

EVIDENCE OF COVERAGE

TRS-ActiveCare Program
Large Group HMO

Plan Year 2005

Valley Baptist Health Plan, Inc.

This Evidence of Coverage is not to be used for small employer health plans covered by Texas Insurance Code, Art. 26.01, et. seq.

EVIDENCE OF COVERAGE

This Evidence of Coverage is issued to You (and Your eligible enrolled Dependents), because You have enrolled in the health maintenance organization of VALLEY BAPTIST HEALTH PLAN through The TRS-ActiveCare Program. Your Evidence of Coverage constitutes Your contract with VALLEY BAPTIST HEALTH PLAN. By completing Your Enrollment Form, making or having made on Your behalf payment of applicable premiums, and accepting this Evidence of Coverage, You (and Your Dependents, if any) agree to abide by and adhere to the provisions, terms, and conditions contained in Your Evidence of Coverage.

The effective date of coverage of Your Evidence of Coverage shall be as indicated on Your VALLEY BAPTIST HEALTH PLAN Member ID card and confirmed by VALLEY BAPTIST HEALTH PLAN.

WELCOME to VALLEY BAPTIST HEALTH PLAN

Dear Employee:

On behalf of VALLEY BAPTIST HEALTH PLAN, I would like to welcome You to Our Health Plan.

Please take a few minutes to read this booklet and become familiar with the HMO benefits Your Plan covers and does not cover as explained herein.

If You are new to VALLEY BAPTIST HEALTH PLAN, a representative from Our Customer Services Department will be calling to assist You in understanding Your VALLEY BAPTIST HEALTH PLAN coverage. If You are not new to VALLEY BAPTIST HEALTH PLAN, but would like more information about how to use Your VALLEY BAPTIST HEALTH PLAN plan, please contact Our Customer Services Department at (800) 829-6440.

Thank You for selecting VALLEY BAPTIST HEALTH PLAN.

Sincerely,

Karen Pederson
President/CEO

VALLEY BAPTIST HEALTH PLAN
2005 Ed Carey Drive
Harlingen Texas 78550
(956) 389-2273
(800) 829-6440

VALLEY BAPTIST HEALTH PLAN - The HMO of Choice

TRS-ACTIVECARE PROGRAM

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call VALLEY BAPTIST HEALTH PLAN's toll free telephone number for information or to make a complaint at:

(800) 829-6440

You may also write to Us at:

**VALLEY BAPTIST HEALTH PLAN
2005 Ed Carey Drive
Harlingen, Texas 78550**

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

(800) 252-3439

You may write the Texas Department of Insurance:

**P.O. Box 149104
Austin, Texas 78714-9104
FAX# (512) 475-1771**

PREMIUM OR CLAIM DISPUTES:

Should You have a dispute concerning Your premium or about a claim, You should contact VALLEY BAPTIST HEALTH PLAN first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Usted puede llamar al numero de teléfono gratis de VALLEY BAPTIST HEALTH PLAN's para información o para someter una queja al:

(800) 829-6440

Usted también puede escribirnos a:

**VALLEY BAPTIST HEALTH PLAN
2005 Ed Carey Drive
Harlingen, Texas 78550**

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al:

(800) 252-3439

Puede escribir al Departamento de Seguros de Texas:

**P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771**

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con VALLEY BAPTIST HEALTH PLAN primero. Si no se resuelve la disputa, puede entonces comunicarse con al Departamento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de información y no se convierte en parte o condición del documento adjunto.

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SPECIAL TOLL-FREE BEHAVIORAL HEALTH COMPLAINT NUMBER:

To make a complaint about a private psychiatric Hospital, chemical dependency treatment center, or psychiatric or chemical dependency services at a general Hospital, call:

(800) 228-1570

Your complaint will be referred to the state agency that regulates Hospital or chemical dependency treatment centers.

AVISO DE NUMERO TELFONICO GRATIS ESPECIALMENTE PARA QUEJAS DE SALUD MENTAL

Para someter una queja acerca de un hospital psiquiatrico privado, de centro tratamiento para la dependencia quimica, de servicios piquiatrico o de dependencia quimica en un hospital general, llame a:

(800) 228-1570

Su queja sera referida a la agencia estatal que regula la hospital o centro de tratamiento para la dependencia quimica.

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This document, known as the "Evidence of Coverage," describes the benefits available to You under Your VALLEY BAPTIST HEALTH PLAN Health Plan.

Throughout this document, "You" and "Your" refer to a VALLEY BAPTIST HEALTH PLAN Member, including any eligible dependents of the VALLEY BAPTIST HEALTH PLAN Member (such as spouses and children) who are also enrolled in the Plan. "We," "Our," and "Us" refer to VALLEY BAPTIST HEALTH PLAN. "Your Plan" and "the Plan" refer to the VALLEY BAPTIST HEALTH PLAN Health Plan that is described in this document, together with Your Schedule of Copayments.

Here is what You will find in this document:

SCHEDULE OF COPAYMENTS: The Schedule of Copayments is a list of the Copayment amounts that You and/or any of Your Dependents must pay to the provider at the time You receive any Covered Health Services.

SECTION 1: Requirements For All Health Care Services. This section describes the general requirements that apply to all health care services covered under Your Plan. For instance, it tells You which health care professionals You may go to for covered services. It also describes referrals to specialists and prior approvals for hospitalizations and other services.

SECTION 2: Eligibility and Enrollment. This section explains eligibility requirements for membership in VALLEY BAPTIST HEALTH PLAN and effective dates for newly eligible dependents.

SECTION 3: What Is Covered. This section tells You which health care services are covered under Your Plan, along with any limits on coverage for specific services. Section 3 also tells You if a Copayment is due at the time You receive services.

SECTION 4: Emergency and Out-of-Area Urgent Care Services. This section describes what services We will cover in a medical emergency, both inside and outside of VALLEY BAPTIST HEALTH PLAN's Service Area. It explains Your coverage for urgent care services when You are *outside* the VALLEY BAPTIST HEALTH PLAN Service Area, and when the situation is not serious enough to be considered a medical emergency. This section also tells You how to get covered care if You urgently need services while You are *inside* the Service Area.

SECTION 5: What Is Not Covered. This section describes health care services that are not covered under Your Plan.

SECTION 6: Termination of Coverage. This section provides specific reasons why Your coverage or benefits may be terminated or canceled. It also explains about COBRA coverage, as well as continuation of coverage provisions offered by the state, and individual conversion enrollment through VALLEY BAPTIST HEALTH PLAN.

SECTION 7: Coordination of Benefits, On-the-Job Injury and Subrogation. This section outlines coordination of benefits rules and reimbursement procedures when a Member is covered by both VALLEY BAPTIST HEALTH PLAN and another Health Plan or other responsible third party.

SECTION 8: Member Complaint and Appeal Procedure. This section describes the process VALLEY BAPTIST HEALTH PLAN has developed for You to follow should You have a complaint or dissatisfaction about any aspect of Our operation. The section also tells You how to use Our Appeal process if You disagree with Our resolution to Your complaint.

SECTION 9: Miscellaneous Provisions. This section describes certain provisions including reimbursement of claims that You have paid, authority to examine Your health records, and incontestability provisions.

SECTION 10: Definitions. This section provides definitions of some of the terms used throughout this document. This document also uses specific medical terms for certain illnesses and treatments, which may not be defined in Section 10. If You have questions about any of these terms, please call the VALLEY BAPTIST HEALTH PLAN Customer Services Department at (800) 829-6440.

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The following is a summary of the Copayment amounts You and any Dependents must pay when receiving the services listed below. These services must be performed, prescribed, or directed by Your Primary Care Physician or designated OB/GYN Physician. Please refer to Your Evidence of Coverage for a detailed explanation of covered and non-covered services.

