TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

BlueCross BlueShield of Texas

2022-23 BENEFITS BOOKLET



TRS-ActiveCare HD
TRS-ActiveCare 2

Effective Sept. 1, 2022 – Aug. 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

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

The TRS-ActiveCare Health Plans are offered by your Group as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for *medically necessary* services and supplies.

Coverage under this *plan* is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this benefits booklet that affect your health care coverage. It is important that you read the benefits booklet carefully, so you will be aware of the benefits and requirements of this 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*.

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/trsactivecare 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/trsactivecare, 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 providers*, 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**
Websites	**www.bcbstx.com/trsactivecare 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/trsactivecare 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 an 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.

Notice About Mental Health Parity

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act, also known as the Mental Health Parity and Addiction Equity Act. However, these employers are permitted to elect to exempt a plan from those requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. TRS has elected to exempt TRS-ActiveCare from the Mental Health Parity and Addiction Equity Act which require that benefits for mental health and substance use disorders may not have more restrictions than those that apply to medical and surgical benefits covered by the plan.

This means that you still have access to inpatient admissions and outpatient services for mental health or substance abuse without any day or visit limitations; however, TRS medical plans will not have to meet certain requirements of the Mental Health Parity and Addiction Equity Act. Your mental health and substance abuse benefits are described in more detail in this benefits booklet.

SCHEDULE OF COVERAGE

TRS-ActiveCare HD Plan

The following chart summarizes the coverage available under your ***TRS-ActiveCare HD 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 Plan Year		
Per Individual	$3,000	$5,500
Per Family	$6,000	$11,000
Maximum Out-of-Pocket Per Plan Year		
Per Individual	$7,050	$20,250
Per Family	$14,100	$40,500
Professional Services		
Primary Care Provider (PCP) Office or Home Visit **Specialist Physician ("Specialist") Office or Home Visit**	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Inpatient Hospital Services		
Inpatient Hospital Services	30% *coinsurance* after *deductible* No penalty for failure to obtain *prior authorization* for services	50% *coinsurance* after *deductible,* $500 per day maximum allowed amount* $250 penalty for failure to obtain *prior authorization* for services
Outpatient Facility Services		
Outpatient Surgery	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Radiation Therapy and Chemotherapy	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Dialysis	30% *coinsurance* after *deductible*	50% *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-ActiveCare HD 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)	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Other X-Ray Services	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Other Outpatient Lab	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Labs – Outpatient Hospital setting	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Diagnostic imaging of the breast (including diagnostic mammograms, ultrasound imaging, MRI or CT scan)	Plan pays 100%	50% *coinsurance* after *deductible*
Rehabilitation Services*		
Rehabilitation Services and Therapies, all services billed by a Chiropractor will apply to the visit maximum of 35.	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Maternity Care and Family Planning Services		
Maternity Care Prenatal Postnatal ***Inpatient Hospital Services*****, for each admission	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Family Planning Services: • diagnostic counseling, consultations and planning services • insertion or removal of intrauterine device (IUD), including cost of device • diaphragm or cervical cap fitting, including cost of device • insertion or removal of birth control device implanted under the skin, including cost of device • injectable contraceptive drugs, including cost of drug • voluntary sterilization • vasectomy	30% *coinsurance* after *deductible*; unless otherwise covered under *Contraceptive Services* described in ***Preventive Care Services.***	50% *coinsurance* after *deductible*
Infertility Services • treatment of underlying conditions	30% *coinsurance* after *deductible*	50% *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-ActiveCare HD Plan

	In-Network Benefits	Out-of-Network Benefits
Behavioral Health Services		
***Outpatient mental health care, serious mental illness* and *treatment of substance use disorder* (SUD) – Office Setting**	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
***Outpatient mental health care, serious mental illness* and *treatment of substance use disorder* (SUD) – Other Outpatient services**	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*, $500 per day maximum allowed amount*
***Inpatient mental health care, serious mental illness* and *treatment of substance use disorder* (SUD)- Facility services**	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Inpatient *mental health care, serious mental illness* and *treatment of substance use disorder* (SUD)- Professional services	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Emergency Care Services		
Facility (If admitted, any charges described in *Inpatient Hospital Services* will apply.)	30% *coinsurance* after *deductible*	
Physician	30% *coinsurance* after *deductible*	
	$500 *copay*, plus 30% *coinsurance* after *deductible* for services rendered at a Free-Standing Emergency Room.	$500 *copay*, plus 50% *coinsurance* after *deductible* for services rendered at a Free-Standing Emergency Room.
Urgent Care Services		
Urgent Care	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Retail Health Clinics		
Retail Health Clinics	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Ambulance Services		
Ambulance Services, per service	30% *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-ActiveCare HD Plan

	In-Network Benefits	Out-of-Network Benefits
Extended Care Services		
Skilled Nursing Facility Services, for each day, up to 25 days per *plan year*	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*[*]
Hospice Care, per visit	30% *coinsurance* after *deductible*; unless otherwise covered under *Inpatient Hospital Services*.	50% *coinsurance* after *deductible*[*]
Home Health Care, per visit, up to 60 visits per *plan year*	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Private Duty Nursing	30% *coinsurance* after *deductible*	50% *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-ActiveCare HD Plan

	In-Network Benefits	Out-of-Network Benefits
Preventive Services		
Well child care through age 17	Plan pays 100%	50% *coinsurance* after *deductible*
Periodic health assessments for *participants* age 18 and older	Plan pays 100%	50% *coinsurance* after *deductible*
Immunizations		
• childhood immunizations required by law for *participants* through age 6	Plan pays 100%	50% *coinsurance* after *deductible*
• immunizations for *participants* over age 6	Plan pays 100%	50% *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%	50% *coinsurance* after *deductible*
Well-woman exam, once per *plan year*, includes, but not limited to, exam for cervical cancer (Pap smear), for female *participants* age 18 and older.	Plan pays 100%	50% *coinsurance* after *deductible*
Screening mammogram for female *participants* age 35 and over and for female *participants* with other risk factors, once per *plan year.*	Plan pays 100%	50% *coinsurance* after *deductible*
• outpatient facility or imaging centers	Plan pays 100%	50% *coinsurance* after *deductible*
Contraceptive Services and Supplies • contraceptive education, • counseling • certain female FDA approved contraceptive methods • female sterilization procedures and devices	Plan pays 100%	50% *coinsurance* after *deductible*
Breastfeeding Support, Counseling and Supplies • lactation counseling limited to six (6) visits per *plan year* • electric breast pumps limited to two (2) per *plan year* (Hospital grade breast pumps are covered up to purchase price of $150)	Plan pays 100%	50% *coinsurance* after *deductible*
Hearing Loss		
• screening test from birth through 30 days	Plan pays 100%	50% *coinsurance* after *deductible*
• follow-up care from birth through 24 months	Plan pays 100%	50% *coinsurance* after *deductible*

	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 *plan year*	Plan pays 100%	50% *coinsurance* after *deductible*
• flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years	Plan pays 100%	50% *coinsurance* after *deductible*
• colonoscopy, limited to 1 every 10 years	Plan pays 100%	50% *coinsurance* after *deductible*
• Cologuard, limited to 1 every 3 years	Plan pays 100%	50% *coinsurance* after *deductible*
Eye and ear screenings, once per *plan year*	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Early detection test for cardiovascular disease, limited to 1 every 5 years • computer tomography (CT) scanning • ultrasonography	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Early detection test for ovarian cancer (CA125 blood test), once per *plan year*	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Exam for prostate cancer for *participants* age 45 and older or age 40 with family history, once per *plan year*	Plan pays 100%	50% *coinsurance* after *deductible*
Dental Surgical Procedures		
Dental Surgical Procedures (limited covered services)	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Cosmetic, Reconstructive or Plastic Surgery		
Cosmetic, Reconstructive or Plastic Surgery (limited covered services)	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Allergy Care		
Testing and Evaluation	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Injections	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Serum	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*

SCHEDULE OF COVERAGE

TRS-ActiveCare HD Plan

	In-Network Benefits	Out-of-Network Benefits
Diabetes Care		
Diabetes Self-Management Training, for each visit **Diabetes Equipment** **Diabetes Supplies**	30% *coinsurance* after *deductible*	50% *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 *plan year*, for the prevention of complications associated with diabetes.	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Cochlear Implants Limit one (1) per impaired ear every three years for *participants* up to the age of 19, with replacements as *medically necessary* or audiologically necessary.	30% *coinsurance* after *deductible* Any additional charges as described in Outpatient Surgery may also apply.	50% *coinsurance* after *deductible*
Durable Medical Equipment		
Durable Medical Equipment	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Hearing Aids		
Hearing Aids $1,000 maximum per 36 months for hearing aids (applies to *participants* over the age of 19)	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*
Speech and Hearing Services		
Speech and Hearing Services	30% *coinsurance* after *deductible*	50% *coinsurance* after *deductible*

SCHEDULE OF COVERAGE

TRS-ActiveCare HD Plan

	In-Network Benefits	Out-of-Network Benefits
Telehealth Services through TRS Virtual Health		
Medical – • **Teladoc**	30% *coinsurance* after *deductible,* medical consult fee of $42 applies to *deductible*	Not Applicable
• **RediMD**	30% *coinsurance* after *deductible,* medical consult fee of $30 applies to *deductible*	Not Applicable
Behavioral Health – Teladoc only	30% *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-ActiveCare HD Plan

	Blue Distinction Plus Designated Center	Blue Distinction Designated Center	In-Network Benefits	Out-of-Network Benefits
Blue Distinction Centers				
Bariatric Surgery	Not Covered	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	30% *coinsurance* after *deductible* for Inpatient Hospital & Outpatient Hospital services	50% *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*.

SCHEDULE OF COVERAGE

TRS-ActiveCare 2 Plan

The following chart summarizes the coverage available under your ***TRS-ActiveCare 2 Plan***. For details, refer to COVERED MEDICAL SERVICES.

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

	In-Network Benefits	Out-of-Network Benefits
Deductibles Per Plan Year		
Per Individual	$1,000	$2,000
Per Family	$3,000	$6,000
Maximum Out-of-Pocket Per Plan Year		
Per Individual	$7,900	$23,700
Per Family	$15,800	$47,400
Professional Services		
Primary Care Provider (PCP) Office or Home Visit	$30 *copay*	40% *coinsurance* after *deductible*
Specialist Physician ("Specialist") Office or Home Visit	$70 *copay*	
Inpatient Hospital Services		
Inpatient Hospital Services $2,250 maximum *copay* per *plan year* for *In-network* and *out-of-network benefits* combined.	20% *coinsurance* after *deductible* and after $150 *copay* per day ($750 maximum *copay* per admission)	40% *coinsurance* after *deductible,* $500 per day maximum allowed amount*
	No penalty for failure to obtain *prior authorization* for services	$250 penalty for failure to obtain *prior authorization* for services
Outpatient Facility Services		
Outpatient Surgery	20% *coinsurance* after *deductible, $150 copay* per incident	40% *coinsurance* after *deductible, $150 copay* per incident
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*	$1,000 *copay*
Infusion therapy - Home, Office, *Infusion Suite* Setting	$30 *copay*	$250 *copay*

*$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-ActiveCare 2 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* and $100 *copay* per procedure (*copay* waived if performed in ER or if admitted)	40% *coinsurance* after *deductible* and $100 *copay* per procedure (copay waived if performed in ER or if admitted)
Lab & X-Ray Services, office or independent facility setting	0% *coinsurance*	40% *coinsurance* after *deductible*
Outpatient Lab	0%*coinsurance*	40% *coinsurance* after *deductible*
Outpatient X-Ray	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Diagnostic imaging of the breast (including diagnostic mammograms, ultrasound imaging, MRI or CT scan)	Plan pays 100%	40% *coinsurance* after *deductible*
Rehabilitation Services*		
Rehabilitation Services and Therapies, all services billed by a Chiropractor will apply to the visit maximum of 35	$70 *copay* in the office setting 20% *coinsurance* after *deductible* for Outpatient Facility Services, as applicable.	40% *coinsurance* after *deductible*
Maternity Care and Family Planning Services		
Maternity Care		
Prenatal	$30 *copay*	40% *coinsurance* after *deductible*
Postnatal	$30 *copay*	
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-ActiveCare 2 Plan

