the 60th day before the date the modification is effective.

Request for Formulary Information

You or Your Covered Dependent may contact the Health Plan to find out if a specific drug is on the formulary. The Health Plan must respond to Your request about the drug formulary no later than the third business day after the date of the request to disclose whether a specific drug is on the formulary. However, the presence of a drug on a drug formulary does not guarantee that Your Health Professional will prescribe the drug for a particular medical condition or mental illness.

Formulary Lists

Copayments vary based upon the tier level a particular drug has been placed on by the Health Plan. Drugs on the Health Plan formulary, which are preferred generic drugs, require the lowest Copayment. Drugs on the Health Plan formulary, which are preferred name brand drugs require an increased Copayment. Drugs, which are not on the preferred generic or preferred brand tiers on the Health Plan formulary, which are alternate choice drugs or other drugs for some medical conditions not treated by drugs on the preferred tiers, may not be covered by the Health Plan or may require the largest Copayment, depending on the plan of benefits selected. If a particular drug appeared on the Health Plan formulary at the beginning of Your Contract Year, Health Plan shall make such drug available at the contracted benefit level until the end of the Contract Year, regardless of whether the prescribed drug has been removed from the Health Plan's formulary.

Prescription drugs designated on the drug formulary as Specialty Pharmacy drugs that are dispensed at a participating pharmacy and self-administered or administered in the office of a Participating Provider may be covered under this Rider, subject to the Specialty Pharmacy Copayments, Coinsurance, and Deductibles indicated in the Prescription Drug Schedule of Benefits.

You or Your Covered Dependent may contact Health Plan to obtain a copy of the Specialty Pharmacy Drugs appearing on the drug formulary.

Drugs on the health plan formulary and Specialty Pharmacy Drugs may require preauthorization by a Medical Director or be subject to medical coverage requirements.

Drugs not listed on formulary may be covered if:

1. The drug is not excluded from coverage;
2. The drug is medically necessary;
3. The formulary alternatives have been tried but were insufficient to treat your condition, or there are clinically significant reasons why the formulary alternatives would not be appropriate.

The prescribing Health Professional must submit a written request for prior authorization or request for an appeal to the Health Plan for consideration of coverage. If the request is denied, You and the Health Professional may appeal the denial (see UTILIZATION REVIEW PROGRAM in the Evidence of Coverage).

Inpatient Prescription Drugs

Prescription Drugs, including Specialty Pharmacy Drugs, administered while admitted to a Participating Inpatient facility will be covered as part of Your Inpatient benefit.

Specialty Pharmacy Drugs

Certain classes of Specialty Pharmacy Drugs must be dispensed from one of the participating Specialty Pharmacy providers. Such classes of Specialty Pharmacy Drugs dispensed by a participating Specialty Pharmacy provider will be subject to the formulary Copayment for Specialty Pharmacy Drugs specified in the Prescription Drug Schedule of Benefits. Failure to obtain these specific classes of Specialty Pharmacy Drugs from the participating Specialty Pharmacy provider may result in denial of coverage for such Specialty Pharmacy Drug. You or Your Covered Dependent may contact the Health Plan to obtain a copy of the classes of Specialty Pharmacy Drugs which must be obtained from the Participating Scott and White Specialty Pharmacy Providers.

Office or Clinic Administered Non-Specialty Pharmacy Drugs

Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and which are dispensed and administered to You or Your Covered Dependent in the office of a Participating Provider or in another Outpatient setting, will be covered as a part of Your Medical Services benefit, and no additional Copayments are required for outpatient prescription drugs so dispensed and administered. These drugs may require preauthorization by a Medical Director in order to be covered as a part of Your Medical Services benefit.

Specialty Pharmacy Drugs will be covered pursuant to the Preferred Specialty Pharmacy Drugs benefit, regardless of whether or not the Specialty Pharmacy Drug is administered in the office of a Participating Provider or other Outpatient setting.

Authorization Requirements

For certain medications, the Health Plan limits the quantity You or Your Covered Dependent can receive over a certain period to be sure that You are taking a safe amount of a drug. Coverage of certain drugs may also require a previous failure of another medication. Other drugs may be subject to other clinical restrictions. Preauthorization for some drugs may be required.