Covered Services	Copayments
Physician Services Primary Care and Specialist Office Visits includes Evaluation and Management visits and Consultations Physician Home Visits	\$25PCP/\$35SP Copay per office visit \$25PCP/\$35SP Copay per visit
Routine Gynecological Exam & Pap Test	\$25PCP/\$35SP Copay
Immunizations (if only service performed)	Covered in full
Injectable Medications administered in office	20% of Health Plan Profile** Copay (except chemotherapy)***
Laboratory and Radiology Services (except services related to infertility) Infertility Laboratory and Radiology Services	Covered in full 50% Copay
Allergy Services Office Visits, including Testing and Injections Serum	\$25PCP/\$35SP Copay per office visit 50% Copay
Maternity Services Physician Office Visits Inpatient Services	\$25PCP/\$35SP Copay per pregnancy \$1,500 Copay per admission
Family Planning Services Counseling Contraceptive Devices Infertility Testing and Treatment Subdermal Contraceptive Implants Sterilization	\$25PCP/\$35SP Copay per office visit \$25PCP/\$35SP Copay per office visit 50% Copay per visit \$300 Copay for insertion, \$40 copay for removal, premature removal for the purpose of conception is not covered. \$25PCP/\$35SP Copay per office visit \$500 outpatient surgery copay

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<p>Mental Health Services Outpatient Services</p> <p>Inpatient Services</p>	<p>\$25 Copay per visit limited to 20 visits per contract year.</p> <p>\$1,500 Copay per admission limited to 15 days per contract year.</p>
<p>Serious Mental Illness Health Services Outpatient</p> <p>Inpatient</p>	<p>\$25PCP/\$35SP Copay per admission limited to sixty (60) visits per contract year.</p> <p>\$1,500 Copay per admission limited to forty-five (45) days per contract year.</p>
<p>Chemical Dependency Services Outpatient</p> <p>Inpatient</p>	<p>\$25 Copay per visit for outpatient services \$1,500 Copay per admission for inpatient services.</p> <p>Limited to three (3) series of treatments per lifetime.</p>
<p>Hospital Services* Hospital Inpatient admissions including Chemical Dependency or Mental Health Treatment Center, Maternity and Rehabilitation Facility</p>	<p>\$1,500 Copay per admission</p>
<p>Skilled Nursing Facility</p>	<p>\$1,500 Copay per admission.</p> <p>Skilled Nursing Facility is limited to 100 days per contract year.</p>
<p>Outpatient Procedures When performed at Plan Provider's Outpatient Surgical Facilities, Outpatient Department of Hospital, or Free Standing Outpatient Surgical Facility</p>	<p>\$500 Copay</p>
<p>Rehabilitation Services</p>	<p>\$35 Copay per visit</p>
<p>Emergency Services Emergency Room Facility</p> <p>Free-standing Emergency Center</p>	<p>\$150 Copay per Hospital emergency room visit (copay is waived if member is admitted as inpatient within 24 hours)</p> <p>\$35 Copay per visit</p> <p>\$35 Copay per ambulance trip</p>

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Ambulance Services	
Prosthetics/Orthotics External	20% of Health Plan Profile Copay per initial prosthetic/orthotic (coverage is for initial prosthetics and orthotics only, replacements are not covered unless required due to skeletal growth.)
Internal	Covered in full
Hearing Aids	Coverage limited to a maximum of \$500 per ear once every 36 months.
Cochlear Implants	50% Copay for all charges associated with this procedure.
Reduction Mammoplasty	50% Copay for all charges associated with this procedure when medically necessary.
Hospice	Covered in full
DME (Durable Medical Equipment)	20% of Health Plan Profile Copay per device Coverage limited to a maximum of \$4,000 per Member per contract year.
Prescription Drugs	Retail
Generic	\$15
Preferred Brand	\$25
Non-preferred Brand	\$45
Self-Injectable and high technology medications	25% Mail Order (Maintenance Drugs) 90-day supply for two applicable copayments.
Diabetes Services Primary Care and Specialist office visits	\$25PCP/\$35SP Copay per visit
Equipment and Supplies	20% Copay for eligible expenses
Insulin	\$10 Copay for 30 day supply
Home Health Services	\$35 Copay per visit
Pain Management Services	20% of Health Plan Profile Copay per visit

*Maximum admission Copayments per contract year are \$3,000 for single contracts and \$6,000 for family contracts.

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** Health Plan Profile is the fee schedule established by Valley Baptist Health Plan.

*** Maximum coinsurance payments for injectable medications administered in office per contract year are \$3,000 for single contracts and \$6,000 for family contracts.

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SECTION 1 – REQUIREMENTS FOR ALL HEALTH CARE SERVICES

To be covered under Your Plan, health care services must meet all of the requirements described in this section.

A. MEDICAL NECESSITY. The service must be *medically necessary* as determined by the VALLEY BAPTIST HEALTH PLAN Medical Director. By *medically necessary*, We mean that the service meets *all* of the following conditions:

1. The service is required to diagnose, treat or prevent a covered illness or injury, or a medical condition, such as pregnancy;
2. If You have a covered illness or condition, it is a service You need in order to improve Your condition or to keep Your condition from getting worse;
3. It is generally accepted as safe and effective under standard medical practice in Your community; and
4. The service is provided in the most cost-efficient way, while still giving You an appropriate level of care.

Not every service that fits this definition is covered under Your Plan. To be covered, a medically necessary service must also be described in *Section 3, What Is Covered*. For example, We do not cover any preventive, family planning or infertility services not specified in Section 3. *Just because a Physician or other health care provider has performed, prescribed or recommended a service does not mean it is medically necessary or that it is covered under Your Plan.* (Also see *Section 5, What Is Not Covered*.)

B. PRIMARY CARE PHYSICIAN. Other than the exceptions described below, all Covered Health Services must be either:

1. Provided by Your Primary Care Physician (PCP); or
2. Referred or arranged by Your PCP after he or she has evaluated Your condition.

Your PCP is the Physician You choose from VALLEY BAPTIST HEALTH PLAN's network of Primary Care Physicians (or the one assigned to You by Us if You have failed to select one Yourself.) For visits to specialists, Your PCP must provide You with a referral *before* the services are provided. Remember to call VALLEY BAPTIST HEALTH PLAN and verify that Your referral to the specialist has been made. Without a valid referral, You will be responsible for all charges and may be required to sign a waiver indicating that You do not have a referral from Your Primary Care Physician.

For more information about who can serve as a PCP, please see the definition of "Primary Care Physician" in *Section 10, Definitions*.

Here are the only exceptions to the PCP referral requirement:

- Emergency and urgent care services that are covered under *Section 4, Emergency and Out-of- Area Urgent Care Services*; and
- Visits to Your designated Plan obstetrician or gynecologist for services within the scope of an obstetrics and gynecological specialty practice. Those services may include the annual well-woman exam, gynecological services and pre- and post-natal care. See *Your Right to Choose an Obstetrician or Gynecologist in this section*.

In addition to referral from Your PCP, some services also require Our pre-approval. *Section 3, What Is Covered* will tell You when Our pre-approval is required before services are received.

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C. YOUR RIGHT TO CHOOSE AN OBSTETRICIAN OR GYNECOLOGIST

As provided in the Texas Insurance Code Article 21.53D, You are permitted to designate an obstetrician or gynecologist to obtain direct access to the health care services provided by Your designated obstetrician or gynecologist, without a referral from Your PCP or prior authorization from Us. You are not required to choose an obstetrician or gynecologist, but may decide to have Your PCP provide these services or to make a referral for You to a VALLEY BAPTIST HEALTH PLAN obstetrician/gynecologist. If You need help choosing a VALLEY BAPTIST HEALTH PLAN obstetrician/gynecologist or to change Your Physician, You may call Our Customer Services Department at (800) 829-6440. If You prefer, You may also go to the VALLEY BAPTIST HEALTH PLAN link at www.trs.state.tx.us/trs-activecare.

Once You have selected a VALLEY BAPTIST HEALTH PLAN obstetrician/gynecologist, You do not need a referral from Your PCP or pre-approval from Us to make an appointment. You may call Your obstetrician or gynecologist's office directly to schedule Your office visit. Remember that You must select a VALLEY BAPTIST HEALTH PLAN network obstetrician/gynecologist *before* Your visit.