	In-Network Benefits	Out-of-Network Benefits
Maternity Care and Family Planning Services (continued)		
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**	$30 *copay*	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* after $150 *copay* per day ($750 maximum *copay* per admission)	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		
Facility (if admitted, any charges described in *Inpatient Hospital Services* will apply) **Physician**	$250 *copay* and 20% *coinsurance* after *deductible* 20% *coinsurance* after *deductible*	
	$500 *copay*, plus 20% *coinsurance* after *deductible* for services rendered at a Free-Standing Emergency Room.	$500 *copay*, plus 40% *coinsurance* after *deductible* for services rendered at a Free-Standing Emergency Room.
Urgent Care Services		
Urgent Care	$50 *copay*	40% *coinsurance* after *deductible*
Retail Health Clinics		
Retail Health Clinics	$30 *copay*	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-ActiveCare 2 Plan

	In-Network Benefits	Out-of-Network Benefits
Extended Care Services		
Skilled Nursing Facility Services, for each day, up to 25 days per *plan 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 60 visits per *plan year*	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Private Duty Nursing	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-ActiveCare 2 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 *plan year*, includes, but not limited to, exam for cervical cancer (Pap smear), for female *participants* age 18 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 *plan 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 and 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 *plan year* • electric breast pumps limited to two (2) per *plan year* (Hospital grade breast pumps are covered up to purchase price of $150)	Plan pays 100%	40% *coinsurance* after *deductible*
Hearing Loss		
• screening test from birth through 30 days	Plan pays 100%	40% *coinsurance* after *deductible*
• follow-up care from birth through 24 months	Plan pays 100%	40% *coinsurance* after *deductible*

SCHEDULE OF COVERAGE

TRS-ActiveCare 2 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 *plan year* • flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years • colonoscopy, limited to 1 every 10 years • Cologuard, limited to 1 every 3 years	 Plan pays 100% Plan pays 100% Plan pays 100% Plan pays 100%	 40% *coinsurance* after *deductible* 40% *coinsurance* after *deductible* 40% *coinsurance* after *deductible* 40% *coinsurance* after *deductible*
Eye and ear screenings, once per *plan year*	$30 *copay* for PCP or $70 for *specialist*	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 *plan year.*	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Exam for prostate cancer for *participants* age 45 and older or age 40 with family history, once per *plan 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*
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*

	In-Network Benefits	Out-of-Network Benefits
Diabetes Care		
Diabetes Self-Management Training, for each visit **Diabetes Equipment** **Diabetes Supplies**	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 *plan year*, for the prevention of complications associated with diabetes.	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Cochlear Implants Limit one (1) per impaired ear every three years for *participants* up to the age of 19, with replacements as *medically necessary* or audiologically necessary.	20% *coinsurance* after *deductible* Any additional charges as described in Outpatient Surgery may also apply.	40% *coinsurance* after *deductible*
Durable Medical Equipment		
Durable Medical Equipment	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Hearing Aids		
Hearing Aids $1,000 maximum per 36 months for hearing aids (applies to *participants* over the age of 19)	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Speech and Hearing Services		
Speech and Hearing Services	20% *coinsurance* after *deductible*	40% *coinsurance* after *deductible*
Speech and Hearing Therapy – Office setting	$70 *copay*	40% *coinsurance* after *deductible*

SCHEDULE OF COVERAGE

TRS-ActiveCare 2 Plan

	In-Network Benefits	Out-of-Network Benefits
Telehealth Services through TRS Virtual Health		
Medical –		
• **Teladoc**	$12 copay	Not Applicable
• **RediMD**	$0 copay	Not Applicable
Behavioral Health – Teladoc only	$70 *copay*	Not Applicable

SCHEDULE OF COVERAGE

TRS-ActiveCare 2 Plan

	Blue Distinction Plus Designated Center	Blue Distinction Designated Center	In-Network Benefits	Out-of-Network Benefits
Blue Distinction Centers				
Bariatric Surgery				
Facility	20% *coinsurance* after *deductible* and after $150 *copay* per day*	Not Covered	Not Covered	Not Covered
Physician	$5,000 *copay* for Surgeon fees			
Transplants	0% *coinsurance* after *deductible* and after $150 *copay* per day* for Inpatient Hospital & Outpatient Hospital services	0% *coinsurance* after *deductible* and after $150 copay per day* for Inpatient Hospital & Outpatient Hospital services	20% *coinsurance* after *deductible* and after $150 *copay* per day* for Inpatient Hospital & Outpatient Hospital services	40% *coinsurance* after *deductible* for Inpatient Hospital** & Outpatient Hospital services

*$750 maximum *copay* per admission, $2,250 maximum *copay* per *plan year*.

**$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.

Dependent children are eligible for *maternity care* benefits.

Preexisting Conditions

Preexisting conditions are covered immediately.

WHO GETS BENEFITS

Employee Eligibility

Who can enroll in TRS-ActiveCare?

To be eligible for TRS-ActiveCare, you:

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

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

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

Starting Sept. 1, 2022, the Medicare Secondary Payer Law will let Medicare-eligible TRS-Care retirees enroll in TRS-ActiveCare if they return to work for a TRS-covered employer. If you're a return-to-work retiree enrolled in TRS-Care and eligible for Medicare, you may enroll in TRS-ActiveCare if you return to a TRS employer and work 10 or more hours per week. TRS will provide more information and guidance on how this new rule works.

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

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

A part-time employee is an individual who:

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

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

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

Note: Although under their particular circumstances, a retiree, a higher education employee, or a state employee may not be covered as an employee of a participating district/entity, they could be covered as a *dependent* of an eligible employee. Employees covered as *dependent*s by a higher education entity or a state program may be able to also be covered under TRS-ActiveCare as an employee.

Who is eligible for TRS-ActiveCare coverage?
Teachers, administrative personnel, substitutes, bus drivers, librarians, crossing guards, cafeteria workers, and high school or college students, among others, are all eligible for coverage, provided no exception applies, if they are employees of the district/entity, not volunteers, and are either active, contributing TRS members or are employed by a participating district/entity for 10 or more regularly scheduled hours each week.

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

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

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

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

Eligible Dependents

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

Eligible *dependents* include:

- a spouse, including a common law spouse (a common law spouse isn't considered eligible unless there is a Declaration of Informal Marriage filed with an authorized government agency)
- a *child* under the age of 26, who is one of the following:
  a. a natural child
  b. an adopted child or a child who is lawfully placed for legal adoption
  c. a stepchild
  d. a foster child
  e. a child under the legal guardianship of the employee
- a grandchild* under age 26 whose primary residence is the household of the employee and who is a *dependent* of the employee for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect

  *For purposes of *dependent* eligibility under TRS-ActiveCare, a grandchild that doesn't fit into the above definition isn't considered a *child*.
- "any other *dependent*" (other than those listed above) under the age of 26 in a regular parent- child relationship with the employee, meeting all four of the following requirements:
  a. the child's primary residence is the household of the employee
  b. the employee provides at least 50% of the child's support
  c. neither of the child's natural parents resides in that household
  d. the employee has the legal right to make decisions regarding the *child's* medical care*

  *This requirement doesn't apply to *dependents* age 18 and over.

- a *child*, age 26 or over, of a covered employee may be eligible for *dependent* coverage, provided that the *child* is either mentally or physically incapacitated to such an extent that they are *dependent* on the employee on a regular basis as determined by TRS, and meet other requirements as determined by TRS
- a *dependent* doesn't include a brother or a sister of an employee, unless the brother or sister is an individual under age 26 who is either: (1) under the legal guardianship of an employee, or (2) in a regular parent-*child* relationship with an employee, as defined in the "any other *child*" category above. Parents and grandparents of the covered employee don't meet the definition of an eligible *dependent*

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

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

Making Changes/Special Enrollment Events

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

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

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

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

What is a special enrollment event?

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

New Dependent

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

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

Note: The COBRA election period is separate from the TRS-ActiveCare *enrollment period*(s), including special *enrollment periods*. For example, you have 60 days to elect COBRA coverage with a prior *employer*, but you must make a request for TRS-ActiveCare coverage within 31 days of the loss of coverage or the addition of a new *dependent*.

Can dependents be added throughout the plan year?
An employee may be able to add eligible *dependents* during a *plan year* if the employee has a qualified status change or special enrollment event. Such events may include marriage, birth, adoption or placement of adoption of a child, or a loss of coverage from another *group* plan. The cost of coverage may change based on the selected coverage category.

Special Eligibility Situations

- If an employee and spouse both work for a participating district/entity, the spouse may be covered as an employee or as a *dependent* of an eligible employee. Only one parent may enroll *dependent children* for coverage.
- A *child* (under age 26) who is employed by a district/entity and is a contributing TRS member can be covered as a *dependent* on their parent's TRS-ActiveCare coverage. However, current law only allows pooling of state and district funds for "married couples." An employee who is covered as a *dependent child* won't be entitled to state or district funding.
- A retiree who returns to work for a participating entity in TRS-ActiveCare is eligible for TRS-ActiveCare coverage if the retiree meets TRS-ActiveCare eligibility requirements, regardless of any prior coverage under TRS-Care.
- Accordingly, for purposes of enrollment in TRS-ActiveCare, individuals who are hired in a substitute position or who have retired under the TRS pension will be considered part-time employees, regardless of the number of hours they work for the participating entity.
- Part-time employees are not entitled to state assistance in the purchase of their TRS-ActiveCare coverage. The participating entity that employs a part-time employee may, but isn't required, to provide assistance in the purchase of TRS-ActiveCare coverage for the part-time employee.
- Upon termination of a retiree's TRS-ActiveCare coverage, the retiree can only enroll in TRS-Care if the retiree: (A) turns age 65 or has a special enrollment event, and (B) is otherwise eligible to enroll in TRS-Care. The opportunity to enroll in TRS-Care under these rights is limited in time, so be sure to timely exercise your rights. For example, if a return-to-work retiree leaves employment and loses TRS-ActiveCare coverage, they have a special enrollment event to enroll in TRS-Care if otherwise eligible.
- If a participant has employee and spouse coverage, and the spouse is hired by a participating district/entity, the employee may drop the spouse (unless restricted by district/entity's Section 125 cafeteria plan rules) so that the spouse may enroll as a new hire. (The cancellation reason would be considered voluntary and wouldn't be eligible for COBRA.)
- If a participant has employee-only or employee and *child* coverage, and the spouse is hired by a participating district/entity, the employee can't enroll the spouse because the spouse is a new hire; there must be a loss of other coverage. The employee may enroll the spouse within 31 days of the spouse's event date for loss of other coverage.

Loss of Coverage

Loss of coverage qualifies as a special enrollment event if:

- You and/or your dependent(s) lost other group coverage due to a loss of eligibility.
- You and/or your dependent(s) elected to drop the other group health coverage because the employer stopped all employer contributions toward the premium (including any employer-paid COBRA premium).
- You and/or your *dependent*(s) exhausted your COBRA continuation coverage.

Note: For TRS-ActiveCare, the loss of coverage from the following also qualifies as a special enrollment event:

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

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

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

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

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

In order to have a special enrollment event, when you or your *dependent* loses other health coverage, you or your *dependent* must have had other health coverage when coverage under TRS-ActiveCare was previously declined in writing.

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

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

Dropping Coverage

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

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

Court-Ordered Dependent Children

If the participating district/entity receives a court order or national medical support notice that directs an employee to provide health coverage for a *dependent child*, the court-ordered *dependent child* will be automatically enrolled from the date the participating district/entity receives the court order or national medical support notice.

A court order or national medical support notice that directs anyone other than the employee to provide health coverage for a *dependent child* doesn't require TRS-ActiveCare to provide *dependent* coverage for the *dependent child* and isn't a special enrollment event for the employee or any of the employee's eligible *dependents*.

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

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

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

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

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

Other Court-Ordered Dependents

A court order or national medical support notice that directs an employee to provide health coverage for an ex-spouse or other *dependents* that are not eligible *children* under TRS-ActiveCare eligibility standards doesn't require TRS-ActiveCare to provide *dependent* coverage as a result of the court order or national medical support notice.

Additionally, this type of court order or national medical support notice doesn't qualify as a special enrollment event to make plan changes. An ex-spouse isn't eligible for TRS-ActiveCare coverage unless the ex-spouse is already covered as a COBRA continuation *participant*.

