FirstCare™
HEALTH PLANS

TRS-ActiveCare Program

2018-2019

Rate Overview and Description of Plan Benefits

TRS ACTIVECARE
TEACHER RETIREMENT SYSTEM OF TEXAS

Rate Overview

Coverage Category	2018 – 2019 Premiums
Employee Only	$534.04
Employee and Spouse	$1,348.92
Employee and Child(ren)	$849.76
Family	$1,385.36

FirstCare HEALTH PLANS

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

TRS ActiveCare
2018 Benefit Summary
FirstCare Select Plus HMO Network
TRS2018T

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

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

PLAN YEAR	Contract Year
PLAN YEAR DEDUCTIBLE	$750 per Member / $2,250 per Family
OUT-OF-POCKET MAXIMUM *Includes medical and Rx deductible and copays.*	$7,350 per Member/ $14,700 per Family
ANNUAL MAXIMUM	Unlimited

COVERED MEDICAL SERVICES	
GENERAL SERVICES *Including Medical & Behavioral Health Services*	*Copay Charges*
• **Adult PCP Office Visit** Include Lab/X-ray services, injectables and supplies. Other services provided in a physician's office are subject to additional copays. *Note: Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	$20 Copay
• **Pediatric PCP Office Visit** (For a covered dependent through age 19). Include Lab/X-ray services, injectables and supplies. Other services provided in a physician's office are subject to additional copays. *Note: Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	No Charge
• **Specialist Office Visit** Include Lab/X-ray services. Other services provided in a physician's office are subject to additional copays. *Note: Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	$60 Copay
• **Behavioral Health Office Visit**	$20 Copay

COVERED MEDICAL SERVICES

GENERAL SERVICES *Including Medical & Behavioral Health Services*	*Copay Charges*
• **Emergency Room**	$500 Copay after Deductible
• **Minor Emergency/Urgent Care**	$75 Copay

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

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

Covered Service Limitations¥:

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

FirstCare HEALTH PLANS

TRS ActiveCare
2018 Prescription Drug Rider
TRSRX18T

CONTRACT YEAR DEDUCTIBLE ***(Tier III, IV, V)***	$100 per Member $300 per Family
OUT-OF-POCKET MAXIMUM	Integrated with Medical

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

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

	PARTICIPATING RETAIL PHARMACY (Standard Drugs) 30-Day Supply	PARTICIPATING HOME DELIVERY / PREFERRED RETAIL PHARMACY (Maintenance Drugs) 90-Day Supply
Tier I	$0 Copayment per Prescription	$0 Copayment per Prescription
Tier II	$15 Copayment per Prescription	$45 Copayment per Prescription
Tier III	$40 Copayment per Prescription	$120 Copayment per Prescription
Tier IV	$100 Copayment per Prescription	$300 Copayment per Prescription
Tier V	20% Copayment per Prescription	20% Copayment per Prescription

WHAT THIS RIDER COVERS

This Rider covers the following Prescription Drugs included in the approved FirstCare Drug Coverage List (DCL) when they are prescribed by a Primary Care Physician (PCP) or other authorized referral Prescribers:

- Medically Necessary Prescription Drugs listed in the FirstCare DCL.
- Diabetes Supplies, which include Blood Glucose Monitors, Glucagon Emergency Kits, Biohazard Containers, Test Strips, Lancets and Lancet Devices, Urine Testing Strips, Insulin Syringes, Injection Aids, Insulin Pumps, and Diabetes Medication.
- Legend Pre-natal vitamins.
- Growth hormone therapy for the treatment of documented growth hormone deficiency in whom epiphyseal closure has not yet occurred.
- Formulas necessary for the treatment of Phenylketonuria (PKU) or other Heritable Disease.
- Selected contraceptive Legend Drugs and devices contained in the FirstCare DCL are covered at no Deductible or Copayment. However, if the You receive a Brand Name Drug when a Generic Equivalent Prescription Drug is available, You are responsible for the cost difference between the Generic Equivalent Prescription Drug and the Brand Name Drug. An exemption to this rule occurs when: (1) both Brand Name Drugs and Generic Equivalent Prescription Drugs are covered at $0 Copayment and (2) the Brand Name Drug is requested by provider for Medical Necessity (e.g. contraindications, allergy, lack of efficacy of the Formulary product), the Brand Name Drug will be covered at no Deductible or Copayment. Any cost differentials do not apply towards the Deductible/Out-of-Pocket Maximum.
- Injectable medications recognized by the FDA as appropriate for self-administration (referred to as “Self-Injectable” drugs), regardless of Your ability to self-administer.
- Drugs prescribed to treat a chronic, disabling, or life threatening condition as required by the Texas Insurance Code TIC §1369.004(a).
- Preventive medications as mandated by the Affordable Care Act