One-time prescriptions or refillable prescriptions that exceed the authorization requirement amounts in the Prescription Drug Schedule of Benefits will require preauthorization by the Medical Director.

If coverage for a particular drug or quantity of drug is denied, You and Your Health Professional may appeal the denial (see MEMBER COMPLAINT & APPEAL PROCEDURE of the Evidence of Coverage).

Your Provider may submit a request for an exception to step therapy protocol. If an exception request is not denied within 72 hours of the request, the request will be considered granted. If the prescribing provider feels that a denial would result in death or serious harm, the request will be considered granted if not denied within 24 hours of the request.

Exclusions

This Prescription Drug Benefit excludes the following:

a. drugs which do not require a Health Professional's order for dispensing (sometimes commonly referred to as "over-the-counter" drugs), except insulin and if drug is listed on the health plan formulary;
b. anything which is not specified as covered or not defined as a drug, such as therapeutic devices, appliances, machines including syringes, except disposable syringes for insulin dependent Members, glucometers, and asthma spacers;
c. Experimental or Investigational drugs or other drugs which, in the opinion of the Pharmacy and Therapeutics Committee or Medical Director, have not been proven to be efficacious. NOTE: Denials based upon experimental or investigational use are considered Adverse Determinations and are subject to the Appeal of Adverse Determination and Independent Review provisions of Your Health Care Evidence of Coverage, drugs not approved by the Food and Drug Administration for use in humans or for the condition being treated, dose, route, duration, and frequency being treated;
d. drugs used for cosmetic purposes;
e. drugs used for Treatments or medical conditions not covered by this Agreement;
f. drugs used primarily for the Treatment of infertility;
g. vitamins not requiring a prescription, except if drug is listed on Health Plan Formulary;
h. any initial or refill prescription dispensed more than one (1) year after the date of the Health Professional's order;
i. except for medical emergencies, drugs not obtained at a Network Pharmacy;
j. drugs given or administered to You or a Covered Dependent while at a hospital, skilled nursing facility, or other facility;
k. blood, blood plasma, and other blood products; except as covered by Medical benefits under the Evidence of Coverage.
l. a prescription that has an over the counter alternative;
m. initial or refill prescriptions the supply of which would extend past the termination of this Rider, even if the Health Professional’s order was issued prior to termination
n. drugs for the treatment of sexual dysfunction, impotence, or inadequacy

Refill Limitations

Refill prescription will not be covered until You or Your Covered Dependent’s existing supply is less than 25% of the prescription amount.

These limitations will be calculated based upon the prescription being taken at the prescribed dosage and appropriate intervals.

Refills of prescription eye drops to treat chronic eye disease are allowed if:

- the original prescription states that additional quantities of the eye drops are needed;
- the refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills; and
- the refill is dispensed on or before the last day of the prescribed dosage period; and
    - not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;
    - not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed;
    - not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed

Maintenance Drugs

In order for a drug to be considered a Maintenance Drug, the drug must appear on the Health Plan's maintenance drug list.

Prescriptions to treat chronic illnesses will be considered for medical synchronization as follows:

- Meet prior authorization criteria
- Is used for treatment and management of a chronic illness
- May be prescribed with refills
- Is a formulation that can be effectively dispensed in accordance with the medication synchronization plan
- Is not a Schedule II or III controlled substance containing hydrocodone
- May qualify for synchronizing refills and pro-rated cost sharing amounts for partial supplies of certain medications.

Copayments, Deductible

You must pay the Copayment per quantity and days' supply dispensed per prescription as stated in the Prescription Drug Schedule of Benefits. Any Deductible, and/or Copayments for prescription drugs shall be considered Out-of-Pocket Expenses for purposes of meeting Your Out-of-Pocket Maximum. The amount You pay for a prescription medication will not be more than the Copayment, as stated in the Schedule of Benefits, the allowed amount for the prescription medication, or the actual price of the medication.