Effective Date of Coverage

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

If…	Your effective date is…	Your eligible *dependent*'s effective date is…
New Entity		
The district/entity first begins participation in TRS-ActiveCare on Sept. 1 and the employee enrolls for coverage during summer enrollment	Sept. 1	Sept. 1
The district/entity begins participation in TRS-ActiveCare after Sept. 1 and the employee enrolls for coverage	The date the district/entity first begins participation in TRS-ActiveCare	The same date as the employee's *effective date* of coverage *In no event will the dependent's coverage become effective prior to the employee's effective date*
Declines		
The employee enrolls for coverage during the *enrollment period* and had originally declined coverage under TRS-ActiveCare	Sept. 1	Sept. 1
New Hires		
A new hire in a TRS-covered position who is a TRS member on their actively-at-work date enrolls for coverage within 31 days after the actively-at-work date	The employee's choice of: their actively-at-work date, or the first of the month following the employee's actively-at-work date *Premium is billed for the full month in which coverage begins. New hires must choose the effective date of coverage within 31 days after the actively-at-work date.*	The same date as the employee's *effective date* of coverage *In no event will the dependent's coverage become effective prior to the employee's effective date*
A new hire in a non-TRS covered position who is regularly scheduled to work 10 or more hours per week on their actively-at-work date enrolls for coverage within 31 days after the actively-at-work date	The employee's choice of: (1) their *eligibility date*, or (2) the first of the month following the employee's *eligibility date*. *Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the actively-at- work date*	The same date as the employee's *effective date* of coverage *In no event will the dependent's coverage become effective prior to the employee's effective date*

If…	Your effective date is…	Your eligible dependent's effective date is…
Non-TRS Covered Positions		
An employee in a non-TRS covered position who works less than 10 regularly scheduled hours per week and becomes employed in a TRS-covered position and enrolls for coverage within 31 days after the date they become an eligible employee. Note: If a current employee was an eligible part-time employee during an enrollment opportunity for the current *plan year*, and later during the current *plan year*, the employee becomes an eligible full-time employee, the employee will have a 31-day opportunity to enroll themselves and/or eligible *dependent*s in TRS-ActiveCare. Their 31-day enrollment opportunity will begin on the first day that this employee becomes an eligible full-time employee. This enrollment opportunity exists even if enrollment in TRS-ActiveCare during the current *plan year* was previously declined by this employee.	The employee's choice of: (1) their *eligibility date*, or (2) the first of the month following *the employee's eligibility date* *Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the eligibility date.*	The same date as your *effective date* of coverage *In no event will the dependent's coverage become effective prior to the employee's effective date.*
An employee in a non-TRS covered position that works less than 10 hours per week and begins to work 10 or more regularly scheduled hours per week and enrolls for coverage within 31 days after the date they become an eligible employee	*The employee's* choice of: (1) their *eligibility date*, or (2) the first of the month following *the employee's eligibility date* *Premium is billed for the full month in which coverage begins the employee must choose the effective date of coverage within 31 days after the eligibility date*	The same date as your *effective date* of coverage *In no event will the dependent's coverage become effective prior to the employee's effective date*
Loss of Eligibility due to address change		
The employee is enrolled in an approved HMO and loses eligibility because they no longer live, work or reside in that HMO service area, the employee may enroll in another approved HMO (if applicable) or TRS-ActiveCare plan within 31 days after losing eligibility	The first of the month following the event date	The same date as the employee's *effective date* of coverage *In no event will the dependent's coverage become effective prior to the employee's effective date*

If…	Your effective date is…	Your eligible dependent's effective date is…
Military		
The employee returns from military service and enrolls (or re-enrolls) in TRS-ActiveCare within 31 days after their actively-at-work date… *If the employee returns to active employment within the same plan year and chooses to re-enroll in TRS-ActiveCare, the employee must select the same plan option in which they were previously enrolled*	*The employee's* choice of: (1) their actively-at-work date, or (2) the first of the month following *the employee's* actively-at-work date *Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the actively-at-work date*	The same date as the employee's *effective date* of coverage *In no event will the dependent's coverage become effective prior to the employee's effective date*
Leave Without Pay		
The employee returns from leave-without-pay status and enrolls (or reenrolls) for coverage within 31 days after their actively-at-work date… *If the employee returns to active employment within the same plan year and chooses to reenroll in TRS-ActiveCare, the employee must select the same plan option in which they were previously enrolled*	*The employee's* choice of: (1) their actively-at-work date, or (2) the first of the month following *the employee's* actively-at-work date *Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the actively-at-work date*	The same date as *the employee's effective date* of coverage *In no event will the dependent's coverage become effective prior to the employee's effective date*

If…	Your effective date is…	Your eligible dependent's effective date is…
Newborn/Adoption/Legal Guardian		
A covered employee has a newborn *child*, the employee may enroll: (1) newborn only, or (2) spouse only, or (3) spouse and newborn. Other eligible *dependents* can also be added at this time. Subject to applicable law, the spouse and other eligible *dependents* can only be added within 31 days after the newborn's date of birth		The newborn's date of birth. If only enrolling the newborn, premium is waived for the first calendar month if the date of birth is other than the first of the month. If enrolling any other eligible *dependents*, premium is billed for the full month in which coverage begins. For example: Employee adds *child* (no plan change) *child* is born March 5. Effective date is March 5 and premium begins (if applicable) on April 1. Employee adds *child* (plan change) *child* is born March 5. Effective date is March 5 on current plan. Plan change and new premium effective on April 1. Employee not adding *child* (first 31 days only) *child* is born March 5. Coverage is effective March 5-April 5. No premium impact. TRS-ActiveCare automatically provides coverage for a newborn *child* of a covered employee for the first 31 days after the date of birth, but this coverage ends unless the newborn is added to employee's coverage within 31 days of the newborn's date of birth.

If…	Your effective date is…	Your eligible dependent's effective date is…
Newborn/Adoption/Legal Guardian (cont.)		
An eligible, but not covered employee adopts a *child* and chooses to enroll within 31 days after the date of adoption or date on which the *child* to be adopted is placed with the employee, the employee may enroll: • employee only, or • employee and spouse or • employee and adopted *child*, or • employee, spouse and adopted *child*	The date of adoption or date on which the *child* to be adopted is placed with the employee *Premium is billed for the full month in which coverage begins*	The date of adoption or the date on which the *child* to be adopted is placed with the employee *Premium is billed for the full month in which coverage begins*
An eligible, but not covered employee, has a newborn *child*, the employee may enroll: • employee only, or • employee and spouse only, or • employee and newborn, or • employee, spouse and newborn	The newborn's date of birth *Premium is billed for the full month in which coverage begins*	The newborn's date of birth *Premium is billed for the full month in which coverage begins.*
A covered employee adopts a *child* and chooses to enroll within 31 days after the date of adoption or date on which the *child* to be adopted is placed with the employee, the employee may enroll: • adopted *child* only, or • spouse only, or • spouse and/or adopted *child*		The date of adoption on which the *child* to be adopted is placed with the employee *If only enrolling the adopted child, premium is waived for the first calendar month if the date of birth is other than the first of the month. If enrolling any other eligible dependent, premium is billed for the full month in which coverage begins*
A covered employee becomes a legal guardian of an eligible *dependent child* and chooses to enroll the *dependent* within 31 days after the date the legal guardianship is granted… *Other eligible dependents can also be added at this time* *An award of legal guardianship isn't a special enrollment event for a non-covered employee or their dependents*		The date the guardianship is granted *Premium is waived for the first calendar month if the date of notification is other than the first of the month*
A covered employee adds a court-ordered eligible *dependent child* after the participating district/entity receives notice of the court order or national medical support notice *Other eligible dependents can also be added at this time* *A court order on the spouse (or ex-spouse) of a covered employee doesn't require TRS-ActiveCare to provide dependent coverage*		The date the participating district/entity receives notification of the court order or national medical support notice *Premium is waived for the first calendar month if the date of notification is other than the first of the month*

If…	Your effective date is…	Your eligible dependent's effective date is…
An eligible, but not covered employee adds a court-ordered eligible *dependent child* after the participating district/entity receives notice of the court order or national medical support notice… *Other eligible dependents can also be added at this time. A court order is a special enrollment event for the employee. If the employee chooses to enroll themselves and other eligible dependents, they have 31 days after the date the participating district/entity receives the court order or national medical support notice to enroll*	The date the participating district/entity receives notification of the court order or national medical support notice *Premium is billed for the full month in which coverage begins*	The date the participating district/entity receives notification of the court order or national medical support notice *Premium is billed for the full month in which coverage begins*
A covered employee adds an eligible newborn grandchild or another newborn *child* who is in a regular parent-*child* relationship with the employee within 31 days after the date of birth		The newborn's date of birth *Premium is waived for the first calendar month if the date of birth is other than the first of the month*
A covered employee adds an eligible grandchild or another *child* who is in a regular parent-*child* relationship with the employee within 31 days after the *child* qualifies as a *dependent*… *Adding a grandchild or another child who is in a regular parent-child relationship with the employee isn't a special enrollment event for anon-covered employee or their dependents*		First of the month following the date the *child* qualifies as a *dependent*
Marriage/Name Change		
A covered employee gets married and chooses to enroll within 31 days after the date of marriage, you may enroll: • spouse only • spouse's eligible *children*, or • spouse and spouse's eligible *children* *Other eligible dependents can also be added at this time*		The first of the month following the date of marriage

If…	Your effective date is…	Your eligible dependent's effective date is…
An eligible, but not covered employee gets married and chooses to enroll within 31 days after the date of marriage, the employee may enroll: (1) employee only, or (2) employee and spouse, or (3) employee and spouse's eligible *children*, or (4) employee, spouse and spouse's eligible *children* *Other eligible dependents can also be added at this time*	The first of the month following the date of marriage	The first of the month following the date of marriage
Special enrollment situations		
An employee receives an Insurance Enrollment Notification letter from the Texas Health and Human Services agency, regarding eligibility for HIPP and chooses to enroll within 60 days after the date of eligibility	The first of the month following the date of the notification letter	The first of the month following the date of the notification letter
The employee makes changes to coverage due to other special enrollment events within 31 days after the qualifying event	The first of the month following the event date	The first of the month following the event date

Promptly notify your Benefits Administrator to:

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

When coverage is terminated, benefits for expenses incurred after termination will not be available. If you receive benefits to which you are not entitled, refunds will be requested.
Also remember to notify your Benefits Administrator if you or your covered *dependents* have an address change.

When Coverage Ends

Your TRS-ActiveCare employee coverage will end:

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

A *dependent*'s coverage will end:

- when the employee's coverage ends
- the last day of the month in which they lose their status as an eligible *dependent* (for example, your spouse's coverage will end if you get divorced)
- the last day of the month in which they enter into active, full-time military, naval, or air service except as provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) or other applicable law
- the last day of the month in which eligibility for COBRA continuation coverage expires
- when you stop paying required premium contribution payments for *dependent* coverage

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

When is a dependent child no longer eligible for coverage?

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

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

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

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

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

Continuation of Group Coverage (COBRA)

Please refer to the **Continuation of Group Coverage – Federal** subsection in this benefits booklet for additional information.

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* 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* 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* necessary services.

Identification Card

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

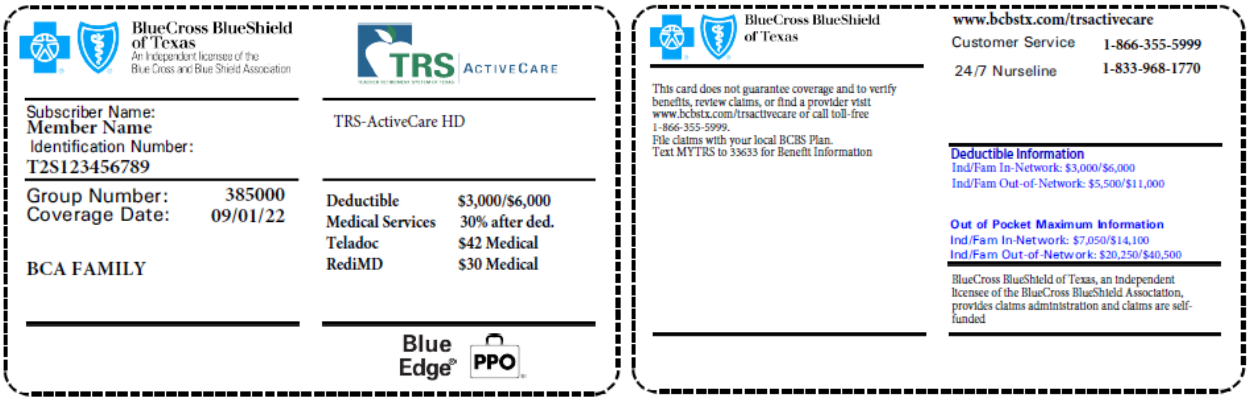
- ***your subscriber identification number***
  This unique identification number is preceded by a three-character alpha prefix that identifies BCBSTX as your Claim Administrator.
- ***your group number***
  This is the number assigned to identify your *employer's plan* with BCBSTX.
- ***any copays that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

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

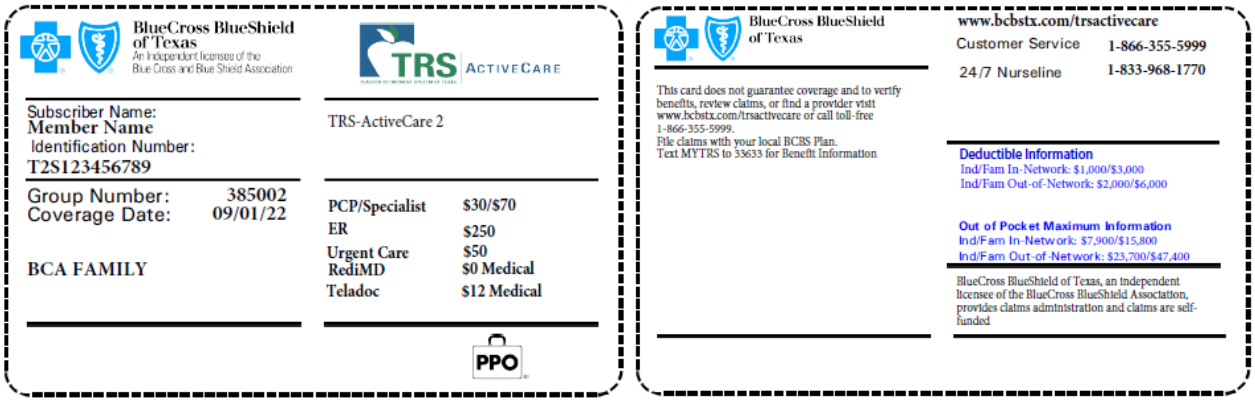
Please remember that any time a change in your family takes place it may be necessary for a new ID Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, BCBSTX will provide a new ID Card.