LIMITATIONS

- Certain medications are subject to dispensing limitations based upon generally accepted medical practice, including but not limited to, medications contained in the FirstCare DCL.
- Certain medications are subject to prior authorization, including but not limited to, medications contained in the FirstCare DCL.
- New FDA approved medications (unique chemical entities) will require prior authorization until they have been reviewed by the FirstCare P&T committee, and their coverage status is determined.
- Medications covered under this Rider are limited to a 30-day supply. Maintenance medications for chronic conditions may be filled up to a 90-day supply through the Participating Retail Pharmacies or through the Home Delivery Pharmacy program.
- Prescriptions must be filled at a Participating Network Pharmacy
- Prescription Drugs that are dispensed by an Out-of-Network Pharmacy are not covered unless authorized for emergency purposes. Refills or new prescriptions must be filled at a Participating Pharmacy.
- Prescriptions will not be refilled until 75% percent of the prescription has been used.
- Where a medication is not covered on the Formulary or awaiting Formulary review, an Exception Prior Authorization allows clinical review for Medical Necessity and coverage. In which case, medications approved by the Exception process will be charged at the highest Tier for their therapeutic class: Non-Preferred Brand Tier (non-specialty drugs) and Specialty Tier (for specialty drugs, including self-administered injectable).
- One vacation override is allowed each Plan Year.

WHAT IS NOT COVERED

- Medications not listed on the Drug Coverage List (DCL) unless otherwise stated.
- Drugs that by law do not require a prescription unless listed in the DCL.
- Prescriptions written in connection with any treatment or service that is not a covered benefit unless listed in the DCL.
- With the exception of contraceptive devices, devices of any kind, even those requiring a prescription, including but not limited to therapeutic devices, health appliances, hypodermic needles or similar items.
- Any medication that is not Medically Necessary. Denials for medications that are not medically necessary are subject to the Member Complaint and Appeal Procedures outlined in Section 9 of Your Evidence of Coverage.
- Any over-the-counter medications that are not required by the Affordable Care Act.
- Vitamins, minerals, and/or nutritional supplements that are required by the Affordable Care Act (regardless of whether or not these are legend or over-the-counter).
- Medications prescribed for non-FDA approved indications, referred to as off-label drug use are not covered. This includes Experimental, Investigational, and any disease or condition that is excluded from coverage under this Rider; or that the FDA has determined to be contraindicated for treatment of the current indication. Off-label drug use may be covered if the drug is approved by the FDA for at least one indication; and is recognized for treatment of the indication for which the drug is prescribed in substantially accepted peer-reviewed national medical professional journals and a nationally recognized medical technology evaluation service.
- Appetite suppressants, anti-smoking aids in excess of what is required by Section 2713 of the Patient Protection & Affordable Care Act,, medications used for any cosmetic improvement, including wrinkles, uncomplicated nail fungus regardless of ambulation or pain, hair loss, growth or removal, idiopathic non-growth hormone deficiency short stature, and DESI Drugs.
- Prescriptions or refills that replace lost, stolen, spoiled, expired, spilled or are otherwise misplaced or mishandled by the You.
- Prescriptions written for the treatment of infertility.
- Prescriptions written for the treatment of erectile dysfunction.
- Any medication covered under Your medical plan.
- Compound Medications