Oral Anticancer Medications

Oral anticancer medications are covered under the Preferred Specialty Drug benefit, and are subject to the cost-sharing amounts applied to Specialty Drugs in the Prescription Drug Schedule of Benefits.

Prescriptions for drugs included in the Oral Oncology Dispensing Program will be restricted to a 15-day supply for the first two months of therapy. Note that for members with a flat fee co-payment, drugs included in the Oral Oncology Dispensing Program will be subject to 50% of the applicable copayment amount as listed in the schedule of benefits. Following the first four fills of a drug in the Oral Oncology Dispensing Program, members continuing on therapy may fill their prescription for a maximum day supply allowed per the schedule of benefits.

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FirstCare HEALTH PLANS

Plan Exclusions

1. **Additional expenses** incurred as a result of the Member's failure to follow a Participating Provider's medical orders.

2. The following types of **Alternative Services,** therapy, counseling and relates services or supplies:
   - Acupuncture, naturopathy, hypnotherapy or hypnotic anesthesia, Christian Science Practitioner Services or biofeedback;
   - For or in connection with marriage, child, career, social adjustment, finances, or medical social services;
   - Psychiatric therapy on Court Order or as a condition of parole or probation.
   - Lifestyle Eating and Performance (LEAP) program.

3. **Ambulance** services/transportation are not covered:
   - When another mode of transportation is clinically appropriate;
   - For stable, non-emergency conditions, unless pre-authorized;
   - When provided for the convenience of the Member, family, companion, ambulance provider, Hospital, or attending Physician;
   - Where no transportation of a Member occurs.

   Additionally, Air or Sea Ambulance services are not covered:
   - When ground ambulance is clinically appropriate;
   - To locations other than an acute care Hospital.

4. **Assistant Surgeons**, unless determined to be Medically Necessary.

5. **Biofeedback** services, except for the treatment of Acquired Brain Injury and for rehabilitation of Acquired Brain Injury.

6. **Circumcision** in any male other than a newborn (age 30 days or less), unless Medically Necessary.

7. Services that are supplied by a person who ordinarily resides in the Member's home or is a Family member or **close relative** of the Member.

8. Televisions, telephones, guest beds, and other items for Your **comfort or convenience** in a Hospital or other inpatient facility. Admission kits, maternity kits, and newborn kits provided to You by a Hospital or other inpatient facility.

9. **Cosmetic**, plastic, medical or surgical procedures, and cosmetic therapy and related services or supplies, including, but not limited to Hospital confinements, prescription drugs, diagnostic laboratory tests and x-rays or or surgery and other reconstructive procedures (including any related prostheses, except breast prosthesis following mastectomy), unless specifically provided in *Section 3, What Is Covered*. Among the procedures We do not cover are:
   - Excision or reformation of any skin on any part of the body, hair transplantation, removal of port wine stains, chemical peels or abrasions of the skin, removal of superficial veins, tattoos or tattoo removal, the enlargement, reduction, implantation or change in the appearance in a portion of the body unless determined to be Medically Necessary;
   - Removing or altering sagging skin;
   - Changing the appearance of any part of Your body (such as enlargement, reduction or implantation, except for breast reconstruction following a mastectomy);

- Hair transplants or removal;
- Peeling or abrasion of the skin;
- Any procedure that does not repair a functional disorder; and
- Rhinoplasty and associated surgery except when Medically Necessary to correct deviated septum.

10. **Cryotherapy** devices such as PolarCare™.

11. Respite or Domiciliary care and Inpatient or outpatient **custodial care**. Custodial care is care that:
    - Primarily helps with or supports daily living activities (such as, cooking, eating, dressing, and eliminating body wastes); or
    - Can be given by people other than trained medical personnel.

    Care can be custodial even if it is prescribed by a Physician or given by trained medical personnel, and even if it involves artificial methods such as feeding tubes or catheters. This includes Custodial Care for conditions such as, but not limited to, Alzheimer's disease, senile deterioration, persistent vegetative state, mental retardation, mental deficiency, or any other persistent illness or disorder.