Your VALLEY BAPTIST HEALTH PLAN obstetrician/gynecologist may also refer You for treatment for a disease or condition that is within the scope of an obstetrics and gynecological specialty practice, including treatment of medical conditions concerning the breasts. However, if You need a referral for the treatment of any other type of disease or condition, this referral must be obtained from Your PCP before You receive services or resulting charges will not be covered.

For follow-up services related to the treatment of a disease or condition that is not within the scope of an obstetrics and gynecological specialty practice, You must return to Your PCP and obtain a referral to schedule an appointment for those follow-up services.

D. PLAN PROVIDERS

The service must be provided:

1. By a Physician or other health care professional who participates in the VALLEY BAPTIST HEALTH PLAN network; and
2. At a Hospital, laboratory or other facility that also participates in the VALLEY BAPTIST HEALTH PLAN network.

"Plan Providers" are health care providers in Your community who participate through a contract with VALLEY BAPTIST HEALTH PLAN to provide services to VALLEY BAPTIST HEALTH PLAN Members. The provider must be a Plan Provider at the time the service is rendered. A more detailed definition of Plan Provider appears in *Section 10, Definitions*.

For more information on participating providers, check the VALLEY BAPTIST HEALTH PLAN Provider Directory. Remember that the provider directory is subject to change, so You may want to call Our Customer Services Department at (800) 829-6440 or go to the VALLEY BAPTIST HEALTH PLAN link at www.trs.state.tx.us/trs-activecare for current information.

There are special circumstances under which You may obtain Covered Health Services from providers who are not part of the VALLEY BAPTIST HEALTH PLAN network:

- You may have to use out-of-network providers for emergency or out-of-area urgent care services described in *Section 4, Emergency and Out-of-Area Urgent Care Services*;
- If We determine medically necessary care cannot be provided by any health care provider participating in the VALLEY BAPTIST HEALTH PLAN network, Your PCP may refer You to an out-of-network provider. However, for these services, We must approve the referral at least five days in advance;
- Out-of-plan providers may be used in cases of court-ordered coverage for Dependent children who live outside of VALLEY BAPTIST HEALTH PLAN's Service Area. However, We must approve services that normally require a referral or Our prior approval (e.g.

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inpatient and outpatient procedures, rehabilitation, speech, occupational or physical therapies) in advance or it will not be covered. Please refer to the specific benefit coverage detailed in *Section 3, What Is Covered*;

- When We agree to continue coverage for the services of a provider who stops participating in the VALLEY BAPTIST HEALTH PLAN network, You may only use an out-of-area provider in accordance with the *Continuity of Coverage* provision in this section when these arrangements have been pre-approved by Us; or
- In all cases, out-of-plan providers will be reimbursed the Usual, Customary and Reasonable (UCR) Amount for care received or We will arrange to pay those providers directly at rates negotiated with the provider by VALLEY BAPTIST HEALTH PLAN.

E. ANCILLARY PROVIDERS

An Ancillary Provider is a provider with whom a PCP may be required to consult and/or coordinate referrals for certain Covered Health Services on Your behalf. Your PCP may be required to consult with an Ancillary Provider on Your behalf to provide certain services, such as mental health services or chemical dependency services. If You need to obtain information about the health care services that require consultation with an Ancillary Provider, the identity of the Ancillary Providers who coordinate referrals for such health care services in Your area, or a current list of providers of those health care specialty services in Your area, call Our Customer Services Department at (800) 829-6440.

F. CONTINUITY OF COVERAGE

You will be notified if You are under the care of a Plan Provider and he or she stops participating in the VALLEY BAPTIST HEALTH PLAN network. Special circumstances may exist where We will continue to provide coverage for that provider's services even though he or she is no longer a Plan Provider with Us. Special circumstances may include a person with a disability, an acute condition, a Life-Threatening illness or who is past the 24th week of pregnancy. We will continue to provide coverage only if all the following conditions are met:

- The provider submits a written request to Us for continued coverage of Your care. The request must (a) identify the condition for which You are being treated and (b) indicate that the provider reasonably believes that discontinuing his or her treatment of You could cause harm to You; and
- The provider agrees to continue accepting the same rate of reimbursement that applied when he or she was still a Plan Provider, and agrees not to seek payment from You for any amounts for which You would not be responsible if the provider were still participating in the VALLEY BAPTIST HEALTH PLAN network.

The continuity of coverage available under this section shall not exceed 90 days beyond the date the provider's termination takes effect, except for Members who are past the 24th week of pregnancy at the time the provider's termination takes effect. Coverage may be extended through delivery of the child, immediate postpartum care and the follow-up check-up within the first six weeks of delivery. You will continue to be responsible for appropriate Copayments. If the enrollee has been diagnosed with a terminal illness at the time of termination, coverage will continue for no more than nine months after the effective date of termination.

G. OTHER RESTRICTIONS

In addition to the general requirements described above, there are specific restrictions on Your coverage for some services. For instance, some services are only covered if We pre-approve them. There are also time limits on Your coverage for some services. These restrictions are described in *Section 3, What is Covered*.

H. COPAYMENTS

Copayments are the amounts You are required to pay to a Plan Provider or other authorized provider in connection with the provision of Covered Health Services. The Copayment amounts are indicated in the Schedule of Copayments.

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I. OUT-OF-POCKET MAXIMUM

Out-of-Pocket Maximum means the total amount You must pay each Plan Year before We pay benefits at 100% of the contract rate for Plan Providers and 100% of Usual, Customary and Reasonable (UCR) Amount for out-of-plan Providers. Out-of-Pocket Maximum amounts are amounts for which You and each Dependent are responsible during a Plan Year and are limited to a total of 200% of the total annual premium cost which is required to be paid by You or on Your behalf. Your Copayments count toward the Out-of-Pocket Maximum amount. The Out-of-Pocket Maximum *does not* include charges for non-covered services, prescription drug Copayments, and any amounts owed over Usual, Customary and Reasonable (UCR) Amount. You are responsible for informing Us when You have reached your Out-of-Pocket Maximum.

J. VALLEY BAPTIST HEALTH PLAN REVIEW

In making any decision about coverage of Your health care services under the Plan, We may consult with any health care professional or organization that We believe will be helpful, if permitted by law. We also have the right to have health care professionals of Our choice examine Your medical records and physical condition, if permitted by law. We may use this information to assist in the coordination of Your covered services (such as planning for Your care after You are discharged from the Hospital), to help Us in making decisions about pre-approval of services, and other decisions concerning Your coverage under the Plan.

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SECTION 2 – ELIGIBILITY

A. Employee Coverage

To be eligible to enroll as a VALLEY BAPTIST HEALTH PLAN Subscriber in the TRS-ActiveCare Program, You must:

- Live or work in the VALLEY BAPTIST HEALTH PLAN Service Area; and
- Be a full-time or part-time employee (including bus drivers) of a Participating Entity.

To determine if You are eligible, answer the following questions:

1. Are You an active contributing TRS Member?
2. Are You employed for 10 or more hours each week?

If the answer is yes to *either* question, then You are eligible for TRS-ActiveCare coverage *unless* You are also:

1. Receiving health care coverage as an employee or retiree under the Texas State College and University Employees Uniform Insurance Benefits Act, for example, a school employee that has UT Select coverage as an employee with The University of Texas.
2. Receiving health care coverage as an employee or retiree under the Texas Employee Uniform Group Insurance Benefits Act, for example, a school employee that has HealthSelect coverage as an employee with ERS.
3. A TRS retiree receiving, or who waived coverage, under TRS-Care, including a retiree who has returned to work.

Note: Although a retiree, a higher education employee or a state employee may not be covered as an **employee** of a Participating Entity, he or she can be covered as a **Dependent** of an eligible employee.

