

FirstCare - The HMO of Choice

TRS-ACTIVECARE PROGRAM SCHEDULE OF COPAYMENTS

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 accident and sickness insurance policies/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 and 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 and non-covered services.

Covered Services	Copayment Amount
ANNUAL DEDUCTIBLE	\$100 per Member
OUT-OF-POCKET MAXIMUM	\$3,500 per Member
Outpatient Services	
<p><i>Office Visits</i> including medications (except certain injectable medications) and materials administered in the Physician's office, and surgical procedures performed in the Physician's office. (Additional Copayments apply for surgical procedures and injectable medications.)</p> <ul style="list-style-type: none"> • Primary Care Physician • Specialist Physician 	<p>\$20 per visit to the PCP*</p> <p>\$40 per visit to the Specialist*</p>
Laboratory Services	No Copay*
Diagnostic Radiology Services (except for the following procedures):	No Copay*
<ul style="list-style-type: none"> • Arteriograms, CT Scan, Magnetic Resonance Imaging (MRI); EEG; Myelogram; and PET Scan • Radio-nuclide Stress Test 	<p>\$100 per procedure</p> <p>\$100 per procedure</p>
Surgical Procedures performed in the Physician's office	\$50 per procedure
Pre- and Post-Natal Obstetrical Care	No Copay*
Rehabilitation, Speech, Occupational and Physical Therapy	\$40 per visit
Outpatient Surgery	\$150 Copay per admission
Physician Home Visits	\$40 per visit
Allergy Services	
<ul style="list-style-type: none"> • Office Visits including Testing • Serum • Injection Administration 	<p>\$20 per visit to the PCP *</p> <p>\$40 per visit to the Specialist*</p> <p>50% of the Allowable Amount</p> <p>50% of the Allowable Amount per visit</p>
Short-term Mental Health Services	\$40 per visit.* Limited to 20 outpatient visits per Plan Year.

*No Deductible
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Covered Services	Copayment Amount
Outpatient Services (cont.)	
Serious Mental Illness Health Services	\$40 per visit.*
Chemical Dependency Services	\$40 per visit.* Limited to 3 series of treatments per lifetime.
Autism Spectrum Disorder	\$20 per visit to the PCP* \$40 per visit to the Specialist*
Preventive Health Care Services	
Routine Physical Exams	\$20 per visit to the PCP* \$40 per visit to the Specialist*
Well-Baby and Well-Child Care	\$20 per visit to the PCP* \$40 per visit to the Specialist*
Routine Immunizations	No Copay*
Well-Woman Examinations	\$20 per visit to the PCP or designated OB/GYN* \$40 to a non-designated OB/GYN* (referral required)
Screening Mammograms, including X-ray, Digital, and Ultrasound	No Copay*
Bone Mass Measurement	\$40 per procedure*
Examinations for Detection of Prostate Cancer	Included in the office visit Copay*
Routine Sight, Speech and Hearing Screenings for Children	No additional Copay required when performed during an Office Visit.*
Family Planning and Infertility Services	
Family Planning Counseling	\$20 per visit to the PCP* \$40 per visit to the Specialist*
Sterilization Performed at an Outpatient Surgical Facility	\$150 per admission
Contraceptive Devices and Implants <ul style="list-style-type: none"> • Diaphragm • IUD • Subdermal Contraceptive Implants & Removal • Depo Provera Injections 	20% of the Allowable Amount for all charges. Applies to materials, procedures, and services.
Sterilization Performed in the Physician's office	\$50 per procedure

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Family Planning and Infertility Services (cont.)	
Infertility Services	50% of the Allowable Amount, applies to all office visits and services. Infertility drugs are not covered.
Inpatient Services	
Inpatient Admissions including: <ul style="list-style-type: none"> • Rehabilitation Facility • Skilled Nursing Facility • Chemical Dependency Treatment Center • Psychiatric Hospital Observation Unit Admission	\$150 per day; not to exceed \$750 maximum per admission <i>Skilled Nursing Facility: Limited to 100 days per Plan Year.</i> <i>Chemical Dependency: Limited to 3 series of treatments per lifetime.</i> <i>Short-Term Mental Illness: 15 Inpatient days per Plan Year.</i> <i>Serious Mental Illness: 45 Inpatient days per Plan Year</i> \$150 per admission
Other Health Care Services	
Limited Accidental Dental-Related Services	\$10,000 annual maximum benefit
Home Health Services	No Copay
Non-Emergency Ambulance Services	\$100 per trip
Prosthetics	\$250 per device External devices – Lifetime Maximum - \$10,000 per device/Limb
Orthotics	\$250 per device
Durable Medical Equipment (DME) & Medical Supplies	20% of the Allowable Amount per piece or equipment or supply. DME is limited to \$4,000 per Plan Year. DME used in the treatment of diabetes, oxygen and monitoring devices are not included in \$4,000 maximum.
Insulin and Diabetic Medications (Non-Maintenance, up to a 30-day supply) <ul style="list-style-type: none"> • Generic • Preferred Brand Name • Non-Preferred Brand Name 	<ul style="list-style-type: none"> • \$5 per prescription* • \$25 per prescription* • \$55 per prescription*
Insulin and Diabetic Medications (Maintenance - after 2nd fill ¹ , up to a 30-day supply) <ul style="list-style-type: none"> • Generic • Preferred Brand Name • Non-Preferred Brand Name 	<ul style="list-style-type: none"> • \$10 per prescription* • \$35 per prescription* • \$70 per prescription*

