FirstCare™
HEALTH PLANS

TRS-ActiveCare Program

2017-2018

Rate Overview / Description of Plan Benefits

TRS ACTIVECARE
TEACHER RETIREMENT SYSTEM OF TEXAS

Rate Overview

Coverage Category	2017 – 2018 Premiums
Employee Only	**$514.82**
Employee and Spouse	**$1,287.60**
Employee and Child(ren)	**$816.07**
Family	**$1,298.52**

FirstCare HEALTH PLANS

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

FirstCare HEALTH PLANS

TRS ActiveCare
2017 Benefit Summary
TRS2017T

You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization that, either in whole or in part, does not provide state-mandated health benefits normally required in accident & sickness insurance policies/evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage. The following is a summary of the Copay amounts You & 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.

PLAN YEAR	Contract Year
PLAN YEAR DEDUCTIBLE	$750 per Member /$2,250 per Family
OUT-OF-POCKET MAXIMUM[1]	$6,000 per Member / $12,000 per Family
ANNUAL MAXIMUM	Unlimited

GENERAL SERVICES *(Including Medical & Behavioral Health Services)*

- **Adult PCP Office Visit[2]** $20 copay
- **Pediatric PCP Office Visit[2,3]** No copay
- **Specialist Office Visit[4]** $60 copay
- **Emergency Room** $500 copay after deductible
- **Minor Emergency/Urgent Care** $75 copay
- **Behavioral Health Office Visit** $20 copay

PREVENTIVE CARE SERVICES *(For a list of preventive care services please refer to your Evidence of Coverage.)*

- **Preventive Care** No copay

OTHER HEALTH CARE SERVICES *All other services, including but not limited to those listed below:*

- **Inpatient Services** *(Facility Charges; Physician Services; Surgical Procedures; Pre-Admission Testing; Operating/Recovery Room; Labor & Delivery; Neonatal Intensive Care Unit (NICU); Intensive Care Unit (ICU); Coronary Care Units; Laboratory Tests/X-rays; Rehabilitation Facility; Behavioral Health Facilities; Skilled Nursing Facility¥)* — 25% copay after deductible
- **Outpatient Services** *(Facility Charges; Physician Services; Surgical Procedures; Observation Unit; Behavioral Health Facilities)* — 25% copay after deductible
- **Ambulance *(Air/Ground)*** — 25% copay after deductible
- MRI, CT Scan; PET Scan (Facility/Physician) — $250 copay after deductible
- *Sleep Study; Stress Test; EKG; Ultrasound; Cardiac Imaging; Genetic Testing; Non-Preventive Colonoscopy* (Facility/Physician) — 25% copay after deductible
- **Other Services** *(Allergy Testing/Serum/Injections; Surgical Procedures in Physician Office; Family Planning Services; Medical Supplies; Hospice Care; Pain Management; Dialysis Services; Organ Transplant Services; Durable Medical Equipment; Home Infusion Medications; Internal Implantable Devices; Amino Acid-Based Elemental Formulas; Diabetes Services; Limited Accidental Dental Care; Prosthetics; Orthotics; Home Health Care¥; Spinal Manipulation¥; Therapy Services ¥)* — 25% copay after deductible
- **All Other Covered Services *(not specified herein)*** — 25% copay after deductible

¥Covered Service Limitations:

- **Skilled Nursing Facility –** *Limited to 30 days per Plan Year*
- **Home Health Care** – *Limited to 60 visits per Plan Year*
- **Spinal Manipulation –** *Limited to 10 visits per Plan Year*
- **Therapy Services -** *Limited to 35 visits per Plan Year for each service (Physical, Occupational, Speech, Habilitation)*

[1]***Out of Pocket Maximum*** – *Includes deductible and copays.*
[2] ***PCP Office Visits*** *- include Lab/X-ray services, injectables & supplies. Other services provided in a physician's office are subject to additional deductible & copays.*
[3]***Pediatric*** – *Defined as a benefit provided to a covered dependent through age 19.*
[4] ***Specialist Office Visits*** *- include Lab/X-ray services. Other services provided in a physician's office are subject to additional deductible & copays.*

Note: *Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*

If you would like more information about FirstCare's benefits and medical services go to www.firstcare.com or contact our Customer Service at 1-855-572-7238, TTY Line 1-800-562-5259

TRS ActiveCare Program
Prescription Drug Rider
TRSRX17T

CONTRACT YEAR DEDUCTIBLE
(Tiers III, IV, V and diabetes supplies)
OUT-OF-POCKET MAXIMUM

$100 per Member / $300 per Family
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 per Prescription	$0 per Prescription
Tier II	$15 per Prescription	$45 per Prescription
Tier III	$40 per Prescription	$120 per Prescription
Tier IV	$100 per Prescription	$300 per Prescription
Tier V	20% per Prescription	20% per Prescription
Diabetes Supplies		
• *Preferred*	10% per Prescription	10% per Prescription
• *Non-Preferred*	20% per Prescription	20% 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, and 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 copay. However, if the member receives a name brand drug when a generic equivalent is available, the Member is responsible for the cost difference between the generic and the name brand drug. An exception to this rule occurs when: (1) both brand and generics are covered at $0 copay and (2) the brand is requested by the provider for medical necessity (e.g.

contraindications, allergy, lack of efficacy of the formulary product), the branded product will be covered at no deductible or copay. 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 the Insured's 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 80% 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 contract year.

WHAT IS NOT COVERED

- Medications not listed on the 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 Member.
- 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 drugs ("required generic"). If You receive a name brand drug when a generic equivalent is available, You shall pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name brand drug. An exemption to this rule occurs when: (1) both brand and generics are covered at $0 copy and (2) the brand is requested by the provider for medical necessity (e.g. contraindications, allergy, lack of efficacy of the formulary product), the branded product will be covered at no deductible or copay. Any cost differentials do not apply towards the Deductible/Out-of-Pocket Maximum.
- 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.
- Inclusion of a drug on the FirstCare DCL does not guarantee Your healthcare provider will prescribe this medication.
- 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. To determine whether a specific drug is included on the formulary review the DCL listed at www.firstcare.com or contact Customer Service.

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.

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

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 ingredients 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

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 from time to time.

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 First Data Bank or other 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 Copayments for these drugs 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.

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
12940 N. Highway 183
Austin, Texas 78750
1-512-257-6000
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.
    - Nutritional counseling, except for the treatment and self-management of diabetes.
    - 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, 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. PolarCare™ devices for **cryotherapy**.

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 aids, hearing aid batteries, and temporary or disposable hearing aids, unless an additional rider has been purchased.

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, 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 Evidence of Coverage; 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.

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 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, court ordered evaluation, diagnosis, and treatment for mental conditions are excluded unless this Evidence of Coverage would otherwise cover such services.

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. **Nutritional** counseling, testing and diet planning, unless We have pre-approved it. We do not cover the Lifestyle Eating and Performance (LEAP) program and/or mediator release testing

43. **Obesity:** Services intended primarily to treat obesity, such as gastric bypasses and balloons, stomach stapling, jaw wiring, vertical banding, 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.

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. Procedures, services or supplies for or related to **Sex-change** surgery, transformation or reassignment; modification surgery and services, any treatment of gender identity disorders, or any treatment or surgery related to sexual dysfunction or inadequacies including but not limited to: hormone therapy, impotency, regardless of medical necessity.

64. All surgical procedures for **snoring and sleep apnea** except in members under age 12. (Procedures that are frequently performed in relation to treatment of snoring and sleep apnea, such as adenoidectomy and or tonsillectomy for members over age 12)