B. Dependent Coverage

Eligible dependents of a covered employee include Your legal spouse (including common law) and an unmarried child under the age of 25 described by any of the following:

1. A natural or adopted child;
2. A stepchild;
3. A foster child;
4. A child under the legal guardianship of the employee;
5. A child in a regular parent-child relationship with the employee, meaning that:
 - a. The child's primary residence is the household of the employee;
 - b. The employee provides at least 50% of the child's support;
 - c. Neither of the child's natural parents reside in that household; and
 - d. The employee has the legal right to make decisions regarding the child's medical care.
6. A grandchild whose primary residence is the household of the employee and who is a Dependent on the employee for federal income tax purposes, and who otherwise meets the eligibility requirements above. Coverage may not be terminated solely because the covered child is no longer You or Your spouse's Dependent for federal income tax purposes; and
7. A child of a covered employee, regardless of age, may be eligible for Dependent coverage provided the child is either mentally retarded or physically incapacitated to such

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an extent to be dependent on the employee on a regular basis and meets other requirements as determined by TRS-ActiveCare.

8. Be a newborn child of You or Your spouse. To make sure Your child has continued coverage, generally, You must enroll Your newborn as a Dependent within 60 days following Your child's birth, and pay any necessary premium charges. If the employee has family or employee and child(ren) coverage with TRS-ActiveCare at the time of birth, coverage for a newborn child may be added up to a year from the date of birth.

If Your newborn child is born outside the VALLEY BAPTIST HEALTH PLAN Service Area due to an emergency, or is born in an out-of-plan facility to a mother who does not have coverage under this Evidence of Coverage, We may require transfer to a network facility and, if applicable, to a Plan Provider. Such transfer must be medically appropriate and approved by the newborn's treating Physician.

9. A child for whom the employee must provide medical support pursuant to a valid order from a court of competent jurisdiction. A child eligible under this provision is not required to reside in the Service Area.

If an employee and spouse both work for a Participating Entity, the spouse may be covered as an employee or as a Dependent of an eligible employee. Only one parent may enroll Dependent children for coverage.

An unmarried child (under age 25) who is employed by a Participating Entity and is a contributing TRS Member cannot be covered as a Dependent on his or her parent's TRS-ActiveCare coverage. This child must be covered as an employee of the Participating Entity. If the child is not a contributing TRS Member, the child may be covered as a Dependent.

Note: Eligible Members residing outside the Service Area must return to the VALLEY BAPTIST HEALTH PLAN Service Area to receive Covered Health Services. Emergency services that meet the requirements for coverage under *Section 4, Emergency and Out-of-Area Urgent Care Services* are covered.

C. Effects of Medicare Eligibility

Medicare eligibility does not change eligibility under this Evidence of Coverage. Medicare eligibility does affect the way benefits are coordinated. Refer to *Section 7, Coordination of Benefits*, for information on primary and secondary coverage.

D. Enrollment

No person meeting Subscriber or Dependent eligibility requirements will be refused enrollment or re-enrollment because of current health status, age, or requirements for health care services because of a pre-existing physical or mental condition on the effective date of coverage, including pregnancy. No Member's coverage shall be terminated due to a Member's health status or health care needs.

1. Initial Enrollment

Each eligible employee of a Participating Entity shall be permitted to apply for coverage for himself or herself and eligible Dependents during the initial Plan Enrollment Period. All persons included for coverage must be listed on the Enrollment Form. No proof of insurability shall be required.

2. Plan Enrollment Period

A Plan Enrollment Period is a time when You and/or Your dependents (if eligible) may enroll as Members of VALLEY BAPTIST HEALTH PLAN. No proof of insurability shall be required.

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3. Newly Eligible Employee

Each new employee of the Participating Entity who becomes eligible for coverage at other than the initial enrollment or open enrollment period shall be permitted to enroll himself or herself and eligible Dependents within the applicable enrollment period of becoming eligible.

4. Newly Eligible Dependents

If You wish to enroll a newly eligible Dependent due to marriage, birth, adoption, Your becoming party in an adoption lawsuit, a court order, or Your grandchild becoming Your Dependent for federal income tax purposes, You must enroll this Dependent within 31 days of the Dependent becoming eligible (generally 60 days for newborns). If a newly eligible Dependent is not added within the 31 days of the date establishing eligibility (generally 60 days for newborns), that Dependent cannot be added to coverage until the next Plan Enrollment period. If the employee has family or employee and child(ren) coverage with TRS-Active Care at the time of birth, coverage for a newborn child may be added up to a year after the date of birth.

5. Limitation

Persons initially or newly eligible for enrollment who do not enroll within the applicable enrollment period as described below may only be enrolled during a subsequent Plan Enrollment Period.

6. Notice of Ineligibility

It is Your responsibility to notify VALLEY BAPTIST HEALTH PLAN and Your employer of any changes that will affect Your or Your Dependent's eligibility for services or benefits under this benefit Plan within 31 days of the event.

E. Effective Date of Coverage

VALLEY BAPTIST HEALTH PLAN must receive Your enrollment information before coverage under this benefit Plan becomes effective. Coverage of medically necessary health services becomes effective on the earliest of the following dates:

1. Initial Enrollment and Plan Enrollment

Coverage shall be effective on the date agreed upon by the Group and VALLEY BAPTIST HEALTH PLAN.

2. Newly Eligible Employees

Coverage will be effective on Your actively at work date, or the first day of the month following Your actively at work date, whichever You choose. If You are hired after September 1, 2003, and are not a TRS member as of the date of employment, You can choose the first day of the calendar month in which You satisfy the 90-day waiting period.

3. Newly Eligible Dependents

Coverage will be effective on the date of the event establishing eligibility, (for example, marriage, adoption, guardianship, or birth). Appropriate enrollment forms must be completed and submitted to Your Benefit Administrator within 31 days of the event (generally 60 days for newborns). You or Your spouse's newborn children and the newborn children of Your enrolled Dependents are covered for the first 31 days from the date of birth. Continued coverage for these newborn children is dependent upon enrollment as explained above. Newly eligible Dependents, not added to coverage within 31 days of the event (generally 60 days for newborns) may not be added until the next Plan Enrollment Period. If the employee has family or employee and child(ren) coverage with TRS-Active Care at the time of birth, coverage for a newborn child may be added up to a year after the date of birth.

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A child for whom You or Your spouse is seeking adoption may be enrolled within either of the following time periods:

- Thirty-one (31) days after You or Your spouse become a party in a suit for adoption; or
- Thirty-one (31) days of the date the adoption is final.

F. Late Enrollee

A Late Enrollee is an eligible employee or Dependent who applies for coverage after the expiration of the initial enrollment period established through TRS or after the expiration of the Plan Enrollment Period. An eligible employee or Dependent requesting enrollment as a Late Enrollee shall be excluded until the next Plan Enrollment Period.

Who is Not a Late Enrollee?

You or Your Dependent is not a late enrollee if:

You or Your Dependent:

- a. Were covered under another health benefit plan or self-funded employer health benefit plan during the time You or Your Dependent were eligible to enroll; and
 - b. Declined coverage in writing during the time You or Your dependent were eligible to enroll stating the basis for declining coverage was coverage under another health benefit plan or self-funded employer health benefit plan; and
 - c. Has coverage under the other health benefit plan or self-funded employer health benefit plan is ending due to termination of the plan, reduction in the number of hours of employment, termination of employment, termination of contributions toward the premium made by the employer, death of a spouse, or divorce; and
 - d. Requests enrollment within 31 days after the date coverage ends under the other health benefit plan or self-funded employer health benefit plan.
- Is employed by an employer who offers multiple health benefit plans and You elect a different health benefit plan during a Plan Enrollment Period.
- Is under a court order to provide coverage for an Employee's child and the request for enrollment is made within 31 days from the date Your Employer receives notification of the court order.
- Is under a court order to provide coverage for an Employee's spouse and request for enrollment is made within 31 days after issuance of the court order.
- As an eligible employee has a change in family composition due to marriage, birth of a child, adoption of a child or becoming a party in a suit for the adoption of a child and requests enrollment within 31 days of marriage, birth, adoption of the date the Member becoming a party in a suit for the adoption of a child.
- As an individual becomes a Dependent due to marriage, birth of a child, adoption of a child or an eligible employee becoming a party in a suit for the adoption of a child and requests enrollment within 31 days of marriage, birth, adoption, or becoming a party in a suit for the adoption of a child.