GENERAL PROVISIONS

- The monthly premium rate charged for this Rider is included in the monthly premium charged for the Group Contract. The applicable rate is specified on the rate schedule attached to the Group Employer Agreement and the Group agrees to remit to FirstCare the Rider premium due, including the subscriber contribution, if any, along with and on the same date as its regular premium.
- In the event any Member's coverage under the Group Contract terminates, this Rider will terminate automatically without further action or notice unless otherwise prohibited by applicable law.
- Until further notice, all terms, limitations, exclusions and conditions of the Group Contract Evidence of Coverage remain unchanged except as provided in this Rider.
- If We place a medication on a higher tier during the Plan Year, You will continue to pay the Copayment for the drug at the lower cost tier until Your next plan renewal date. We will provide written notice of the modification to the affected Employer Group and each affected Member not later than the 60th day before the effective date of the modification.
- If a medication is removed from the DCL during the Plan Year, it will continue to be covered at the tier Copayment the drug was originally listed at, until the next plan renewal date. We will provide written notice of the modification to the affected Employer Group and each affected Member not later than the 60th day before the effective date of the modification.
- This prescription benefit requires the use of Generic Equivalent Prescription Drugs ("required generic"). If You receive a Brand Name Drug when a Generic Equivalent Prescription Drug is available, You shall pay no more than the Generic Equivalent Prescription Drug Copayment plus the difference between the cost of the Generic Equivalent Prescription Drug and the cost of the Brand Name Drug. An exemption to this rule occurs when: (1) both Brand Name Drug and Generic Equivalent Prescription Drugs are covered at $0 Copayment and (2) the Brand Name Drug is requested by the provider for Medical Necessity (e.g. contraindications, allergy, lack of efficacy of the Formulary product), the Brand Name Drug will be covered at no Deductible or Copayment.
- This prescription benefit uses a single Formulary. The Formulary is reviewed on a quarterly basis. To determine whether a specific drug is included on the Formulary review the DCL listed at www.FirstCare.com or contact Customer Service. We will disclose to a Member on request, not later than the third business day after the date of the request, whether a specific drug is included in a particular drug Formulary.
- This prescription benefit requires that certain drugs obtain a Step Therapy Prior Authorization (ST-PA) approval before it can be dispensed. FirstCare uses a range of guidelines (e.g. specialized clinicians in specific treatment areas, national-based recommendations, peer-reviewed articles, FDA approved drug package insert etc.) to determine these limitations and ensure appropriateness.
- Drugs subjected to a Step Therapy Prior Authorization (ST-PA) may require trial and failure of other therapies before the requested medication is approved for use. A medication subjected to a Step Therapy Prior Authorization will be approved with a written request when 1 or more of following criteria are met: (1) the required trial/failure of an initial step-through drug is contraindicated, may cause You harm (e.g. side effect), or is expected to be ineffective based on its known drug characteristics, (2) You have tried/failed this required step-through drug (or something similar in its class) previously and it is not expected to be effective or may cause harm based on its drug characteristic, (3) the step-through drug is expected to worsen other condition(s) You may have, is expected to decrease Your ability to perform daily activities, or causes a significant barrier to You becoming compliant, (4) You have been stable on this requested medication and a change in this medication is expected to be ineffective or cause harm based on Your characteristic and/or the drug's characteristics.
- Step Therapy PA requests are made similar to other prior authorization requests, and a response to the request will be mailed out within 72 hours of receipt of the request. In case of emergency, and Your doctor reasonably believes that a delay may result in serious harm or death, a response will be provided within 24 hours of receipt. If no response is provided by the timeline above, the requested drug is considered granted. If Your request is denied, and You do not agree with our finding, You have the right to an appeal. You may appeal Yourself, or use legal counsel, a relative, friend or other spokesman. Refer to the Member Complaint and Appeal Procedures outlined in Section 9 of Your Evidence of Coverage.
- Inclusion of a drug on the FirstCare DCL does not guarantee Your healthcare provider will prescribe this medication.
- We shall prorate any cost-sharing amount charged for a partial supply of a prescription drug if the pharmacy or Your prescribing physician or health care provider notifies Us that the quantity dispensed is to synchronize the dates that the pharmacy dispenses Your prescription drugs; and the synchronization of the dates is in the best interest of You; and You agree to the synchronization. The proration must be based on the number of days' supply of the drug actually dispensed.