*No Deductible
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Covered Services	Copayment Amount
Other Health Care Services (cont.)	
Insulin and Diabetic Medications (Mail order, up to a 90-day supply) <ul style="list-style-type: none"> • Generic • Preferred Brand Name • Non-Preferred Brand Name 	<ul style="list-style-type: none"> • \$15 per prescription* • \$75 per prescription* • \$165 per prescription*
Preferred Glucose Meters	No Copay*
Preferred Diabetic Testing Supplies (up to a 30-day supply)	10% per item*
Non-Preferred Diabetic Supplies (up to a 30-day supply)	20% per item*
Diabetic Self-Management Education	\$20 per visit to the PCP* \$40 per visit to the Specialist*
Hearing Aids	Coverage limited to a maximum of \$500 per ear once every 36 months
Dialysis Services	Included in the office visit, outpatient surgery or inpatient Hospital Copay
Organ Transplant Services	Included in the office visit, outpatient surgery or inpatient hospital Copay
Chemotherapy and Radiation Therapy Services, including Infusion Supplies & Administration (See Injectable Medications below for additional copayments)	Included in the office visit, outpatient surgery or inpatient hospital Copay.
Any Injectable Medication greater than \$500 per service (See Prescription Drugs for Self Injectable Drugs coverage)	\$100 per injectable, subject to the Injectable Drug Out-of-Pocket Maximum of \$2,500. See Section 10, Definitions.
Hospice Services	No Copay
Pain Management Services	Included in the office visit, outpatient surgery or inpatient hospital Copay.
Emergency Services	
Emergency Room	\$100 per hospital emergency room visit. Emergency room Copay is waived if admitted to hospital.
Minor Emergency or Urgent Care Center	\$40 per visit

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Covered Services	Copayment Amount
Emergency Services (cont.)	
Ambulance	\$100 per ambulance trip
Prescription Drugs¹	
Prescription Deductible	\$50
Plan Year Maximum Benefit	\$10,000
<i>Retail Pharmacy (Non-Maintenance, up to a 30-day supply)</i>	
<ul style="list-style-type: none"> • Generic (Tier I) • Preferred Brand Name (Tier II) • Non-Preferred (Tier III) • Self-Injectable, Preferred² (Tier IV) • Self-Injectable, Non-Preferred² (Tier V) 	<ul style="list-style-type: none"> • \$5 per prescription • \$25 per prescription • \$55 per prescription • 15% per prescription • 35% per prescription
<i>Retail Pharmacy (Maintenance - after 2nd fill, up to a 30-day supply)</i>	
<ul style="list-style-type: none"> • Generic (Tier I) • Preferred Brand Name (Tier II) • Non-Preferred (Tier III) • Self-Injectable, Preferred² (Tier IV) • Self-Injectable, Non-Preferred² (Tier V) 	<ul style="list-style-type: none"> • \$10 per prescription • \$35 per prescription • \$70 per prescription • 15% per prescription • 35% per prescription
<i>Mail Service Pharmacy (up to a 90-day supply)</i>	
<ul style="list-style-type: none"> • Generic (Tier I) • Preferred Brand Name (Tier II) • Non-Preferred (Tier III) • Self-Injectable, Preferred² (Tier IV) • Self-Injectable, Non-Preferred² (Tier V) 	<ul style="list-style-type: none"> • \$15 per prescription • \$75 per prescription • \$165 per prescription • 15% per prescription • 35% per prescription

¹ Plan provides two (2) fills of maintenance medications through Participating Retail Pharmacies at the standard drug copayment level. After that, maintenance medications can be procured through the Home Delivery Pharmacy or through the Participating Retail Pharmacy at the applicable maintenance drug copayments.

² 4th & 5th Tier medications not subject to the Maximum Benefit.