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SECTION 3 – WHAT IS COVERED

This section describes:

- The health care services covered under Your Plan; and
- Restrictions and limitations related to a specific type of health care service, including whether We must pre-approve the service for it to be covered. Your Copayment (if any) can be found in the Schedule of Copayments.

PLEASE REFER TO THE SCHEDULE OF COPAYMENTS FOR COPAYMENT AMOUNTS AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

A. Outpatient Services

The outpatient services covered by Your Plan are:

1. Physician Office Visits

We cover visits to the Physician's office for diagnosis or treatment of an illness or injury.

The office visit Copayment applies when You have patient contact with the Physician, physician assistant, nurse, or nurse practitioner.

2. Physicians Services at Home

We cover Physician services provided to You in Your home, but only if You are unable to leave Your home for medical reasons and the services could not be performed by someone who is not a Physician.

3. Laboratory Services

We cover medically necessary laboratory services when the PCP, a Plan Provider, or other authorized referral Physician prescribes them.

4. Radiology Services

We cover x-rays and other radiology services needed for diagnosis and/or treatment.

5. Surgical Procedures In Your Physician's Office

We cover surgical procedures performed in Your Physician's office.

If the surgical procedure involves general anesthesia or is performed in a Plan surgical facility, it must meet the requirements for outpatient surgery (including Copayment and pre-approval by Us). Please see *Outpatient Surgery* in this section.

6. Materials Provided In Your Physician's Office

We cover materials and supplies that are generally available in the Physician's office, and are administered or applied during an office visit. Such covered materials or supplies included but are not limited to those necessary for:

- Inhalation therapy and other medically necessary respiratory therapies;
- The administration of medications or Injectable Drugs; and
- Dressings, casts and splints (where splints are commonly used instead of casts).

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7. Injectable Drugs

We cover Injectable Drugs administered in Your Physician's office or in an outpatient facility. Refer to the Schedule of Copayments for details.

8. Pre-Natal And Post-Natal Obstetrical Care

We cover Physician services for pre-natal and post-natal office visits. We also cover amniocentesis and chorionic villus sampling when medically indicated.

9. Rehabilitation, Speech, Occupational And Physical Therapy

We cover medically necessary outpatient rehabilitation including: speech, cardiac rehabilitation, occupational, and physical therapy services that meet these conditions:

- Your PCP, or the specialist to whom You have been correctly referred, orders such rehabilitation or therapy services; and
- The services can be expected to meet or exceed the treatment goals established for You by Your Physician.

Your coverage is limited to services that continue to meet or exceed the treatment goals established for You. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of other deterioration.

10. Acquired Brain Injury

We provide coverage for certain benefits related to acquired brain injury. Coverage includes the following services:

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy and rehabilitation;
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment;
- Neurofeedback therapy;
- Remediation;
- Post-acute transition services; or
- Community reintegration services necessary as a result of and related to an acquired brain injury.

11. Outpatient Surgery

We cover outpatient surgery performed in an outpatient surgery facility and same-day surgery performed in a Hospital, including invasive diagnostic procedures such as endoscopic examinations, if:

- Your PCP refers You, or the specialist to whom You have been correctly referred, orders or arranges the surgery; and
- We pre-approve the service.

12. Pain Management Services

We cover medically necessary Pain Management treatment and related services. All covered services must meet these conditions:

- Your PCP or the specialist to whom You have been correctly referred, orders such pain management services;

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- Services can be expected to meet or exceed treatment goals established for You by Your Physician;
- Services are scientifically proven and evidence-based to improve Your medical condition; and
- Services must be pre-approved by Us.

13. Allergy Testing And Injections

We cover medically necessary allergy testing performed to evaluate and determine the cause of allergy. We also cover appropriate allergy treatments including injections and serum.

14. Short Term Outpatient Mental Health Services

Short-term outpatient evaluation and treatment for mental illnesses and disorders are covered when all of these conditions are met:

- The mental illness or disorder being treated is listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders when the services are provided.
- There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning manifesting itself predominately in at least two settings, for example, at home and at school or work.
- The services must be for evaluation or crisis intervention.
- The behavioral health provider must pre-approve services.

The initial evaluation, diagnosis and medical management of attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) are also covered. Ongoing medication management is covered when provided by Your PCP. Visits for medication management are not included in the maximum allowed visits.

Treatment for certain mental illnesses is not covered. Refer to *Section 5, What is Not Covered*.

15. Serious Mental Illness Services

Treatment of serious mental illness is covered if the mental illness or disorder being treated is one of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence.

The contracted behavioral health provider must pre-approve all serious mental illness services.

Coverage is provided for serious mental illness, including group and individual outpatient treatment. Outpatient visits for the purpose of medication management of serious mental illnesses are treated the same as any physical illness and are not included in the maximum allowed visits.

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16. Chemical Dependency Treatment

Medically necessary outpatient treatment for chemical dependency (abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance) is covered. Coverage is limited to a lifetime maximum of three separate chemical dependency treatment series for each Member. A series of treatments is a planned, structured, and organized program to promote chemical free status. The series may include different facilities or modalities and is complete when the Member:

- Is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial Hospitalization, or intensive outpatient;
- Completes a series of these levels of treatment without a lapse in treatment; or
- Fails to materially comply with the treatment program for 30 days.

The contracted behavioral health provider must pre-approve all chemical dependency services.

PLEASE REFER TO THE SCHEDULE OF COPAYMENTS FOR COPAYMENT AMOUNTS AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

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B. Preventive Health Care Services

PLEASE REFER TO THE SCHEDULE OF COPAYMENTS FOR COPAYMENT AMOUNTS AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

The preventive health care services covered by Your Plan are:

1. Routine Physical Exams

We cover routine exams by Your PCP for Plan Members 18 years of age or older. Your PCP decides how often and extensive these exams should be, based on national and regional medical standards of care.

2. Well-Baby And Well-Child Care

We cover well-baby and well-child preventive care by Your PCP for Plan Members through age 18. Your PCP decides how frequent and extensive this care should be, based on national and regional medical standards of care.

3. Routine Immunizations

We cover routine immunizations recommended by the American Academy of Pediatrics and U.S. Public Health Service for people in the United States, including immunizations for travel outside the United States. However, We do not cover immunizations for employment, school sports or extracurricular activities, or recreation activities. We cover routine immunizations for children and adolescents as recommended or approved by the Food and Drug Administration (FDA) and the Center for Disease Control (CDC). Immunizations must be properly ordered and directed by Your PCP.

4. Well-Woman Examinations

For women who are Plan Members, We cover one well-woman gynecological exam per Plan Year. You may choose to have Your PCP or Your designated obstetrician/gynecologist perform the well-woman exam. These exams include Pap smears on the schedule recommended by the examining Physician, based on national and regional medical standards of care.

5. Screening Mammogram

We cover screening mammograms (non-diagnostic) to detect breast cancer according to guidelines as developed by the American College of Obstetrics and Gynecology (ACOG). Mammograms may be obtained by referral from Your Plan obstetrician/gynecologist or PCP, whether or not a well-woman examination is performed at the same time.

6. Bone Mass Measurement

These services include bone mass measurement for the detection of low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis.

7. Examination for Detection of Prostate Cancer

We cover an annual prostate examination by Your PCP to detect prostate cancer, including a physical examination and a prostate-specific antigen (PSA) test. Not all men need this examination; however You are eligible for this benefit if You are at least 50 years old, or at least 40 years old with a family history of prostate cancer or other recognized prostate cancer risk factors.