- You will not be required to pay for a prescription drug at the point of sale in an amount greater than the lesser of the applicable copayment; the allowable claim amount for the prescription drug; or the amount You would pay for the drug You purchased without using a health benefit plan or any other source of drug benefits or discounts.
- A 30/60/90-day supply of prescription eye drops to treat a chronic eye disease or condition may be refilled for a 21/42/63-day supply if You pay at the point of sale the maximum amount allowed and the original prescription states that additional quantities of the eye drops are needed; the refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills; and the refill is dispensed on or before the last day of the prescribed dosage period.
- HMO only accepts Premium payments from (1) the Member; (2) the Member's family; (3) Required Entities (the entities the law requires HMO to accept cost-sharing payments from, which as of the Effective Date currently are Ryan White HIV/AIDS programs, under title XXVI of the Public Health Service Act, Indian tribes, tribal organizations and urban Indian organizations; and State and Federal government programs, as described in 45 C.F.R. § 156.1250); and (4) private non-profit foundations that make cost-sharing assistance available to the Member: (a) for the entire coverage period of the Member's Policy, (b) based solely on financial criteria (c) regardless of the Member's health status, and (d) regardless of which insurance issuer and/or benefit plan the applicant chooses. Cost-sharing payments such as prescription Copayment assistance cards from any other party, other than those listed above, will not be applied to Your coverage. Premium payments from any party, other than those listed above, will not be credited to Your account which may result in termination or cancellation of coverage in accordance with the Termination provisions of this Evidence of Coverage.

DEFINITIONS

Brand Name Drug means a drug that has no Generic Equivalent or a drug that is the innovator or original formulation for which the Generic Equivalent forms exist.

Copayment means the amount that will be charged to the Member by the Participating Pharmacy or Home Delivery Pharmacy for dispensing or refilling any Prescription Order.

Covered Drugs means those medications prescribed by a Physician that, under state or federal law, may be dispensed only by a Prescription Order for a medically necessary condition, and active ingredient(s) is/are FDA approved legend drug(s) or insulin. The maximum amount dispensed will not exceed an amount required for 30 consecutive days. Some medications for chronic conditions may be filled up to a 90-day supply through the Home Delivery Pharmacy Program.

Compound Medications: When two or more drugs or chemicals are combined to make one medicinal product.

Plan Year Deductible is the amount of Covered Prescription Drug Expenses You must pay for each Member before any benefits are available.

DESI Drugs: Any drug targeted in the FDA's Drug Efficacy Study Implementation (DESI) which demonstrates a lack of evidence supporting the drug's efficacy.

Drug Coverage List or DCL means a comprehensive list of medications consisting of Generic Equivalent drugs and single source (sometimes referred to as Brand Name) drugs. The FirstCare DCL is the list of medications authorized by the FirstCare Pharmacy and Therapeutics Committee to be dispensed through Participating Pharmacies. The DCL may be revised on a quarterly basis.

Experimental or Investigational means any drug, device, treatment or procedure that would not be used in the absence of the Experimental or Investigational drug, device, treatment or procedure. We consider a drug, device, treatment or procedure to be Experimental or Investigational if:

- It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time it is provided; or
- It was reviewed and approved by the treating Facility's Institutional Review Board or similar committee, or if federal law requires it to be reviewed and approved by that committee. This exclusion also applies if the informed consent form used with the drug, device, treatment or procedure was (or was requested by federal law to be) reviewed and approved by that committee; or
- Reliable evidence shows that the drug, device, treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigational arm of ongoing Phase III clinical trials; or is otherwise under

study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis;

- The safety and/or efficacy has not been established by reliable, accepted medical evidence; or
- Reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials of the drug, device, treatment or procedure are needed to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis.

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

Facility means a health care or residential treatment center licensed by the state in which it operates to provide medical inpatient, residential, day treatment, partial hospitalization, or outpatient care. Facility also means a treatment center for the diagnosis and/or treatment of Chemical Dependency or Mental Illness.

Formulary is a list of covered drugs selected by FirstCare Health Plans in consultation with a team of health care professionals that represents the prescription therapies believed to be a necessary part of a value based high quality treatment program.