12. All expenses associated with routine **dental care** or oral surgery (except for corrective treatment of an accidental Injury to natural teeth) or any treatment relating to the teeth, jaws, or adjacent structures (for example, periodontium), including but not limited to:
    - Cleaning the teeth;
    - Any services related to crowns, bridges, filings, or periodontics;
    - Rapid palatal expanders;
    - X-rays or exams;
    - Dentures or dental implants;
    - Dental prostheses, or shortening or lengthening of the mandible or maxillae for Members, correction of malocclusion, and any non-surgical dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, such as oral appliances and devices;
    - Treatment of dental abscess or granuloma;
    - Treatment of gingival tissues (other than for tumors);
    - Surgery or treatment for overbite or underbite and any malocclusion associated thereto, including those deemed congenital or developmental anomalies; and
    - Orthodontics, such as splints, positioners, extracting teeth, or repairing damaged teeth.

    The only dental-related coverage We provide is described in *Section 4, What Is Covered, Limited Dental Care Service.*

    This Plan must remain in effect during the entire time the corrective treatment of an Injury to natural teeth is being completed.

13. Charges for the normal **delivery of a baby** (vaginal or cesarean section) outside Our Plan's Service Area if the delivery is within thirty days of Your due date specified by Your participating Physician, or Your Physician has advised against travel outside Our Service Area, except in case of emergency as

specified in *Section 4, Emergency and Out-of-Area Urgent Care Services.* Complication of a pregnancy or delivery is treated as any other illness.

14. The following **devices**, **equipment, and supplies** are excluded:
    - Corrective shoes, shoe inserts, arch supports, and Orthotic inserts, except as provided for under *Section 3, What is Covered* and for the treatment of diabetes;
    - Equipment and appliances considered disposable or convenient for use in the home, such as over-the counter bandages and dressings;
    - Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, and exercise equipment;
    - Environmental control equipment, such as air conditioners, purifiers, humidifiers, dehumidifiers, electrostatic machines, and heat lamps;
    - Consumable medical supplies, such as over-the-counter bandages, dressings, and other disposable supplies, skin preparations, surgical leggings, elastic stockings, TED stockings, stump socks and compression garments.
    - Foam cervical collars;
    - Stethoscopes, sphygmomanometers, and recording or hand-held pulse oximeters;
    - Hygienic or self-help items or equipment; and
    - Electric, deluxe, and custom wheelchairs or auto tilt chairs.
    - Sequential lymphedema compression devices, except for treatment after a mastectomy.

15. The following **drugs, equipment, and supplies**, except immunizations and prescribed treatment of Phenylketonuria (PKU) and diabetes:
    - Outpatient prescription drugs, or as covered under the Prescription Drug Rider;
    - Medications for use outside of the Hospital or other inpatient facility, including take-home and over-the-counter drugs, except those used in the treatment of diabetes or if otherwise covered under the Prescription Drug Rider.
    - Experimental drugs and agents;
    - Drugs used to treat cosmetic conditions; or
    - Drug Efficacy Study Implementation (DESI) Drugs.

16. **Educational testing** and therapy, motor or language skills, or services that are educational in nature or are for vocational testing or training except in cases of Autism Spectrum Disorder and Acquired Brain Injuries as described in *Section 3, What Is Covered*.

17. **Electron Beam Tomography (EBT).**

18. Treatments, services or supplies for **non-Emergency Care** at an emergency room.

19. Weekend admission charges for **non-Emergency Care** services, unless medically necessary.

20. Non-**Emergency** confinement, treatment, services, or supplies received outside the United States.

21. **Equine or Hippo therapy.**

22. **Experimental or investigational** drugs, devices, treatments, or procedures. This includes any drug, device, treatment, or procedure that would not be used in the absence of the experimental or investigational drug, device, treatment, or procedure. We consider a drug, device, treatment, or procedure to be experimental or investigational if:
    - It cannot be lawfully marketed without the approval of the U. S. Food and Drug Administration, and approval for marketing has not been given at the time it is provided;
    - It was reviewed and approved by the treating Facility's Institutional Review Board or similar committee, or if federal law requires it to be reviewed and approved by that committee. This exclusion also applies if the informed consent form used with the drug, device, treatment or procedure was (or was requested by federal law to be) reviewed and approved by that committee;
    - Reliable evidence shows that the drug, device, treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental study, or investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis;
    - The safety and/or efficacy has not been established by reliable, accepted medical evidence; or
    - Reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials of the drug, device, treatment, or procedure are needed to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis.