Sample ID Cards

TRS-ActiveCare HD



TRS-ActiveCare 2



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 obtain *prior authorization*s 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 may be referred to as *medical necessity* reviews, utilization review (UR) or medical management reviews. Requirements for *medical necessity* may vary based upon your *plan* benefits. *Medical necessity* reviews may occur when a *provider* requests an authorization prior to services rendered, during the course of care, or after care has been completed for a *post-service medical necessity review*. However, some services may require a *prior authorization* before the start of services.

Types of Utilization Management:

- *prior authorization*
- *predetermination*
- *post-service medical necessity reviews*

Refer to 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.

For more information on the resources available to you, please visit www.trs.texas.gov

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 transportation: fixed wing (please refer to the *fixed-wing air ambulance* definition in the **DEFINITIONS** section of this benefits booklet)
- outpatient procedures/services:
  a. **Cardiac (heart related):**
     (1) stress testing (myocardial perfusion imaging – single-photon emission computed tomography SPECT and PET)
     (2) echocardiography (stress, transthoracic and transesophageal)
     (3) implantable device services: pacemakers, implantable cardioverter-defibrillators
     (4) 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 *plan 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* 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* 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 must be. *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* 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 is, 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.

Predetermination Review

Predetermination is an optional *medical necessity* review by BCBSTX of a medical procedure, treatment or test, that has been recommended by your *provider* in order to determine if it meets approved BCBSTX medical policy guidelines. A *predetermination* review is not the same as *prior authorization*. *Prior authorization* is a required process for the *provider* to get approval from the *plan* before you are admitted to the *hospital* or for certain types of *covered services*. A *predetermination* review can help you avoid unexpected out-of-pocket costs by determining ahead of time if a recommended service will be covered by your health care plan. If a service requires *prior authorization*, a *predetermination* review is not available.

Predetermination 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*. Please coordinate with your *provider* to submit a written request for *predetermination*.

Below are some examples (not an exhaustive list) of some common services for which a *predetermination* review is recommended:

- certain higher cost durable medical equipment
- surgeries that might be considered cosmetic
- services and supplies that may be *experimental/investigational* under certain circumstances.

General Provisions Applicable to All Predetermination Reviews

- **No Guarantee of Payment**
  A *predetermination* 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 on *predetermination*, 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 *predetermination* process may require additional documentation from your *provider* or pharmacist. In addition to the written request for *predetermination*, 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 available when a *prior authorization* or *predetermination* 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*

Prior Authorization 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 *employer* 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/trsactivecare, or by calling your Personal Health Guide at 1-866-355-5999. Follow the instructions on the reverse side of the form to complete the claim.

Remember to file each participant's expenses separately because any copays, deductibles, maximum benefits, and other provisions are applied to each participant separately. Include itemized bills from the health care 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/trsactivecare

Where to Mail Completed Claim Forms

Medical Claims

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

Who Receives Payment

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

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

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

  An Urgent Care Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification.
- contact information for any applicable office of health insurance consumer assistance or ombudsman

Claim Review/Appeal Procedures

Claim Appeal Procedures - Definitions

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

If an ongoing course of treatment had been approved by BCBSTX and BCBSTX reduces or terminates such treatment (other than by amendment or termination of the *employer's* benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination.

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by BCBSTX at the completion of the internal review/appeal process of an Adverse Benefit Determination with respect to which the internal review/appeal process has been deemed exhausted.

Note:* *Expedited Internal Review of Urgent Care Claims

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

How to Appeal an Adverse Benefit Determination

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

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

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

- Within 180 days after you receive notice of a denial or partial denial of your claim, you must call or write to BCBSTX's Administrative Office. BCBSTX will need to know the reasons why you don't agree with the denial or partial denial. Send your appeal request to:

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

- BCBSTX will honor telephone requests for information. However, such inquiries won't constitute a request for review.
- In support of your claim review, you have the option of presenting evidence and testimony to BCBSTX. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information during the internal review process.

  BCBSTX will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the internal review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a Final Internal Adverse Benefit Determination on the appeal is made 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 BCBSTX Headquarters at 1-866-355-5999. Your Personal Health Guide at 1-866-355-5999 is accessible from 24 hours a day, 7 days a week.

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 Employer'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 *plan year* benefit period basis unless otherwise stated. At the end of a *plan year*, a new benefit period starts for each *participant*.

Copays

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

A *copay*, 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.

A *copay*, if shown on your **SCHEDULE OF COVERAGE**, will be required for facility charges for each *inpatient hospital* visit.

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

A *copay*, if shown on your **SCHEDULE OF COVERAGE**, will be required for each *certain diagnostic procedure*.

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

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

Deductibles

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

The *deductibles* are explained as follows:

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

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

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

The following are exceptions to the *deductibles* described above:

- In-Network ***Preventive Care Services*** are not subject to *deductibles*.
- *Eligible expenses* applied toward satisfying the "individual" and "family" *in-network deductible* will only apply to the *in-network deductible*. *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 *plan 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 *plan 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.

COVERED MEDICAL SERVICES

Inpatient Hospital Expenses

Your health plan provides coverage for *inpatient hospital expenses* for you and your eligible *dependents*. Each inpatient *hospital admission* requires *prior authorization*. Refer to the **UTILIZATION MANAGEMENT** section of this Benefit 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. Coverage may be limited when an alternative to a *hospital* setting can be used.

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

- certain diagnostic procedures

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

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

- *telehealth services* and *telemedicine medical services*

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

- elective male and female sterilizations

- dietary formula necessary for treatment of Phenylketonuria or other heritable diseases. All other enteral formula isn't covered

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

- private duty nursing

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

Extended Care Expenses

Your health plan also provides benefits for *extended care expenses* for you and your covered *dependents*. 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 *employer* with BCBSTX immediately prior to the *participant's effective date* of coverage under your health plan.

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

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

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

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

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

  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*.

Benefits for Maternity Care

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

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

A *copay* may be required for the initial office visit for *maternity care* but won't be required for subsequent visits.

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

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

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

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

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

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

Charges for well-baby nursery care, including the initial examination, of a newborn *child* during the mother's *hospital admission* for the delivery will be considered *inpatient hospital 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.

Notwithstanding anything in this benefits booklet to the contrary, for *out-of-network emergency care* services rendered by non-contracting *providers*, the *allowable amount* shall be equal to the greatest of the following three possible amounts, not to exceed billed charges:

- the median amount negotiated with in-network providers for emergency care services furnished
- the amount for the emergency care service calculated using the same method your health plan generally uses to determine payments for out-of-network services but substituting the in-network cost-sharing provisions for the out-of-network cost sharing provisions
- the amount that would be paid under Medicare for the emergency care service

Each of these three amounts is calculated excluding any *in-network copay* or *coinsurance amount* imposed with respect to the *participant*.

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**.

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*.

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 for more specific information about how visit maximums for *physical medicine services* and speech services apply to benefits for *Autism Spectrum Disorder*.

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 Screening Tests for Hearing Impairment

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

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

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

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

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

Covered services include:

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

Benefits for Dental Services

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

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

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

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this benefits booklet, for which a *participant* incurs *inpatient hospital 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 **PREAUTHORIZATION REQUIREMENTS** 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 *plan year*, for the prevention of complications associated with diabetes
- *diabetes supplies*
  a. test strips specified for use with a corresponding blood glucose monitor
  b. visual reading and urine test strips and tablets for glucose, ketones, and protein
  c. lancets and lancet devices
  d. insulin and insulin analog preparations
  e. injection aids, including devices used to assist with insulin injection and needleless systems
  f. biohazard disposable containers
  g. insulin syringes
  h. prescriptive and non-prescriptive oral agents for controlling blood sugar levels
  i. glucagon emergency kits

  ***Note*:** Diabetic supplies (test strips, lancets, insulin syringes, blood glucose monitors) are covered under the prescription drug plan.
- Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump, may be covered.

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

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

  Initial and follow-up instruction concerning:

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

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

A *Qualified Participant* means an individual eligible for coverage under this *plan* who has been diagnosed with (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 won't be provided for more than the maximum number of visits (outpatient facility and office combined) shown on your **SCHEDULE OF COVERAGE**. All services billed by a Chiropractor will apply to the maximum number of visits.

Benefits for Routine Patient Costs for Participants in Approved Clinical Trials

Benefits for *eligible expenses* for *routine patient care costs* are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and recognized under state and/or federal law.

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

Routine Patient Care Costs don't include:

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

Benefits for Certain Tests for Detection of Prostate Cancer

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

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

Benefits for Preventive Care Services

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

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

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

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

Examples of covered services included are

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

Examples of covered immunizations included are:

- Diphtheria
- Haemophilus influenzae type b
- Hepatitis B
- Measles
- Mumps
- Pertussis
- Polio
- Rubella
- Tetanus
- Varicella and any other immunization that is required by law for a *child*

Allergy injections are not considered immunizations under this benefit provision.

Examples of covered services for women with reproductive capacity are:

- female sterilization procedures
- outpatient contraceptive services
- FDA-approved over-the-counter female contraceptives with a written prescription by a health care provider
- specified FDA-approved contraception methods with a written prescription by a health care provider provided in this section from the following categories:

  a. progestin-only contraceptives
  b. combination contraceptives
  c. emergency contraceptives
  d. extended cycle/continuous oral contraceptives
  e. cervical caps
  f. diaphragms
  g. implantable contraceptives
  h. intra-uterine devices
  i. injectables
  j. transdermal contraceptives
  k. vaginal contraceptive devices
  l. spermicide
  m. female condoms

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

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

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

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 two per *plan year*. Limited benefits are also included for the rental only of *hospital* grade breast pumps, up to the purchase price of $150.

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

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 *plan 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 *plan year*, and a flexible sigmoidoscopy performed every five years
- a colonoscopy performed every ten years
- Cologuard performed every three years

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

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

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

Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

- HPV/Cervical Cancer Testing billed in combination with Pap smears for screening woman aged 30 or older are covered once every 3 years. Services are not covered for participants under the age of 30.
- High-risk HPV testing alone for screening women 30 years of age or older covered once every 5 years. Services are not covered for participants under the age of 30.

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

Behavioral Health Services

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

Benefits for *eligible expenses* incurred for *mental health care*, treatment of *serious mental illness* and treatment of Substance Use Disorder will be the same as for treatment of any other sickness. Refer to the **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
- 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 offers lower out-of-pocket costs when you receive treatment at a BDC and/or BDC+ Provider for certain services related to transplants and bariatric services. 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.

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:
  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. stockings and bandages
  h. garter belts
  i. ostomy bags
- any benefits in excess of any specified dollar, day/visit, or *plan year* maximums
- any services and supplies provided to a *participant* incurred outside the United States if the *participant* traveled to the location for the purposes of receiving medical services, supplies, or drugs
- replacement *prosthetic appliances* when it is necessitated by misuse or loss by the *participant*

- any outpatient prescription or 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-ActiveCare 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 *employers*, 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

- 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.

- ***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.

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

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

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

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.

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, mechano-therapy, muscle manipulation therapy and hydrotherapy.

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

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

- cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells)
- urine auto injection (injecting one's own urine into the tissue of the body)
- skin irritation by 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

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

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

- controlled environment
- sanitizing the surroundings, removal of toxic materials
- use of special non-organic, non-repetitive diet techniques

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated and any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

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

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

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

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the *hospital* or *facility other provider* in which they were performed; 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.