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8. Screening for Detection of Colorectal Cancer

We cover screening examinations and procedures for Plan Members 50 years old or older and at a normal risk for developing colon cancer. These exams include fecal occult blood tests performed annually, a flexible sigmoidoscopy performed every five years, or a colonoscopy performed every 10 years.

9. Routine Sight, Speech And Hearing Screening

We cover routine screenings of vision, speech and hearing for Plan Members through age 18, when performed by the Member's PCP. We also cover one hearing screening every Plan Year for all Members when performed by Your PCP. A screening test for hearing loss is covered for a newborn child through the date the child is 30 days old. We also cover the necessary diagnostic follow-up care related to the screening test through the date the child is 24 months old.

We *do not* cover eye exams to prescribe glasses or contact lenses, even after vision surgery (except for Keratoconus).

PLEASE REFER TO THE SCHEDULE OF COPAYMENTS FOR COPAYMENT AMOUNTS AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

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C. Family Planning and Infertility Services

PLEASE REFER TO THE SCHEDULE OF COPAYMENTS FOR COPAYMENT AMOUNTS AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

1. Family Planning

We cover these family planning services when Your PCP or Your designated obstetrician/gynecologist provides them.

- Physical exams, related laboratory tests and medical supervision; and
- Information and counseling on contraception.

Coverage is provided for the following contraceptive materials and services:

- Insertion or removal of an intrauterine device (IUD);
- Fitting a diaphragm contraceptive;
- Insertion or removal a birth control device implanted under the skin (such as Norplant);and
- Vasectomies and tubal ligations-

2. Infertility Services

We cover these infertility services, if We have pre-approved them:

- Diagnostic testing to determine the cause of infertility; and
- Medical services for artificial insemination.

However, We do not cover infertility drugs; reversal of voluntary sterilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); In Vitro fertilization; any costs related to surrogate parenting; infertility services required because of a sex change by the Member or the Member's partner; or any assisted reproductive technology or other treatment related to infertility that is not specified above.

PLEASE REFER TO THE SCHEDULE OF COPAYMENTS FOR COPAYMENT AMOUNTS AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

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D. Inpatient Services

PLEASE REFER TO THE SCHEDULE OF COPAYMENTS FOR COPAYMENT AMOUNTS AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

To be covered, all admissions must be to a Plan Hospital, skilled nursing facility or other inpatient facility and be pre-approved by Us. The only exception to this requirement is admissions covered under *Section 4, Emergency and Out -of-Area Urgent Care Services*. Inpatient services must be prescribed, directed or arranged by Your PCP. If We determine that medically necessary services cannot be performed at one of Our participating inpatient facilities, We will approve admissions to out-of-plan facilities.

We will approve inpatient admissions only for the length of time that is medically necessary. We will, however, approve inpatient admissions for obstetrical services and mastectomy or related procedures in accordance with the standards described below. If You stay longer than the time We authorize, You will have to pay the charges for Your additional stay.

- **Obstetrical Services.** We cover inpatient care following childbirth for You and Your newborn child for a minimum of 48 hours following an uncomplicated vaginal delivery, and 96 hours following an uncomplicated delivery by cesarean section, if determined to be medically necessary by Your Physician or requested by You and Your Physician.

In the event that You or Your newborn is discharged from inpatient care before the expiration of the minimum hours of coverage described above, We will cover a post-delivery outpatient visit. The post-delivery visit may take place at Your provider's office or in Your home. Post-delivery care services include maternal and neonatal physical assessments (physical evaluations for both You and Your newborn); parent education, assistance and training in breast-feeding and bottle-feeding; and the performance of any medically necessary and appropriate clinical tests. A Physician, registered nurse or other licensed health care professional may provide the services. This visit is in addition to Your coverage for outpatient post-natal obstetrical care. See *Pre-Natal and Post Natal Obstetrical Care* in this section.

- **Mastectomy or Related Procedures.** We cover inpatient care following a mastectomy or related procedures for the treatment of breast cancer for a minimum of 48 hours and 24 hours following a lymph node dissection, unless You and Your attending Physician determine that a shorter period of inpatient care is appropriate.

We cover reconstruction of a breast incident to mastectomy, including surgical reconstruction to restore or achieve breast symmetry or balance of a breast on which mastectomy surgery has not been performed.

1. Semi-private Room, Meals and Nursing Care

We cover a semi-private room, meals and general nursing care. We will cover a private room only if it is necessary for isolation due to an infectious disease or immune problem and We have pre-approved it. If a semiprivate room is not available, We will cover a private room until a semi-private room becomes available. You may choose a private room even if We do not pre-approve it, but You must pay the difference between the cost of the private room and a semi-private room.

We cover special diets if they are medically necessary and prescribed by a Physician. We cover special duty nursing only in exceptional cases. Your Physician must recommend it and We must pre-approve it.

2. Medical, Surgical and Obstetrical Services

We cover these medical, surgical and obstetrical services:

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- Physician services;
- Operating room and related facilities;
- Anesthesia and oxygen services;
- Intensive care and other special care units and services;
- X-ray, laboratory and other diagnostic tests;
- Prescription medications and biologicals for use while You are an inpatient;
- Radiation and inhalation therapies; and
- Whole blood, blood derivatives or blood components and their administration.

3. Observation Unit Admission

We cover admissions to the Observation Unit of a Hospital or other approved facility if the following conditions are met:

- The admission for observation is ordered by Your PCP or other specialist to whom You have been properly referred; and
- We pre-approve such admission.

4. Rehabilitation, Speech, Occupational, and Physical Therapy

We cover inpatient rehabilitation, speech, occupational and physical therapy services, including cardiac rehabilitation services that meet all of these conditions:

- Your PCP refers You, or the specialist to whom You have been correctly referred, orders such rehabilitation or therapy services;
- The services can be expected to meet or exceed the treatment goals established for You by Your Physician; and
- We pre-approve the services.

Your coverage is limited to services that continue to meet or exceed the treatment goals established for You. For a physically disabled person, treatment goals include maintenance of functioning or prevention of or slowing of further deterioration.

5. Skilled Nursing Facility

We cover inpatient care in a skilled nursing facility if it meets all of these conditions:

- If You were not admitted to a skilled nursing facility, You would need acute care hospitalization;
- The skilled nursing services are of a temporary nature and will lead to rehabilitation and increased ability to function;
- Your PCP or attending specialist refers You; and
- We pre-approve the services.

We *do not* cover custodial care as described in *Section 5, What Is Not Covered*.

6. Short-Term Mental Illness Services

Short-term evaluation and crisis intervention is covered for Members and Dependents who are demonstrating an acute psychiatric crisis of severe proportions, which substantially impairs thoughts, perception of reality, judgment or grossly impairs behavior.

Limited inpatient coverage is provided for acute psychiatric conditions when referred or arranged by Your PCP through the behavioral health provider. Treatment may be provided in any combination of treatment days as follows:

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- One day in an approved inpatient psychiatric Hospital equals one inpatient treatment day.
- One day in an approved Psychiatric Day Treatment Facility equals one-half inpatient treatment day.
- One day in an approved Crisis Stabilization Unit or Adolescent Residential Treatment Center for Children and Adolescents equals one-half inpatient treatment day.

The contracted behavioral health provider must pre-approve all services. Call VALLEY BAPTIST HEALTH PLAN Customer Services at (800) 829-6440 for additional information.

Treatment for certain mental illnesses is not covered. Refer to *Section 5, What is Not Covered*.

7. Serious Mental Illness Services

Treatment for serious mental illness is covered if the mental illness or disorder being treated is one of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence.

Limited inpatient coverage is provided for acute psychiatric conditions when referred or arranged by Your PCP through the behavioral health provider. Treatment may be provided in any combination of treatment days as follows:

- One day in an approved inpatient psychiatric Hospital equals one inpatient treatment day;
- One day in an approved Psychiatric Day Treatment Facility equals one-half inpatient treatment day; or
- One day in an approved Crisis Stabilization Unit or Adolescent Residential Treatment Center for Children and Adolescents equals one-half inpatient treatment day.