Generic Equivalent Prescription Drug means a Prescription Drug that is pharmaceutically and therapeutically equivalent to a Brand Name Drug as classified by a nationally recognized drug classification service.

Heritable Disease means an inherited disease that may result in mental or physical retardation or death.

Member means either the Employee or his eligible Dependents covered under the Plan.

Legend Drug means a drug that federal law prohibits dispensing without a written prescription.

Maintenance Drug means medication prescribed for a chronic long term condition and is taken on a regular recurring basis. Conditions that may require maintenance drugs are high blood pressure and diabetes.

Out-of-Pocket Maximum - Amounts for which You and each Dependent are responsible during a Plan Year. Your Deductibles, Copayments for these drugs and Coinsurance count toward the Out-of-Pocket Maximum amount specified in this Rider. The Out-of-Pocket Maximum *does not* include charges for non-covered services. See Your Schedule of Copayments for more information.

Participating Pharmacy means a pharmacy that has been approved by FirstCare to provide Prescription Drugs to Members.

Participating Home Delivery Pharmacy means a pharmacy providing prescription service by mail which has contracted with FirstCare to provide such services.

Phenylketonuria means an inherited condition that may cause severe developmental deficiency, seizures or tumors, if not treated.

Preferred Participating Retail Pharmacy means a retail pharmacy, providing prescription service for a 90-day supply of maintenance drugs at the Participating Mail Order Pharmacy rate, which has contracted with FirstCare to provide such services.

Prescription Drug means any Legend Drug that has been approved by the Food & Drug Administration (FDA), is not Experimental or Investigational, and requires a prescription by a duly licensed Physician.

Standard Drug means a FDA approved medication that requires a written prescription by a licensed physician.

For more information and to view the DCL, please visit www.FirstCare.com.

SHA, L.L.C. dba FirstCare
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Austin, Texas 78750
(512) 257-6000
1-800-884-4901

FirstCare HEALTH PLANS

Plan Exclusions

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

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

3. **Amniocentesis,** except when Medically Necessary.

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

5. **Biofeedback** services, except for the treatment of acquired brain injury and for rehabilitation of acquired brain injury.

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

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

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

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

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

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

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

12. All expenses associated with routine **dental care** or oral surgery (except for corrective treatment of an accidental Injury to natural teeth) or any treatment relating to the teeth, jaws, or adjacent structures (for example, periodontium), including but not limited to:
    - Cleaning the teeth;
    - Any services related to crowns, bridges, filings, or periodontics;
    - Rapid palatal expanders;
    - X-rays or exams;
    - Dentures or dental implants;
    - Dental prostheses, or shortening or lengthening of the mandible or maxillae for Members over age 18, correction of malocclusion, and any non-surgical dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, such as oral appliances and devices;
    - Treatment of dental abscess or granuloma;
    - Treatment of gingival tissues (other than for tumors);
    - Surgery or treatment for overbite or underbite and any malocclusion associated thereto, including those deemed congenital or developmental anomalies; and
    - Orthodontics, such as splints, positioners, extracting teeth, or repairing damaged teeth.

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

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

13. Charges for the normal **delivery of a baby** (vaginal or cesarean section) outside Our Plan's Service Area if the delivery is within thirty days of Your due date specified by Your participating Physician, or Your Physician has advised against travel outside Our Service Area, except in case of emergency as specified in *Section 4, Emergency and Out-of-Area Urgent Care Services.* Complication of a pregnancy or delivery is treated as any other illness.

14. The following **devices**, **equipment, and supplies** are excluded:
    - Corrective shoes, shoe inserts, arch supports, and orthotic inserts, except as provided for under Diabetic Services;
    - Equipment and appliances considered disposable or convenient for use in the home, such as over-the counter bandages and dressings;

- Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, and exercise equipment;
- Environmental control equipment, such as air conditioners, purifiers, humidifiers, dehumidifiers, electrostatic machines, and heat lamps;
- Consumable medical supplies, such as over-the-counter bandages, dressings, and other disposable supplies, skin preparations, surgical leggings, elastic stockings, TED stockings, stump socks and compression garments, unless prior approval is obtained from the Medical Director for Medical Necessity.
- Foam cervical collars;
- Stethoscopes, sphygmomanometers, and recording or hand-held pulse oximeters;
- Hygienic or self-help items or equipment; and
- Electric, deluxe, and custom wheelchairs or auto tilt chairs.
- Sequential lymphedema compression devices, except for treatment after a mastectomy.