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 *plan year deductible*, incurred by the *participant* during a *plan year*.

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

- at the direction or prescription of a *physician*, *behavioral health provider* or *professional other provider*
- not included as an item of *inpatient hospital expense* or *extended care 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.

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*.

Neuropsychological Testing means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

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

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

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

- **Professional Other Provider** - a person or provider, when acting within the scope of their license and who is appropriately certified, only as listed:
  a. Advanced Practice Nurse (APN)
  b. Christian Science Practitioner
  c. Doctor of Chiropractic
  d. Doctor of Dentistry
  e. Doctor of Optometry
  f. Doctor of Podiatry
  g. Doctor in Psychology
  h. Licensed Acupuncturist
  i. Licensed Audiologist
  j. Licensed Substance Use Disorder Counselor
  k. Licensed Dietitian
  l. Licensed Hearing Instrument Fitter and Dispenser
  m. Licensed Marriage and Family Therapist
  n. Licensed Clinical Social Worker
  o. Licensed Occupational Therapist
  p. Licensed Physical Therapist
  q. Licensed Professional Counselor
  r. Licensed Speech-Language Pathologist
  s. Licensed Surgical Assistant
  t. Midwife
  u. Nurse First Assistant
  v. Physician Assistant
  w. Psychological Associates who work under the supervision of a Doctor in Psychology

In states where there is a licensure requirement, other *providers* must be licensed by the appropriate state administrative agency.

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

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

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

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

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

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

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians' Current Procedural Terminology 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 *employer's plan* begins with BCBSTX.

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

Plan Service Area means the geographical area(s) or areas in which a *network* of *providers* is offered and available and is used to determine eligibility for **Managed Health Care Plan** benefits.

Plan Sponsor means the Teacher Retirement System of Texas as trustee of the Texas Public School Employees Group Benefits Program.

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

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.

Predetermination 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.

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

Primary Care Provider (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

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.

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL PROVISION

Agent

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

Amendments

Your health plan may be amended or changed at any time by agreement between the *group* 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/trsactivecare or by calling your Personal Health Guide at 1-866-355-5999. Services may automatically end when the person is no longer an eligible *participant*. Services may change or be discontinued at any time with reasonable notice. BCBSTX doesn't guarantee that a particular vendor or service will be available at any given time.

Medicare

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

Participant/Provider Relationship

The choice of a *health care provider* should be made solely by you or your *dependents*. BCBSTX doesn't 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

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

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

Coordination of Benefits – Definitions

- **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:

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

  Plan doesn't include:
  a. any coverage held by the *participant* for hospitalization and/or *medical-surgical expenses* which is written as a part of or in conjunction with any automobile casualty insurance policy
  b. school accident type coverage
  c. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended)

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

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

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

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

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

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

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

Order of Benefit Determination Rules

- **General Information**

  a. When there is a basis for a claim under This *plan* and another *plan*, This *plan* is a Secondary Plan which has its benefits determined after those of the other *plan*, unless (a) the other *plan* has rules coordinating its benefits with those of This *plan*, and (b) both those rules and This *plan*'s rules require that This *plan*'s benefits be determined before those of the other *plan*.

  b. If this benefits booklet contains any dental or vision benefits, the benefits provided by the health portion of This *plan* will be the Secondary Plan.

- **Rules**
  This *plan* determines its order of benefits using the first of the following rules which applies:

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

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

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

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

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

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

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

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

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

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

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

(1) first, the benefits of a *plan* covering the *participant* as an *employee*, *member* or *subscriber* (or as that *participant's dependent*)
(2) second, the benefits under the continuation coverage

If the other *plan* doesn't have this rule, and if, as a result, the *plan*s don't agree on the order of benefits this Paragraph 'f' doesn't apply.

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

Effect on the Benefits of This Plan

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

  a. The benefits that would be payable for the Allowable Expense under This *plan* in the absence of this COB provision
  b. The benefits that would be payable for the Allowable Expense under the other *plan*s, in the absence of provisions with a purpose like that of this COB provision, whether the claim that is made exceeds those Allowable Expenses in a Claim Determination Period

  In that case, the benefits of This *plan* will be reduced so that they and the benefits payable under the other *plan*s don't total more than those Allowable Expenses.

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

Right to Receive and Release Needed Information

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

Facility of Payment

A payment made under another *plan* may include an amount that should have been paid under This *plan*. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This *plan*. We won't have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

- the persons We have paid or for whom We have paid
- insurance companies
- *hospital*s, *physicians*, or *other providers*
- any other person or organization

Termination of Coverage

Termination of Individual Coverage

Coverage under the *plan* for you and/or your *dependents* will automatically terminate when:

- your contribution for coverage under the *plan* isn't received timely by the plan administrator
- you no longer satisfy the description of an employee as described in this benefits booklet, including termination of employment
- the *plan* is terminated, or the *plan* is amended, at the direction of the plan administrator, to terminate the coverage of the class of employees to which you belong
- a *dependent* ceases to be a *dependent* as defined in the *plan*

However, when any of these events occur, you and/or your *dependents* may be eligible for continued coverage. See **Continuation of Group Coverage – Federal** in the **GENERAL PROVISIONS** section of this benefits booklet.

TRS may terminate coverage at any time or refuse to renew the coverage of an eligible participant in the event of fraud, waste, or abuse of the plan, or deliberate deception or intentional misrepresentation of a material fact. Examples of these may include, but are not limited to:

- submitting false or misleading information about a person's eligibility or continuing eligibility to participate in the plan
- failing to timely notify of a person's ineligibility to continue participation in the plan
- failing to timely notify the plan or a health care provider of the existence of another health plan, worker's compensation, liability coverage, or other coverage that may be responsible for covering medical services, medications, or devices which may be also payable under this plan
- allowing another person to use a participant's health plan ID card or the participant's identity to allow that person or someone else to access medical services, medications, or devices payable under this plan
- using the plan to try to get health care providers to prescribe or give access to controlled substances, or other medical services, medications, or devices by using schemes, deception, or manipulation, or using the health plan to pay for such controlled substances, medical services, medications, or devices acquired through such schemes, deception, or manipulation
- submitting a false claim to the plan or supporting a claim by using false, misleading, altered, or incomplete documentation

Coverage for a *child* of any age who is medically certified as *Disabled* and dependent on the parent won't terminate upon reaching the limiting age shown in your **SCHEDULE OF COVERAGE** if the *child* continues to be both:

- *disabled*
- dependent upon you for more than one-half of their support as defined by the Internal Revenue Code of the United States

Disabled means any medically determinable physical or mental condition that prevents the *child* from engaging in self-sustaining employment. The disability must begin while the *child* is covered under the *plan* and before the *child* attains the limiting age. You must submit satisfactory proof of the disability and dependency through your plan administrator to BCBSTX within 31 days following the *child*'s attainment of the limiting age. As a condition to the continued coverage of a *child* as a *Disabled dependent* beyond the limiting age, BCBSTX may require periodic certification of the *child*'s physical or mental condition but not more frequently than annually after the two-year period following the *child*'s attainment of the limiting age.

Termination of the Group

The coverage of all *participants* will terminate if the *group* is terminated in accordance with the terms of the *plan*.

Continuation of Group Coverage -Federal

COBRA Continuation - Federal

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), *participants* may have the right to continue coverage after the date coverage ends. Participants won't be eligible for COBRA continuation if the *employer* is exempt from the provisions of COBRA.

Minimum Size of Group

The Group must have normally employed more than twenty (20) employees on a typical business day during the preceding *plan year*. This refers to the number of full-time and part-time employees employed, not the number of employees covered by a health *plan*.

Loss of Coverage

If coverage terminates (other than for non-payment of premiums) as the result of termination (other than for gross misconduct) or reduction of employment hours, then the *participant* may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cease.

A covered *dependent* may elect to continue coverage for thirty-six (36) months from the date coverage would otherwise cease if coverage terminates as the result of:

- divorce from the covered employee
- death of the covered employee
- the covered employee becomes eligible for *Medicare*
- a covered *dependent child* no longer meets the *dependent* eligibility requirements

COBRA continuation under the *plan* ends at the earliest of the following events:

- the last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months
- the last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months
- the first day for which timely payment of contribution isn't made to the *plan* with respect to the qualified beneficiary
- the TRS ActiveCare is canceled
- the date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other *group* health plan in the event you have a preexisting condition and would be denied coverage under the new health *plan* for a preexisting condition, continuation coverage won't be terminated until the last day of the continuation period, or the date upon which the preexisting condition becomes covered under the new health *plan*, whichever occurs first
- the date, after the date of the election, upon which the qualified beneficiary first becomes entitled to *Medicare* benefits

Extension of Coverage Period

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a *participant* for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the initial qualifying event.

If a *participant* is determined to be disabled as defined under the Social Security Act and the *participant* notifies the *employer* before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to *participants* who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours. You may be charged a higher rate for the extended period.

Notice of COBRA Continuation Rights

The *employer* is responsible for providing the necessary notification to *participants* as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this benefits booklet.

Cancellation

Except as otherwise provided herein, BCBSTX shall not have the right to cancel or terminate any *plan* issued to any *subscriber* while the Administrative Services Agreement remains in force and effect, and while said *subscriber* remains in the eligible class of employees of Group, and their contributions are paid in accordance with the terms of this *plan*.

Gender

The use of any gender herein shall be deemed to include the other gender and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

AMENDMENTS

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 provider 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 *hospital*s 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, employer has with Blue Cross and Blue Shield of Texas, Blue Cross and Blue Shield of Texas and employer 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 Prior authorization 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 *employers* may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your *employer* or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your *employer's group* health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your *group* health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their *group* health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your *dependent children* could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes enrolled in *Medicare* benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other
- than their gross misconduct;
- The parent-employee becomes enrolled in *Medicare* (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The *child* stops being eligible for coverage under the Plan as a "*dependent child*."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your *employer*, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and *dependent children* will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the *employer*, or the employee's becoming entitled to *Medicare* benefits (under Part A, Part B, or both), the *employer* must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a *dependent child*'s losing eligibility for coverage as a *dependent child*), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your *employer* and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their *children*.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to *Medicare* benefits (under Part A, Part B, or both), your divorce or legal separation, or a *dependent child*'s losing eligibility as a *dependent child*, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to *Medicare* benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of *Medicare* entitlement. For example, if a covered employee becomes entitled to *Medicare* 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and *children* can last up to 36 months after the date of *Medicare* entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact your *employer* and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving
18 months of COBRA continuation coverage, the spouse and *dependent children* in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and *dependent children* receiving continuation coverage if the employee or former employee dies, becomes entitled to *Medicare* benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the *dependent child* stops being eligible under the Plan as a *dependent child*, but only if the event would have caused the spouse or *dependent child* to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting *group* health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your *employer* for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Information Provided by Your Employer

Your Prescription Drug Plan

TRS-ActiveCare HD Plan

Prescription Drugs*			
Prescription Drugs	Deductible *(per person, per plan year)*	Subject to plan year deductible for all medical and prescription benefits	
	Retail Short-Term *(up to a 31-day supply)* and Retail Maintenance *(after 1st fill up to 31-day supply)* - Generic - Preferred brand - Non-Preferred brand	 -20% coinsurance -25% coinsurance -50% coinsurance	You pay 100% of the full cost at the time of purchase, and after the deductible is met, you will be reimbursed the allowable amount as determined by CVS Caremark (must submit claim to CVS Caremark within 12 months of service date to be reimbursed)
	Mail Order Pharmacy *(60-90-day supply)* and Retail-*Plus* Network *(60-90-day supply at Retail-Plus participating pharmacies)* - Generic - Preferred brand - Non-Preferred brand	 -20% coinsurance -25% coinsurance -50% coinsurance	You pay 100% of the full cost at the time of purchase, and after the deductible is met, you will be reimbursed the allowable amount as determined by CVS Caremark (must submit claim to CVS Caremark within 12 months of service date to be reimbursed)
	Specialty prescription medications *(limited to a 31-day supply)*	-20% coinsurance	

*If you obtain a brand-name drug when a generic is available, you will pay the difference between the brand discount and the generic discount.

**Deductible and coinsurance waived for certain generic preventive drugs. Go to info.caremark.com/trsactivecare to view the list.

***When you use third-party copayment assistance for any specialty medication, you will not receive credit toward your out-of-pocket maximum or deductible for any copayment or coinsurance amounts that are applied by a manufacturer coupon or rebate. *Only the amount you pay out of pocket will apply toward your deductible and out-of-pocket maximum*.