The contracted behavioral health provider must pre-approve all services. Call VALLEY BAPTIST HEALTH PLAN Customer Services at (800) 829-6440 for additional information.

8. Chemical Dependency Treatment

Inpatient treatment for chemical dependency (abuse of, psychological or physical dependence on, or addiction to alcohol or a Controlled Substance) is covered if the behavioral health provider pre-approves treatment.

Treatment for Chemical Dependency is limited to a lifetime maximum of three separate series of treatments for each Member. A series of treatments is a planned, structured and organized program to promote chemical free status. Treatment is considered complete when the Member is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient, or a series of these

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levels of treatments without a lapse in treatment. Treatment may also be considered complete or terminated when a Member does not comply with the treatment program for a period of 30 days.

PLEASE REFER TO THE SCHEDULE OF COPAYMENTS FOR COPAYMENT AMOUNTS AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

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E. Other Health Care Services

PLEASE REFER TO THE SCHEDULE OF COPAYMENTS FOR COPAYMENT AMOUNTS AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

1. Home Health Care

We cover medically necessary services for the care and treatment of a covered illness or injury provided in Your home. Covered home health care services must meet all of these conditions:

- The services could only be provided by a health professional;
- The services must be provided by a participating Home Health Agency;
- Your PCP refers You or arranges the services; and
- We pre-approve the services.

However, We *do not* cover custodial care as described in *Section 5, What Is Not Covered*.

2. Non-Emergency Ambulance Transport Service

We cover non-emergency ambulance transport (for example, a Member is discharged from an inpatient facility and needs to be moved to a skilled nursing facility). Non-emergency ambulance transport must meet these conditions:

- It is medically necessary; and
- We pre-approve the service.

Ambulance transport services for convenience are not covered.

For emergency ambulance services, see *Section 4.C, Emergency and Out-of-Area Urgent Care*.

3. Reconstructive Surgery Services

We cover health care services for the following:

- Surgery to correct a functional defect which results from a congenital and/or acquired disease or anomaly;
- Surgery to correct a seriously disfiguring condition resulting from accidental injury;
- Surgery incidental to the treatment of disease, including breast reconstruction necessitated by a mastectomy. Reconstruction of the unaffected breast will be covered when necessary to achieve symmetry. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy are covered. Initial breast reconstruction resulting from a mastectomy that occurred prior to the effective date of coverage is a covered benefit; and
- Surgery for a child who is younger than 18 years of age for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease.

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4. Non-Cosmetic Prosthetic Devices

Internal. We cover internal, non-cosmetic prosthetic, orthotic, and implantable devices, including permanent aids and supports for defective parts of the body. All prosthetic devices must be referred or arranged by Your PCP and pre-approved by Us.

Examples of covered internal prosthetic devices include: joint replacements, cardiac valves, internal cardiac pacemakers, and intra-ocular implantable lenses following cataract surgery or to replace an organic lens missing because of congenital absence. Benefits are provided for implantable lenses in connection with surgery for cataracts or other diseases of the eye or to replace an organic lens missing because of congenital absence. Contact lenses are covered for the treatment of Keratoconus only.

We also cover the replacement, repair and maintenance of any covered internal prosthetic device. However, We *do not* cover mechanical organ replacement devices such as artificial hearts.

External. We cover standard external, non-cosmetic prosthetic devices if We pre-approve them. Examples of covered prosthetic devices include, artificial arms, legs, hands, feet and eyes, breast prostheses and surgical brassieres after mastectomy for breast cancer.

We do not cover repair or maintenance of any external prosthetic device. We do not cover replacement of any external prosthetic device, except for standard replacements needed because of physical growth by Members who are under 18 years of age.

5. Durable Medical Equipment and Supplies

The following durable medical equipment and supplies are covered as a basic Plan Benefit:

Durable Medical Equipment

Durable Medical Equipment (DME) is medical equipment that in the absence of illness or injury is of no medical or other value to You, which is able to withstand repeated use by more than one person, and is not disposable. Examples of such equipment include; crutches, Hospital beds, and wheelchairs.

Coverage is provided for the medically necessary DME meeting the following conditions:

- DME must be ordered or prescribed by a health care provider and provided by a contracted supplier;
- DME must be medically necessary as determined by the Medical Director;
- DME may be purchased or rented, whichever is most cost effective, as determined by the Medical Director; and
- Coverage is provided for the initial equipment only.
- Only the standard equipment is covered. Special features which are not part of the basic equipment are not covered, such as electric beds, electric wheelchairs.

In the event it is determined to be more cost effective to purchase or when the rental payments equal the purchase price of any DME, then that DME becomes the property of the company. You are responsible for any replacement, repair, adjustment or routine maintenance of Your equipment. Repairs are covered if the need for repair is not caused by neglect or abuse of the equipment.

The following items are not included in the DME limitation:

- Oxygen and mechanical equipment necessary for treatment of chronic or acute respiratory failure;
- Durable medical equipment used for the treatment of diabetes; and

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- Monitoring devices, such as apnea monitors, uterine monitors, for use in the home when prescribed and directed by health care provider.

Medical Supplies

- Medical supplies used for the treatment of diabetes are covered. Examples of these supplies include test strips, lancets and lancet devices. For a more complete listing of these supplies, see the definition of *Diabetes Supplies* in Section 10, *Definitions*.
- Standard ostomy supplies, sterile dressing kits, such as tracheostomy and central line dressing kits, as well as those medical supplies requiring a Physician's order to purchase, when purchased through a participating Plan Provider. Supplies, which can be purchased over-the-counter without a Physician order, are not covered. See Section 5, *What is Not Covered*.
- Allergy syringes.

6. Diabetic Services

For those Members diagnosed with diabetes, elevated blood glucose levels induced by pregnancy or other medical conditions associated with elevated blood glucose levels, diabetic supplies, equipment, medications and self-management education for the treatment of diabetes are covered. An annual eye examination is also covered for Members or Dependents with diabetes.

Diabetic Equipment and Supplies

See *Durable Medical Equipment and Supplies* in this section.

Diabetic Medications

The following medications for the treatment of diabetes are covered:

- Insulin;
- Insulin analog preparations;
- Prescriptive and non-prescriptive medications for controlling blood sugar levels; and
- Glucagon emergency kits.

Medications are limited to a 30-day supply when purchased through a retail Plan pharmacy or a 90-day supply when purchased through a Participating Mail Service Pharmacy. For information on participating pharmacies, see the Provider Directory or call the VALLEY BAPTIST HEALTH PLAN Customer Services Department at (800) 829-6440 or go to the VALLEY BAPTIST HEALTH PLAN link at www.trs.state.tx.us/trs-activecare.

Diabetic Self-Management Education

Diabetes self-management training programs are covered when ordered by Your Physician and provided by a licensed Plan Provider under the following circumstances:

- After the initial diagnosis, including nutritional counseling and proper use of Diabetes Equipment and Supplies;
- When the provider diagnoses a significant change in the condition which requires a change in Your self-management regimen; or
- When the provider prescribes, orders or recommends such additional training in order to teach the Member about new techniques and treatments for diabetes.

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7. Hearing Aids

Hearing aids will be provided when determined to be medically necessary by a Plan Physician and pre-approved by Us. Hearing aids must be obtained from a Plan Provider. We do not cover hearing aid batteries, temporary or disposable hearing aids, nor repair or replace hearing aids due to normal wear and tear, loss or damage.