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

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

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

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

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

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

21. **Equine or Hippo therapy.**

22. **Experimental or investigational** drugs, devices, treatments, or procedures. This includes any drug, device, treatment, or procedure that would not be used in the absence of the experimental or investigational drug, device, treatment, or procedure. We consider a drug, device, treatment, or procedure to be experimental or investigational if:
    - It cannot be lawfully marketed without the approval of the U. S. Food and Drug Administration, and approval for marketing has not been given at the time it is provided;
    - It was reviewed and approved by the treating facility's Institutional Review Board or similar committee, or if federal law requires it to be reviewed and approved by that committee. This

exclusion also applies if the informed consent form used with the drug, device, treatment or procedure was (or was requested by federal law to be) reviewed and approved by that committee;

- Reliable evidence shows that the drug, device, treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental study, or investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis;
- The safety and/or efficacy has not been established by reliable, accepted medical evidence; or
- Reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials of the drug, device, treatment, or procedure are needed to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis.

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

Denials for Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on complaints and appeal procedures.

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

24. **Genetic counseling and testing**, except medically necessary peri-natal genetic counseling and certain genetic testing approved by FirstCare's Medical Technology Assessment Committee. Genetic testing related to pre-implantation of embryos for in-vitro fertilization is not covered. Genetic testing results or the refusal to submit to genetic testing will not be used to reject, deny, limit, cancel, refuse to renew, increase premiums for, or otherwise adversely affect eligibility for or coverage under this plan.

25. **Growth hormone** drugs for persons 18 years of age or older. However, growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred, are covered if Your group has purchased the Prescription Drug Rider.

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

27. All charges for a **Hospital** admission for procedures to diagnose or evaluate, unless determined to be Medically Necessary.

28. All charges for inpatient **Hospital** days that exceed the medically recommended length of stay for the diagnosis, unless medically necessary.

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

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

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

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

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

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

    Denials for Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on complaints and appeal procedures.

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

    Denials for Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on complaints and appeal procedures.

36. **Medications** for use outside of the Hospital or other inpatient facility, including take-home and over-the-counter drugs, except those used in the treatment of diabetes or as covered by a Rider.

Denials for Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on complaints and appeal procedures.

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

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

39. Implanted **neurological stimulators**, including but not limited to spinal or dorsal column stimulators for Parkinson's, movement disorders, or seizures, except for stimulators implanted for relief or neurogenic pain as approved by FirstCare's Medical Technology Assessment Committee and when meeting established clinical criteria; and except for neurogenic bladder.

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

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

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

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

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

44. **Orthotic** devices, except for the treatment of diabetes and those described in *Section 3, What is Covered.*

45. **Orthotripsy** and related procedures.

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

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

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

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

50. **Reduction mammoplasty**, except for surgical reconstruction related to treatment of breast cancer.

51. Long-term **rehabilitative services**. Long term is defined as more than two months.

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

53. **Self-Injectable Medications** recognized by the FDA as appropriate for self-administration, regardless of the enrollee's ability to self-administer, are not covered, except as covered in the Prescription Drug Rider or coverage is otherwise specified in this document. Refer to Your prescription drug Rider for details.

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

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

    Denials for Experimental/Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See *Section 9* for information on complaints and appeal procedures.

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

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

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

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

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

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

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

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

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

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

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

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

68. Elective, non-therapeutic **termination of pregnancy** (abortions) including any abortion-inducing medications, except where the life of the mother would be endangered if the fetus were to be carried to term.

69. **Transportation**, except for ambulance or air ambulance used for transport in a medical emergency or when We have pre-approved services for medical transport purposes only (e.g. from a Hospital to a skilled nursing facility).

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

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

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

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

Limitations Due To Certain Conditions

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