TRS-ActiveCare 2 Plan

Prescription Drugs*			
Prescription Drugs	Deductible *(per person, per plan year)*	$0 for generic, $200 per person for brand-name drugs	
	Retail Short-Term *(up to a 31-day supply)* - Generic - Preferred brand - Non-Preferred brand	 $20 copay 25% coinsurance (Min $40/Max $80) 50% coinsurance (Min $100/Max $200)	You will be reimbursed the allowable amount as determined by CVS Caremark for the amount that would have been charged by a network pharmacy less the required copay after the drug deductible is met (Must submit claim to CVS Caremark within 12 months of service date to be reimbursed)
	Retail Maintenance *(after first fill of a maintenance, up to a 31-day supply)* - Generic - Preferred brand - Non-Preferred brand	 $35 copay 25% coinsurance (Min $60/ Max $120) 50% coinsurance (Min $105, Max $210)	
	Mail Order Pharmacy *(up to a 90-day supply)* and Retail-*Plus* Network *(up to a 90-day supply at Retail-Plus participating pharmacies)* - Generic - Preferred brand - Non-Preferred brand	 $45 copay 25% coinsurance (Min $105/Max $210) 50% coinsurance (Min $215/Max $430)	You will be reimbursed the allowable amount as determined by CVS Caremark for the amount that would have been charged by a network pharmacy less the required copay after the drug deductible is met (Must submit claim to CVS Caremark within 12 months of service date to be reimbursed)
	Specialty prescription medications *(limited to a 31-day supply)*	30% coinsurance (Min $200/Max $900)	

* If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug. This amount does not count toward the $200 drug deductible for brand-name drugs.

**When you use third-party copayment assistance for any specialty medication, you will not receive credit toward your out-of-pocket maximum or deductible for any copayment or coinsurance amounts that are applied by a manufacturer coupon or rebate. Only the amount you pay out of pocket will apply toward your deductible and out-of-pocket maximum.

How Your Prescription Drug Plan Works

About CVS Caremark

CVS Caremark is one of the largest pharmacy health care providers in the United States. CVS Caremark's network includes more than 64,000 pharmacies nationwide, including chain pharmacies and 20,000 independent pharmacies.

Through CVS Caremark pharmacy services, you can order maintenance and specialty medications online or by phone and have them delivered directly to you. The CVS Caremark website offers these and other services, including Ask-a-Pharmacist, for answers and information about your medications. To start using these and other features and services, register at info.caremark.com/trsactivecare

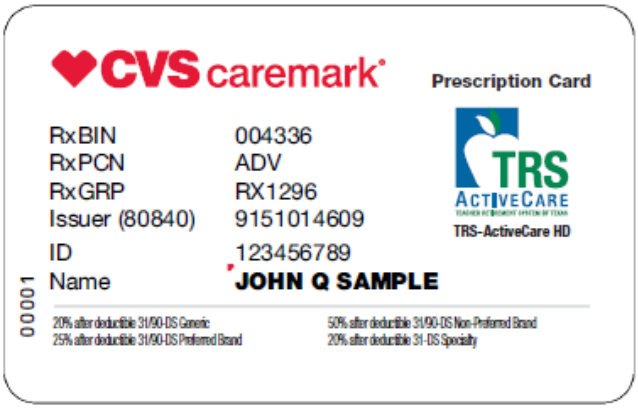
CVS Caremark ID Cards

Your prescription benefit plan is designed to bring you quality pharmacy care that will help you save money. If you enroll in one of the TRS-ActiveCare plan options, you will receive a new CVS Caremark prescription drug ID card in the mail. Included with the ID card will be CVS Caremark Welcome Kit reflecting your elected prescription benefit plan. If you need to obtain a temporary ID card or order additional cards, you can call 1-866-355-5999 to speak to a CVS Caremark representative, or you can go online at www.Caremark.com

Be sure to take your prescription ID card to your pharmacy when you get a prescription filled for the first time. You can also access a digital copy of your ID cards in the CVS Caremark App.

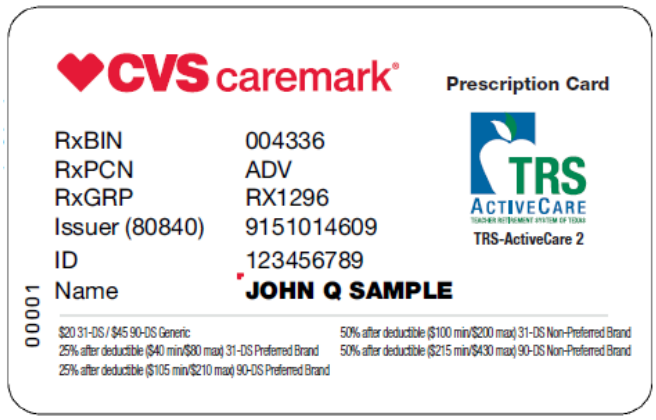
Sample ID Cards

TRS-ActiveCare HD





TRS-ActiveCare 2





Drug Exclusions

CVS Caremark and TRS regularly review formulary options to look for ways to control costs while preserving individual choice and access to clinically effective drugs. Updates to the tier status of individual medications happen on an ongoing basis.

Drug exclusions from the formulary will occur once per year and will typically go into effect on January 1st. During the four months preceding January 1st, patients utilizing drugs that are to be excluded will receive notification prior to the changes to assist with identifying potential substitute therapies. For a complete list of this year's formulary exclusions, visit CVS Caremark's website at info.caremark.com/trsactivecare

CVS Caremark Preferred Drug list

TRS-ActiveCare HD and TRS-ActiveCare 2, include a formulary, which is a list of drugs indicating preferred and non-preferred status. Each covered drug is Food and Drug Administration (FDA) approved and is also reviewed by an independent group of doctors and pharmacists for safety and efficacy. TRS-ActiveCare encourages the use of the preferred drugs on this list to help control rising prescription drug costs. You will usually pay a lower copayment/coinsurance for generic drugs (Tier 1) and brand-name medications that are on the formulary (Tier 2).

Save Money on Prescriptions

You will pay:

- the lowest copayment/coinsurance for Tier 1 generic drugs
- a higher copayment for Tier 2 preferred brand-name drugs
- the highest copayment for Tier 3 non-preferred brand-name drugs

Your doctor may be able to help you save money by prescribing Tier 1 and Tier 2 drugs if appropriate. Visit CVS Caremark's website to check the price and coverage of medications under your plan.

Generic Medications

FDA approved generics are safe and effective. Generic drugs may have unfamiliar names, but they are safe and effective. Generic drugs and their brand-name counterparts:

- have the same active ingredients
- are manufactured according to the same strict federal regulations

Generic drugs may differ in color, size, or shape, but the U.S. Food and Drug Administration requires that the active ingredients have the same strength, purity, and quality as the brand-name alternatives. Prescriptions filled with generic drugs have lower copayments under TRS-ActiveCare's prescription drug program. For more information about your plan's formulary, visit info.caremark.com/trsactivecare or contact TRS-ActiveCare Customer Service at 1-866-355-5999.

Drugs on the Generics Only Preventive Drug Therapy List maintained by the IRS are covered at no cost to participants on the TRS-ActiveCare HD plan. The list of eligible generic drugs is posted on the CVS Caremark website.

Education and Safety

The prescription drugs that you get through the CVS Caremark Pharmacy, as well as those purchased from a participating retail pharmacy are checked for potential drug interactions. If CVS Caremark ever has a question about your prescription, a CVS Caremark pharmacist will contact your doctor prior to dispensing the medication. If your doctor decides to change the prescription, CVS Caremark will send a notification letter to you and to your doctor.



State and federal laws limit the length of time a prescription is valid, regardless of the number of refills remaining. Please verify the expiration date on your refill slip before refilling your medicine.

Type of Service	TRS-ActiveCare HD Network	TRS-ActiveCare 2 Network	Non-Network
Drug Deductible (per plan year)	$3,000 Individual $6,000 Family	$0 for generic drugs $200 per individual for brand-name drugs	Same as Network
Maximum Out-of-pocket Per plan year, includes medical and pharmacy deductible, applicable copay, and coinsurance	$7,050 Individual $14,100 Family	$7,900 Individual $15,800 Family	Same as Network
Retail Short Term (up to 31-day supply) Generic Preferred Brand Non-preferred Brand	 20% coinsurance 25% coinsurance 50% coinsurance	 $20 copay 25% coinsurance (Min $40/Max $80) 50% coinsurance (Min $100/Max $200)	You will be reimbursed the amount that would have been charged by a network pharmacy less the required deductible and coinsurance
Retail Maintenance (after first fill of maintenance drugs; up to 31-day supply) Generic Preferred Brand Non-preferred Brand	 20% coinsurance 25% coinsurance 50% coinsurance	 $35 copay 25% coinsurance (Min $60/Max $120) 50% coinsurance (Min. $105/Max. $210)	
Mail Order and Retail-*Plus* Network (up to 90-day supply) Generic Preferred Brand Non-preferred Brand	 20% coinsurance 25% coinsurance 50% coinsurance	 $45 copay 25% coinsurance (Min $105/Max $210) 50% coinsurance (Min $215/Max $430)	
Specialty Medications (31-Day Supply Limit)	20% coinsurance	30% coinsurance (Min $200/Max $900)	

Diabetic Supplies	TRS-ActiveCare HD Network	TRS-ActiveCare 2 Network
Preferred Brand glucose meter	$0	$0
Short term 31-day retail supply	Formulary: $0 for needles and syringes only if purchased same day as insulin. Non-Formulary: Deductible and coinsurance apply	Formulary: $0 for needles and syringes only if purchased same day as insulin. Non-Formulary: Deductible and coinsurance apply
90-day supply at Retail-*Plus* or mail-order service	Formulary: $0 needles, lancets, and syringes regardless of whether processed on same day as insulin and regardless of brand. Test strips must be preferred brand. Non-Formulary: Deductible and coinsurance apply	Formulary: $0 needles, lancets, and syringes regardless of whether processed on same day as insulin and regardless of brand. Test strips must be preferred brand. Non-Formulary: Deductible and coinsurance apply

*Dispense as written penalty does not apply to $0 copays.

Network Retail Pharmacy Program

Participating network retail pharmacies will accept your TRS-ActiveCare ID card and charge you the lesser of the negotiated CVS Caremark price or the usual and customary cost for up to a 31-day supply of your prescription at a traditional retail network pharmacy, or a 60-day to 90-day supply at a Retail-*Plus* network pharmacy. For the TRS-ActiveCare HD Plan, after your plan year deductible is met, you will pay the applicable coinsurance percentage based on the cost of the prescription until your out-of-pocket maximum is satisfied. For the TRS-ActiveCare 2 Plan, after your prescription brand-name drug deductible is met, you will pay any applicable copay or coinsurance percentage based on the cost of the prescription. There is no deductible on generic medications on the TRS-ActiveCare 2 plan.

Your traditional retail pharmacy service is most convenient when you need a medication for a short period. For example, if you need an antibiotic to treat an infection, you can go to one of the many pharmacies that participate in the TRS-ActiveCare program and get your medication on the same day. For your short-term prescriptions, you may save money by using pharmacies that participate in the CVS Caremark network.

Mail Order through the CVS Caremark Pharmacy

The CVS Caremark Mail Order Pharmacy offers you convenience and potential cost savings. If you need medication on an ongoing or long-*term* basis, such as medication to treat asthma or diabetes, you can ask your doctor to prescribe up to a 90-day supply for home delivery, plus refills for up to one year.

How to Fill a Mail Order Prescription

For new long-term or maintenance medications, ask your doctor to write two prescriptions:

- the first for up to a 90-day supply, plus any appropriate refills, to fill through the CVS Caremark Mail Order Pharmacy
- the second for up to a 31-day supply, which you can fill at a participating retail network pharmacy for use until your mail order prescription arrives

Complete a Mail Order Form and send it to CVS Caremark, along with your original prescription(s) and the appropriate copayment for each prescription. Be sure to include your original prescription. Photocopies are not accepted.

Please note: You must mail in a CVS Caremark Mail Order Form the first time you request a new prescription through mail service. You can also request for you doctor to submit your prescription directly to CVS Caremark Mail Order Pharmacy electronically or contact CVS Caremark Customer Care for assistance. CVS Caremark's automated refill service is only available after your first prescription order has been processed. You can download a Mail-Service Order Form by visiting www.Caremark.com

A credit card is the preferred payment method, but you can also pay by check or money order. For credit card payments, include your VISA®, Discover®, MasterCard® or American Express® number and expiration date in the space provided on the order form. Through CVS Caremark Mail Order Pharmacy, you can split payments for a 90-day supply into 3 payments over the 3 months.

You can expect to get your mail order prescription 7 to 10 days from the time your order is placed.