    "Reliable evidence" includes only published reports and articles in authoritative medical and scientific literature, and written protocols and informed consent forms used by the treating facility or by another facility studying substantially the same drug, device, treatment, or procedure.

    Denials for Medically Necessary or Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See *Section 9* for information on *Member Complaint and Appeal Procedures*.

23. Routine **foot care**, including treatment of weak, strained or flat feet, corns, calluses, or medications such as Lamisil or Sporanox for the treatment of uncomplicated nail fungus. We also do not cover corrective orthopedic shoes, arch supports, splints or other foot care items, except as noted in *Section 3, What is Covered*. This will not apply to the removal of nail roots. We do not cover ankle braces, with the exception of those listed under *Section 3, What is Covered.*

24. **Genetic counseling and testing**, with the exception of those required under applicable state or federal law and Medically Necessary perinatal genetic counseling. Genetic testing related to pre-implantation of embryos for in-vitro fertilization is not covered. Genetic testing results or the refusal to submit to genetic testing will not be used to reject, deny, limit, cancel, refuse to renew, increase premiums for, or otherwise adversely affect eligibility for or coverage under this plan.

25. **Hearing Devices:** Hearing aid batteries or cords, temporary or disposable hearing aids, repair or replacement of hearing aids due to normal wear, loss, or damage, a hearing aid that does not meet the specifications prescribed for correction of hearing loss.

26. All charges for inpatient **Hospital** days that exceed the medically recommended length of stay for the diagnosis, unless Medically Necessary.

27. **Illegal acts**: Charges for services received as a result of Injury or Sickness caused by or contributed to by the covered person engaging in an illegal act or occupation or by committing or attempting to commit a crime, criminal act, assault or other felonious behavior. For purposes of this exclusion, an act is "illegal" if it is contrary to or in violation of law, and includes, but is not limited to, operating a motor vehicle, recreational vehicle or watercraft while intoxicated. Intoxication includes situations in which the covered person has a blood alcohol content or concentration (BAC) which exceeds the applicable legal limit. This exclusion does not apply if the Injury resulted from an act of domestic violence or medical condition (including both physical and mental health), or in case of emergency, the initial medical screening examination, treatment and stabilization of an emergency condition.

28. Any services or items for which You have no **legal obligation** to pay, or for which no charge would ordinarily be made, unless We have authorized such services in advance, or the care provided was of an emergent or urgent nature. Examples of this include care for conditions related to Your military service, care while You are in the custody of any government authority, and any care that is required by law to be given in a public facility.

29. Appearance at court hearings and other **legal proceedings**.

30. **Massage therapy**, unless associated with a physical therapy modality provided by a licensed physical therapist.

31. **Mastectomy** for relief of pain, prophylactic mastectomy to reduce the risk of breast cancer (except when You have been previously diagnosed with breast cancer), or due to any disease or illness other than for the treatment of breast cancer.

32. Inpatient and outpatient treatment, surgery, service, procedures or supplies that are not **Medically Necessary**; even if they are prescribed or recommended by a Health Care provider, dentist or ordered by a court of law.

    Denials for Medically Necessary or Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See *Section 9* for information on *Member Complaint and Appeal Procedures*.

33. **Medications** prescribed for non-FDA approved indications are not covered. This includes experimental, investigational, and any disease or condition that is excluded from coverage under this Evidence of Coverage; or that the FDA has determined to be contraindicated for treatment of the current indication.

    Denials for Medically Necessary or Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See *Section 9* for information on *Member Complaint and Appeal Procedures*.

34. **Mental health** services for the treatment of the following conditions: mental retardation; senile deterioration, such as progressive dementia of Alzheimer's and Alzheimer's like diseases; sleep disorders and factitious disorders. Marriage counseling is not a covered health service.