Retail-*Plus* Pharmacy Network

Retail pharmacies that choose to participate in the Retail-*Plus* network are able to dispense a 60-day to 90-day supply of medication. You may visit info.caremark.com/trsactivecare or contact CVS Caremark Customer Care for more information on which pharmacies have chosen to participate in the Retail-*Plus* network.

At a Non-Participating Pharmacy

If you utilize a non-participating pharmacy or a network pharmacy that will not file an electronic claim, you must file a direct claim with CVS Caremark. You will be responsible for any cost differences between the pharmacy charge and the plan reimbursement.

If you obtain a prescription outside of the United States, mail a copy of your prescription and purchase receipts along with the claim form. The mailing address is on the back of the form.

Clinical programs — Dispense as Written Prescriptions, Prior Authorization, Step Therapy, and Quantity limits

Dispense-as-Written Prescriptions

If you fill a prescription for a brand-name drug that has a generic version (or equivalent) available, the pharmacist can substitute the generic version unless you or your doctor have indicated on the prescription that you should only receive the brand-name drug.

For instance, the doctor may indicate "Brand Medically Necessary" on the prescription.

Generic equivalents approved by the U.S. Food and Drug Administration (FDA) contain the same active ingredients—and are the same in safety, strength, performance, quality, and dosage form—as their brand counterparts. Generally, generics cost much less than brand-name drugs, for both you and TRS-ActiveCare.

Step Therapy

Under the Step Therapy program, you may be required to try a prerequisite or "first-line" drug before a step therapy or "second-line" drug is approved. Prerequisite drugs and their corresponding step-therapy drugs are FDA approved and are used to treat the same conditions.

If it is Medically Necessary, you can obtain coverage for a step-therapy drug without trying a prerequisite drug first. In this case, your doctor must request coverage for a step-therapy drug as a medical exception. If coverage is approved, your physician will be notified. Your doctor can request a coverage review by calling CVS Caremark Customer Care at 1-866-355-5999.

Supply Limits

Some prescription drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a prescription drug has been assigned a maximum quantity level for dispensing, call CVS Caremark Customer Care at 1-866-355-5999.

Drugs Requiring Prior Authorization

Under TRS-ActiveCare, CVS Caremark may review prescriptions for certain medications with your doctor before they can be covered. This is done under a coverage management program. A prior authorization review follows clinical guidelines that are reviewed and approved by an independent group of doctors and pharmacists.

Coverage Management Programs

Below is a list of each of the three coverage management programs. To find out more information about coverage reviews and prior authorization, please call CVS Caremark Customer Care at 1-866-355-5999.

Prior Authorization

For some medications, you must obtain approval through a coverage review before the medication can be covered under your plan. The coverage review process will allow CVS Caremark to obtain more information about your specific course of treatment (information that is not available on your original prescription) in determining whether a given medication qualifies for coverage under TRS-ActiveCare.

Qualification by History

Certain medications may also require a coverage review based on:

- whether certain criteria are met, such as age, sex, or condition
- whether an alternate therapy or course of treatment has failed or is not appropriate

In either of these instances, pharmacists will review the prescription to ensure that all criteria required for a certain medication are met. If the criteria are not met, a coverage review will be required.

Quantity Management

To promote safe and effective drug therapy, certain covered medications may have quantity restrictions. These quantity restrictions are based on manufacturer or clinically approved guidelines and are subject to periodic review and change.

Coverage Review Process

You can check to see if your medication requires prior authorization (coverage review) by calling CVS Caremark Customer Care at 1-866-355-5999.

If your medication requires a coverage review, you or your doctor may start the process by calling CVS Caremark.

At a Retail Pharmacy in Your Plan's Network

If you are filling a prescription at a retail pharmacy and a coverage review is necessary, CVS Caremark will automatically notify the pharmacist, who in turn will tell you that the prescription needs to be reviewed for prior authorization.

You or your doctor may start the process by calling CVS Caremark.

- CVS Caremark will contact your doctor to request more information than appears on the prescription. After receiving the necessary information, CVS Caremark will notify you and your doctor to confirm whether or not coverage has been authorized.
- If coverage is authorized, you simply pay your normal copayment or coinsurance for the medication. If coverage is not authorized, you may be responsible for the full cost. If appropriate, you can talk to your doctor about alternatives that may be covered.

Through the CVS Caremark Pharmacy

If you are filling a prescription through the CVS Caremark Pharmacy and a coverage review is required, CVS Caremark will contact your doctor to request more information than appears on the prescription. After receiving the necessary information, CVS Caremark will notify you and your doctor to confirm whether or not coverage has been authorized.

If coverage is authorized, you will receive your medication and simply pay your normal copayment or coinsurance for it. If coverage is not authorized, CVS Caremark will send you a notification in the mail, along with your original prescription if it was mailed to the CVS Caremark Pharmacy.

Specialty Pharmacy Program

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they're administered by a health care professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

CVS Caremark Specialty Pharmacy, (a Designated Dispensing Entity), is the preferred specialty pharmacy provider for TRS-ActiveCare. A list of medications that must be dispensed by CVS Caremark Specialty Pharmacy can be obtained by calling CVS Caremark Specialty Pharmacy at **1-888-265-7790**. Specialty medications on this list are subject to change.

In general, specialty medications will not be covered by any pharmacy except for CVS Caremark Specialty Pharmacy, regardless of their medical necessity, their approval, or if the member has a prescription by a physician or other provider. In limited circumstances, however, coverage may be allowed through an alternate provider. Those circumstances include:

- specialty medications billed by a facility as part of an inpatient *hospital* stay*
- specialty medications billed as part of an emergency room visit*
- situations where Medicare is the primary carrier*
- limited distribution Specialty Medications where CVS Caremark does not have access to the drug*
- circumstances where homecare is not clinically appropriate (either due to the member's clinical history or due to characteristics of the drug which require special handling) and an alternative infusion site (that is qualified to administer the drug) is not available for coordination of services within a reasonable proximity (30 miles or less)**

*Prior approval by CVS Caremark is not required.
**Situation will be evaluated by CVS Caremark clinical staff.

Prior authorization and specialty preferred drug plan design management may be required regardless of the benefit under which the drug is covered or the identity of the provider who is administering the drug.

In addition, for designated Specialty Medications where coverage is still allowed under the medical benefit, the drug, drug dosage(s) and site(s) of care for infusion therapy may require prior authorization for medical necessity, appropriateness of therapy and patient safety.

PrudentRx Specialty Program

For the TRS-ActiveCare 2 Plan, CVS Health has partnered with PrudentRx to reduce specialty costs through an innovative copay plan design strategy. PrudentRx is integrated with CVS Specialty Pharmacy Operations as a third party to insure a seamless, premium member experience for our employees. PrudentRx will work with you and the drug manufacturer to get copay card assistance when available and will assist you when copay cards need renewal. Even if your specialty medication has no copay card, your out-of-pocket cost will be $0 as long as you are enrolled in the PrudentRx program.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication.

All eligible members are enrolled in the PrudentRx program via an easy two-step process:

1) The first step of enrollment is already complete as your member information is on file with PrudentRx and

2) You need to call PrudentRx within 5 business days of being prescribed your specialty medication at 1-800-578-4403 within the next 5 days to register for any copay assistance available from drug manufacturers.

You can choose to opt out of the program and you must call 1-800-578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx at 1-800-578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program.

Specialty Copay Assistance Benefit

Some specialty medications may qualify for third party copayment assistance programs which could lower your out-of-pocket costs for those products. If you use third-party copayment assistance for any such specialty medication, you will not receive credit toward your maximum out-of-pocket or deductible for any copayment or coinsurance amounts that apply to a manufacturer coupon or rebate**.**

CVS Caremark Infusion Nursing and Site of Care Management for Specialty Medications

Infusion nursing services for select Specialty Medications that are administered in the home and/or in an ambulatory infusion center are covered through the pharmacy benefit and are coordinated through and dispensed by the CVS Caremark Specialty Pharmacy. For non-oncology infused Specialty Medications that require administration by a medical professional, a CVS Caremark Care Team nurse will work with you and your provider to assess your clinical history and determine clinically appropriate options (location for your infusion) for clinician-infused Specialty Medications. Options may include homecare, an ambulatory infusion center, physician office, etc. CVS Caremark Care Team nurses will contact all impacted members to provide assistance and guidance. Whether they're administered by a health care professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service. By ordering your specialty medications through CVS Caremark, you can receive:

- toll-free access to specialty-trained pharmacists and nurses 24 hours a day, seven days a week
- delivery of your medications within the united states, on a scheduled day, monday through friday, at no additional charge
- most supplies, such as needles and syringes, provided with your medications
- safety checks to help prevent potential drug interactions
- refill reminders
- health and safety monitoring
- up to a 90-day supply of your specialty medication subject to applicable copay/deductible/coinsurance

Coordination of Benefits (COB)

TRS-ActiveCare/CVS Caremark offers Coordination of Benefits (COB) as part of your plan. There are two options for payment of claims.

Paper Claim Submission

Under this program, you may submit a paper claim to CVS Caremark along with an Explanation of Benefits (EOB) from the primary payer or a receipt for out-of-pocket costs. CVS Caremark then reimburses you up to the amount that TRS-ActiveCare would have paid if there were no other coverage.

Electronic Claim Submission (Retail Only)

At the time of purchase, the pharmacy submits a secondary claim electronically to CVS Caremark's real-time claims processing system for the balance unpaid by the primary payer. CVS Caremark then reimburses the pharmacy up to the amount that TRS-ActiveCare would have paid if there were no other coverage. You are then responsible for payment of the unpaid balance.

The secondary benefit will not be more than your benefit under TRS-ActiveCare if there were no other coverage. For example: If you paid $30 under the primary plan, but your TRS-ActiveCare copayment (copay) would have been $20, CVS Caremark will reimburse you $10 as the secondary benefit. If your primary copayment (copay) is $15, CVS Caremark would not pay any secondary benefit because you would have paid $20 in the absence of any other coverage. Claims are either paid or rejected based on plan rules.

Prescription Drug Plan Exclusions

Expenses Not Covered

If any expense not covered is contrary to a law to which the plan is subject, the provision is hereby automatically changed to meet the law's minimum requirement. No payment will be made under any portion of the plan for:

- a drug that can be purchased without a prescription order; these are commonly called over-the-counter (OTC) drugs (contact CVS Caremark for a list of exceptions)
- therapeutic devices or appliances, support garments, and other non-medical devices;
- medication that is to be taken by or administered to a plan participant, in whole or in part, while the plan participant is a patient in a *hospital*, rest home, sanitarium, extended care facility, convalescent *hospital*, nursing home, or similar institution that operates on its premises a facility for dispensing pharmaceuticals
- investigational or experimental drugs; including compounded medications for non-FDA approved use
- prescriptions that a plan participant is entitled to receive without charge under any workers' compensation law or any municipal, state, or federal program
- hair growth stimulants
- drugs prescribed to remove or reduce wrinkles in the skin
- fertility medications
- ostomy supplies
- topical fluoride products
- growth hormones, unless pre-authorized
- injectables (contact CVS Caremark for a list of exceptions)
- charges for the administration or injection of any drug; some vaccine exceptions
- plasma/blood products (except hemophilia factors)
- any prescription filled in excess of the number specified by the doctor or any refill dispensed after one year from the doctor's original order
- drugs with cosmetic implications

Claim Denials and Appeals

Under TRS-ActiveCare, you have the option of appealing adverse coverage determinations.

Initial Review

Non-urgent Claims (Pre-service and Post-service)

If you submit a prescription for a drug that is subject to any limitations—such as prior authorization, preferred drug step therapy, or quantity limitations— your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use the CVS Caremark Pharmacy, your doctor will be contacted directly. CVS Caremark will need the following information:

- patient name
- employee ID
- phone number
- the prescription drug for which benefit coverage has been denied
- the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes)
- any additional information that may be relevant to your appeal

You will be notified of the decision no later than 15 days after receipt of a pre-service claim that is not an urgent care claim if CVS Caremark has sufficient information to decide your claim. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim. If you receive an adverse determination on your claim, you will be provided with a written statement that explains the denial and includes instructions on how to appeal that decision.

If CVS Caremark does not have the necessary information needed to complete the review, we will notify you to request the missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information.

If all the needed information is received within the 45-day time frame, you will be notified of the decision no later than 15 days after the receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45-day period, your claim is considered denied and you have the right to appeal as described below.