35. Charges for **missed appointments** and charges for completion of a Claim form.

36. Charges that exceed the **Non-Participating Provider Reimbursement (NPPR)**. Refer to *Section 1 – Requirements for All Healthcare Services*, for clarification on out-of-network services and services received from non-participating providers.

37. If a service is **not covered** under the Plan, We will not cover any services that are related to it. Related services are:
    - Services provided in preparation for the non-covered service;
    - Services provided in connection with providing the non-covered service; or
    - Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
    - Complications from non-covered service
    - All care related to services that are not covered, including direct complications and pre or post care.

    For example, if a Member undergoes non-covered cosmetic surgery, We will not cover pre-operative care, post-operative care, or hospitalization related to the non-covered surgery. Even if the service was covered by another health plan, it will be considered non-covered under this Plan.

38. **Obesity:** Services intended primarily to treat obesity, such as gastric bypasses and balloons, vertical sleeve gastrectomy, bileo-pancreatic diversion (duodenal switch), stomach stapling, jaw wiring, vertical banding, gastric plication, vagal blocking therapy, AspireAssist, intragastric balloon, weight reduction programs, gym memberships, gym equipment, prescription drugs, or other treatments for obesity (except preventive services related to obesity including screening for obesity in adults, counseling and behavioral interventions to promote sustained weight loss, diet and behavioral counseling in primary care to promote healthy maintenance of hyperlipidemia and cardiovascular risk factors along with other diet-related chronic disease factors) even if prescribed by a Physician or the Member has medical conditions that might be helped by weight loss, regardless of Medical Necessity. Any complications/services related to the treatment of obesity will not be covered under this Plan.

39. Prophylactic **oophorectomy**: removal of one or both ovaries in the absence of malignant disease to reduce the risk of ovarian cancer occurrence.

40. **Orthotripsy** and related procedures.

41. **Outpatient services** received in federal facilities or any items or services provided in any institutions operated by a state government or agency when a Member has no legal obligation to pay for such items or services, except for treatment provided in a tax supported mental health institution or by Medicaid.

42. Intradiscal Electrothermal Annuloplasty (IDET) procedures for **pain management**.

43. **Physical Exams,** Treatments and evaluations required by employers, insurers, schools, camps, courts, licensing authorities, flight clearance and other third parties.

44. **Physical Therapy Services**, unless rendered by a physical therapist.

45. All internal and external **prosthetic items and devices**, except for those specified in *Section 3, What is Covered*. We do not cover splints unless they are needed for urgent or emergency treatment and/or in lieu of castings or surgery.

46. Long-term **rehabilitative services**. Long term is defined as more than two months. Limitations do not apply to Acquired Brain Injury, Therapies for Children with Developmental Delays or Autism Spectrum Disorder as specified in *Section 3, What is Covered* of the Evidence of Coverage.

47. **Reports:** Special medical reports not directly related to treatment.

48. **Services** not completed in accordance with the attending Physician's orders.

49. **Services** required as a result of Experimental/Investigational drug testing done voluntarily by the Member without Our approval.

    Denials for Medically Necessary or Experimental/Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See *Section 9* for information on *Member Complaint and Appeal Procedures*.

50. **Services** provided and independently billed by interns, residents or other employees of Hospitals, laboratories or other medical Facilities; unless the Member is hospitalized due to an emergency (or an approved admission), hospital-based providers must be paid at NPPR or agreed rate.

51. **Services** that are provided, paid for, or required by state or federal law where this Evidence of Coverage is delivered, except under Medicaid, when in the absence of insurance, there is no charge for that service.

52. Volunteer **services**, which would normally be provided at no charge to the Member.

53. **Services** associated with autopsy or post-mortem examination unless requested by Us.

54. Any **services or supplie**s furnished by a provider, which is primarily a place of rest, a place for the aged, a nursing home or similar institution.

55. All **services or supplies** provided while the Member is not covered under this Plan; either before the effective date of coverage or after this Evidence of Coverage ended.