Urgent Claims (Expedited Reviews)

In the case of an urgent care claim, CVS Caremark will notify you of its decision as soon as possible, but no later than 72 hours after receipt of the claim, unless there is insufficient information to decide the claim. If further information is needed, CVS Caremark will notify you within 24 hours of receipt of your claim that further information is needed and that you have 48 hours to submit the additional information. Additional information must be submitted within 48 hours of the request. CVS Caremark will then notify you of its decision within 48 hours of receipt of the information. If the missing information is not received within that 48 hours, the claim is deemed denied and you have the right to appeal the claim.

An urgent care claim is defined as a request for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, or health, or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

Appeal of Adverse Benefit Determination

Non-urgent Appeal

If you are not satisfied with the decision regarding your benefit coverage or if you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered denied because missing information was not promptly submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing:

- your name
- CVS Caremark ID number
- phone number
- the prescription drug for which benefit coverage has been denied
- the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes)
- any additional information that may be relevant to your appeal

This information should be mailed to:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-443-1172

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by CVS Caremark in relation to your appeal; the plan provisions on which the decision is based; a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman, if any, that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file; the right to receive, upon request and at no charge, the information used to review your second level appeal, and to present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you, together with an opportunity to respond prior to issuance to any final adverse determination of this appeal.

The decision made on your second-level appeal is final and binding.

If your second-level appeal is denied and you are not satisfied with the decision of the second-level appeal (i.e., your “final adverse benefit determination”), you can initiate an external review. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

Urgent Appeal (Expedited Review)

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not promptly submitted) if your situation is urgent. An urgent situation is one in which the time period for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your appeal. Urgent appeal requests may be oral or written. You or your physician may call 1-866-443-1183 or send a written request to:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-443-1172

Physicians may submit urgent appeals requests by calling the physician-only toll-free number at 1-866-443-1183.

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination no later than 72 hours after receipt of your appeal request. The notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by CVS Caremark in relation to your appeal; the plan provisions on which the decision is based; a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman, if any, that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your appeal. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you, together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

In addition, in urgent situations, you also have the right to immediately request an urgent (expedited) external review, rather than wait until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time that you request the independent external review. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

Independent External Review

External Appeals Review

Generally, to be eligible for an independent external review, you must exhaust the internal claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal to both CVS Caremark and request an independent external review at the same time, or alternatively you can submit your urgent appeal for the independent external review after you have completed the internal appeal process.

To file for an independent external review, CVS Caremark must receive your external review request within 4 months of the date of the adverse benefit determination (if the date that is 4 months from that date is a Saturday, Sunday, or holiday, the deadline is the next business day) at:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-443-1172

Non-urgent External Review

Once you have submitted your external review request, CVS Caremark will review, within 5 business days, your claim to determine if you are eligible for external review, and within 1 business day of its decision, send you a letter notifying you whether your request has been approved for external review.

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

The IRO will review your claim within 45 calendar days and send you and CVS Caremark written notice of its decision. If you are not satisfied with or you do not agree with the decision, your determination letter will contain contact information for the applicable office of health insurance consumer assistance or an ombudsman.

Generic alternative vs. Generic equivalent drugs

Generic Drug

A medication that is generally sold under the name of its active ingredients—the chemicals that make it work—rather than under a brand name. A generic is typically much less expensive than its brand-name counterpart. There are two classifications of generic drugs: Generic equivalent drugs are approved by the U.S. Food and Drug Administration and contain the same active ingredients—and are the same in safety, strength, performance, quality, and dosage form—as their brand-name counterparts. Generic alternative drugs are U.S. Food and Drug Administration (FDA)–approved generic medications whose active ingredients are different from those in another brand-name drug.

You may be taking a brand-name drug that does not have a generic equivalent. However, there may be a different generic that can sometimes be used to treat the same condition as your current brand-name drug. Generic alternatives are not the same as generic equivalents.

Preventive Medications

The plan covers the following preventative medications- both prescription (Rx) and over-the-counter (OTC) at a $0 copayment/coinsurance. To receive these medications at a $0 copayment/coinsurance, you must have an authorized prescription for the product, and it must be dispensed by a retail network pharmacy or by mail through CVS Caremark Pharmacy. See chart below for the list of covered preventative medications. For a more extensive list of preventive medication please click on the generic only preventive drug list.

Drug Category	Covered	Generic only	Age Limit	Quantity Limit	Gender
Aspirin - OTC	Y	Y	≥ 45	100 units per fill	N/A
Aspirin (81mg only)- OTC	Y	Y	≥ 12	100 units per fill	Female Only
Fluoride Supplements- Rx only	Y	N	≤ 5	N/A	N/A
Folic Acid- OTC	Y	Y	≤ 55	100 units per fill	Female Only
Tobacco Cessation- Rx or OTC (Nicotrol NS Nasal Spray, Nicotrol Inhaler System, and Chantix are included)	Y	Y	N/A	168 Day Supply per calendar year for replacement products & Rx	N/A
Contraceptives (Oral)- Rx only	Y	N	N/A	N/A	Female Only
Contraceptives (Emergency)- Rx or OTC	Y	N	N/A	N/A	Female Only
Contraceptives (Injectables)- Rx only	Y	N	N/A	1 inj. per 75 days or 4 inj. Per 300 days	Female Only
Contraceptives (Implantable Devices & Vaginal Rings)- Rx only	Y*	N	N/A	1 IUD/Device per 300 days; 13 rings per 300 days	Female Only
Contraceptives (Transdermal Patch)- Rx only	Y	N	N/A	N/A	Female Only
Contraceptives (Barrier Methods: Diaphragms & Cervical Caps)- Rx only	Y	N	N/A	1 per 300 days	Female Only

Contraceptives (OTC Spermicides, Female Condoms)- OTC	Y	Y	N/A	N/A	Female Only
Bowel Prep Medication- Rx only. Brands payable until Generic available	Y	N	45-75	N/A	N/A
Primary Prevention of Breast Cancer	Y**	Y	≥ 35	N/A	Female Only

*= May be covered under medical
**= Requires 'Preventive Service Zero Copay Primary Prevention of Breast Cancer Diagnosis Exception'. This is a request to allow a member to receive Raloxifene or Tamoxifen Citrate (Generic products only) for a $0 copayment if using for diagnosis of 'Primary Prevention of Breast Cancer'.

For more specific information regarding coverage options and limitations, please contact CVS Caremark customer service.

CVS Caremark Online Resources and Tools

Your Secure CVS Caremark Member Website

The main CVS Caremark website is available at www.Caremark.com. You can get:

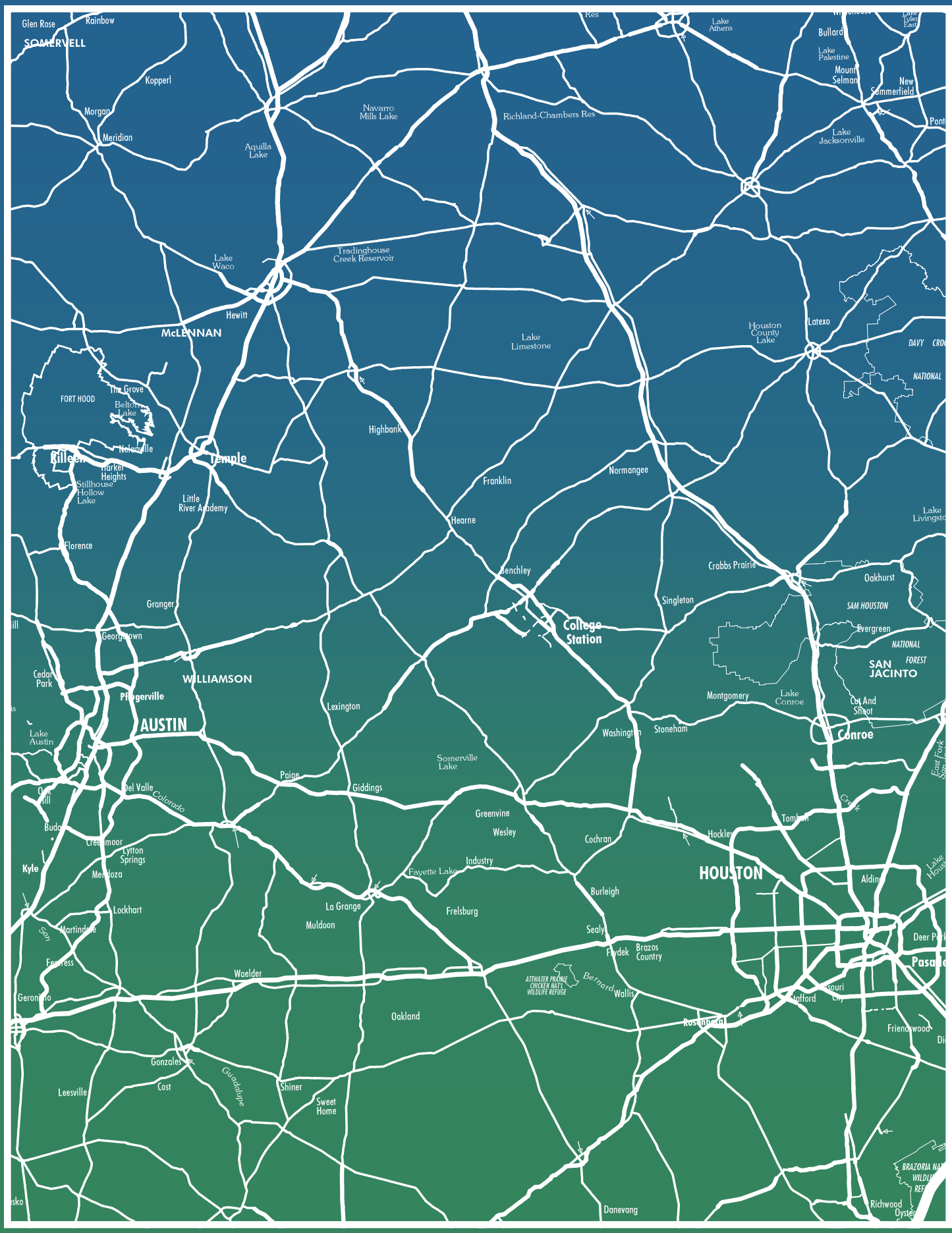
- refill reminders
- view and print temporary ID card
- Rx information
- cost information
- prescription history
- track your Rx spend
- locate local pharmacies

CVS Caremark also hosts a website specifically for TRS-ActiveCare plans: Info.caremark.com/trsactivecare

From this site, you can check drug costs for the different TRS-ActiveCare plan options, access the Generics Only Preventive Therapy Drug List for TRS-ActiveCare HD, and see if a pharmacy is in the Retail-*Plus* Pharmacy Network.

CVS Caremark Mobile Apps

Download the CVS Caremark® mobile app and manage your prescription medications from wherever you are. You can order refills, check drug costs, view your prescription ID card and locate a network pharmacy – anytime, anywhere. You can use the app on your iPhone or Android phone.


Glen Rose
Rainbow
SOMERVELL
Kopperl
Morgan
Meridian
Aquilla Lake
Navarro Mills Lake
Richland-Chambers Res
Lake Athens
Bullard
Lake Palestine
Mount Selman
New Summerfield
Lake Jacksonville
Tradinghouse Creek Reservoir
Lake Waco
Hewitt
McLENNAN
Lake Limestone
Houston County Lake
Latexo
DAVY CROCKETT NATIONAL
FORT HOOD
The Grove
Belton Lake
Nolanville
Killeen
Harker Heights
Stillhouse Hollow Lake
Temple
Little River Academy
Highbank
Franklin
Normangee
Hearne
Florence
Granger
Georgetown
Benchley
Crabbs Prairie
Singleton
Oakhurst
SAM HOUSTON NATIONAL FOREST
Evergreen
SAN JACINTO
College Station
WILLIAMSON
Cedar Park
Pflugerville
AUSTIN
Lexington
Lake Austin
Somerville Lake
Paige
Giddings
Del Valle
Colorado
Oak Hill
Buda
Creedmoor
Lytton Springs
Kyle
Mendoza
Lockhart
San Marcos
Martindale
Fentress
Waelder
Geronimo
Gonzales
Guadalupe
Leesville
Cost
Shiner
Sweet Home
Oakland
La Grange
Muldoon
Fayette Lake
Industry
Frelsburg
Greenvine
Wesley
Cochran
Burleigh
Sealy
Fedyk
Brazos Country
ATTWATER PRAIRIE CHICKEN NAT'L WILDLIFE REFUGE
Bernard
Wallis
Rosenberg
Danevang
Montgomery
Lake Conroe
Cut And Shoot
Conroe
Washington
Stoneham
Tomball
Hockley
HOUSTON
Aldine
Lake Houston
East Fork San Jacinto Creek
Deer Park
Pasadena
Missouri City
Stafford
Friendswood
Richwood
BRAZORIA NATIONAL WILDLIFE REFUGE

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