56. Treatment, implanted devices or prosthetics, or surgery related to **sexual dysfunction** or inadequacies including, but not limited to impotency, regardless of Medical Necessity, unless related to prior surgical treatment or a result of treatment for a covered condition.

57. **Skilled Nursing Facility** inpatient care exclusions:
    - When the criteria in *Section 3, What is Covered, Inpatient Services, Skilled Nursing Facility* is not met;
    - When services do not require the skills of a qualified provider and/or required procedures may be carried out safely and effectively by an appropriately trained patient, family or caregiver;
    - When services are for maintenance programs or care;
    - When the services are for Custodial Care only;
    - When Medically Necessary care/services can be safely and appropriately provided at a less intense level of care.

58. **Sports cords** and transcutaneous electrical nerve stimulation (TENS) units.

59. **Sports rehabilitation** refers to continued treatment for sports related injuries in an effort to improve above and beyond normal ability to perform activities of daily living (ADLs). **Sports-related rehabilitation** or other similar avocational activities is not covered because it is not considered treatment of disease. This includes, but is not limited to: baseball, pitching/throwing, cheerleading, golfing, martial arts of all types, organized football, baseball, basketball, soccer, lacrosse, swimming, track and field, etc. at a college, high school, or other school or community setting, professional and amateur tennis, professional and amateur/hobby/academic dance, and competitive weightlifting and similar activities.

60. Infertility testing and treatment, infertility drugs, reversal of voluntary **sterilization**; gamete intrafallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF), unless an additional rider has been purchased; any costs related to surrogate parenting; sperm banking for future uses, medical services for artificial insemination; or any assisted reproductive technology or related treatment.

61. Disposable or consumable outpatient **supplies**, such as needles, blood or urine testing supplies (except supplies used in the treatment of diabetes and allergy syringes) and sheaths, bags, elastic garments and bandages, home testing kits, vitamins, dietary supplements and replacements, special food items and formulas, except for any such items or supplies specified in *Section 3, What is Covered*.

62. Medical treatment and oral appliances and devices **for temporomandibular joint** (TMJ) syndrome.

63. Elective, non-therapeutic **termination of pregnancy** (abortions) including any abortion-inducing medications, except where the life of the mother would be endangered if the fetus were to be carried to term or a medical emergency places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

64. **Transportation**, except for ambulance or air ambulance (in accordance with *Section 4, Emergency and Urgent Care, Services and Copayments*) used for transport in a medical emergency or when We have pre-approved services for medical transport purposes only (e.g. from a Hospital to a skilled nursing facility).

65. **Treatment** a school system is required to provide under any law.

66. **Urgent Care** inside the Service Area from a Non-Participating Provider.

67. **Vision Care Services**: Vision exams, eye exercises, training, orthoptics, multiphase testing, eyeglasses (including eyeglasses and contact lenses prescribed following vision surgery) contact

lenses, except for treatment of Keratoconus, and any other items or services for the correction of Your eyesight, including but not limited to: orthoptics, vision training, vision therapy, radial keratotomy (RK), automated lamellar keratoplasty (ALK or LK), astigmatic keratotomy (AK), laser vision corrective surgery and photo refractive keratectomy (PRK-laser) unless specifically provided in *Section 3, What Is Covered*, or provided by a Rider.

68. Health care services for any **work-related** injury or illness.

69. Illness or injury incurred as a result of **war** or any act of war, whether declared or undeclared, whether or not You served in the military.

Limitations Due To Certain Conditions

In the event that due to circumstances not within the control of FirstCare, including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, war, riot, civil insurrection, disability of a significant number of Participating Providers and their personnel, or similar causes, the rendering of Covered Health Services provided under this Evidence of Coverage is delayed or rendered impractical, FirstCare shall make a good faith effort to arrange for an alternative method of providing coverage. In such an event, FirstCare and its Participating Providers shall render Covered Health Services insofar as practical, and according to their best judgment; but FirstCare and Participating Providers shall incur no liability or obligation for delay or failure to provide or arrange for services if such failure or delay is caused by any such event.