8. Limited Dental-Related Services

We provide limited coverage for these dental services for the restoration and correction of damage caused by external violent accidental injury and certain oral surgeries:

- a. Treatment of a fractured or dislocated jaw if:
 - The fracture or dislocation results from an accidental injury;
 - Both the injury and treatment occur while Your coverage under this Plan is in effect;
 - Your PCP refers You or arranges the treatment; and
 - We pre-approve the services.
- b. Removal of cysts of the mouth (except for cysts directly related to the teeth and their supporting structures), if:
 - Your PCP refers You or arranges the service; and
 - We pre-approve the services.
- c. Medical services performed in an outpatient facility and are required for the delivery of necessary and appropriate dental services when the dental services cannot be safely provided in a dentist's office due to the Member's physical, mental or medical condition. The services must meet all of these requirements:
 - Your PCP refers You or arranges the services; and
 - We pre-approve the services.
- d. Diagnosis and surgical treatment of disorders of and conditions affecting the temporomandibular joint, which includes the jaw and the cranio-mandibular joint resulting from an accident, a trauma, a congenital defect, a developmental defect or a pathology. These services must meet all these requirements:
 - Your PCP refers You; and
 - We pre-approve the services.

The services described above are the only dental-related services covered under Your Plan. See *Section 5, What Is Not Covered*.

9. Temporomandibular Joint syndrome (TMJ) Services

We provide coverage for the diagnosis and surgical treatment of disorders of, and conditions affecting the temporomandibular joint, which includes the jaw and the cranio-mandibular joint resulting from an accident, trauma, congenital defect, developmental defect, or a pathology. You must obtain a referral from Your PCP, and We must pre-approve the services before You receive treatment.

We do not cover oral appliances and devices used to treat temporomandibular pain disorders and dysfunction of the joint and related structures, such as the jaw, jaw muscles, and nerves. See *Section 5, What is Not Covered*.

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10. Dialysis Services

We cover dialysis services if Your PCP refers You and We pre-approve the services.

11. Organ Transplants

We cover the following transplants:

- Corneal transplants;
- Liver transplants;
- Pancreatic transplants;
- Heart transplants;
- Lung transplants;
- Heart-Lung transplants;
- Kidney transplants; and
- Bone marrow transplants.

The above list of covered transplants must meet the following conditions or they will not be covered:

- A contracted and/or nationally recognized medical facility designated by VALLEY BAPTIST HEALTH PLAN to evaluate the Member's case has determined that the proposed transplant is appropriate for treatment of the Member's condition and has agreed to perform the transplant;
- The proposed transplant is not experimental or investigational for treatment of the Member's condition, and is not to be performed in connection with a drug, device or medical treatment or procedure that is experimental or investigational; and
- We pre-approve the services.

For a covered transplant to a Plan Member, medical costs for the removal of organs, tissues, or bone marrow from a live donor will be covered, but only to the extent that such costs are not covered by the donor's group or individual health plan, benefit contract, prepayment plan or other arrangement for coverage of medical costs, whether on an insured or uninsured basis. If the donor is also a Member of VALLEY BAPTIST HEALTH PLAN, coverage is subject to all procedures, limitations, exclusions, Copayments and deductibles that apply under the donor-Member's plan. We do not cover any other donor expenses, including any transportation costs.

The only types of transplants covered by this Plan are the above listed transplants. Additionally, We do not cover mechanical organ replacement devices, such as artificial hearts.

12. Chemotherapy

We cover chemotherapy services if Your PCP refers You and the services are provided by a Plan Provider or a provider who is otherwise approved by VALLEY BAPTIST HEALTH PLAN.

13. Radiation Therapy

We cover radiation therapy services if Your PCP refers You and the services are provided by a Plan Provider or a provider who is otherwise approved by VALLEY BAPTIST HEALTH PLAN.

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14. Blood and Blood Products

Whole blood, blood plasma, blood derivatives, or blood components and their administration are covered in an inpatient or outpatient setting.

15. Hospice Services

We cover the care and treatment of a Member by a participating hospice if these conditions are met:

- The services are provided by a participating hospice provider licensed by the State of Texas;
- Your Plan Physician has certified that the Member has a limited life expectancy of 6 months or less due to a terminal illness;
- Your PCP must refer or arrange the services; and
- We pre-approve the services.

Covered services include the provision of pain relief, symptom management and supportive services to terminally ill Members and their immediate families on both an outpatient and inpatient basis.

16. Prescription Drug Benefits

Coverage for Prescription Drugs included in the approved VALLEY BAPTIST HEALTH PLAN Preferred Drug List is provided when prescribed by Your PCP or authorized referral Physician. The VALLEY BAPTIST HEALTH PLAN Preferred Drug List is a comprehensive list of medications consisting of generic drugs and single source (sometimes referred to as brand name) drugs. Single source drugs are those drugs that do not have a generic equivalent.

Covered Benefits:

- Medically Necessary Prescription Drugs including Generic drugs and drugs listed in the VALLEY BAPTIST HEALTH PLAN PDL. When a Generic Drug is available and the Brand Name is dispensed, You will be responsible for the Generic Drug Copayment plus the difference between the cost of the Generic Drug and the cost of the Brand Name Drug, even if Your Physician prescribes a name brand drug.
- Medically Necessary Prescription Drugs that are not contained in the VALLEY BAPTIST HEALTH PLAN PDL. These drugs are covered at a higher Copayment.
- Compound medications must contain at least one Legend Drug.
- Pre-natal vitamins.
- Formulas necessary for the treatment of Phenylketonuria (PKU) or other Heritable Disease.
- Contraceptive prescription drugs.
- Injectable medications recognized by the FDA as appropriate for self-administration (referred to as "Self-Injectable" Drugs), regardless of the Member's ability to self-administer.
- Immuno-suppressive drugs used for pre-authorized organ transplants.

Prescription Drug Limitations and Exclusions

- Certain medications are subject to dispensing limitations based upon generally accepted medical practice whether or not these medications are contained in the VALLEY BAPTIST HEALTH PLAN PDL.
- Certain medications are subject to prior authorization whether or not these medications are contained in the VALLEY BAPTIST HEALTH PLAN PDL.

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- Prescriptions covered under this Rider are limited to a 30-day supply. Medications for chronic conditions may be filled up to a 90-day supply, but only when filled through a Participating Mail Service Pharmacy.
- Prescriptions must be written by a Plan Provider or authorized referral Physician and filled at a Participating Pharmacy. Prescriptions written by out-of-plan Providers, or filled by non-Participating Pharmacies will not be covered, except in cases of medical emergency.
- Prescription Drugs that are dispensed by an out-of-area Hospital following an emergency visit will be covered for the initial prescription. Refills or new prescriptions must be filled at a Participating Pharmacy.
- Prescriptions will not be refilled until 70% percent of the prescription has been used.
- Medications prescribed for non-FDA approved indications, referred to as off-label drug use, *are not covered*. This includes experimental, investigational, 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 by reproducible studies 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.
- Drugs that by law do not require a prescription.
- Prescription refills in excess of the number specified by the Physician and any refill dispensed more than one year after the Physician's order.
- Prescriptions written in connection with any treatment or service that is not a covered benefit.
- 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.
- Over-the-counter vitamins and mineral supplements.
- Appetite suppressants, anti-smoking aids (e.g. Nicorette gum and nicotine patches), medications used for any cosmetic improvement, including wrinkles, uncomplicated nail fungus regardless of ambulation or pain, hair loss, growth or removal, and idiopathic non-growth hormone deficiency short stature.
- 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 when services are pre-authorized.
- Any Prescription Drug for which the actual cost is less than the required Copayment.
- 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.

PLEASE REFER TO THE SCHEDULE OF COPAYMENTS FOR COPAYMENT AMOUNTS AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

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SECTION 4 – EMERGENCY AND OUT-OF-AREA URGENT CARE SERVICES

There are special circumstances for health care services that We will cover, even though those services were not provided, referred or arranged by Your PCP, and not provided by a Plan Provider. These are:

A. Emergency Care

1. What is Emergency Care

Emergency care means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Heart attacks, cardiovascular accidents, poisoning, loss of consciousness or breathing, convulsions, severe bleeding and broken bones are examples of medical emergencies for which emergency care would be covered.

Emergency care includes the following services:

- An initial medical screening examination by the facility providing the emergency care or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists;
- Services for the treatment and stabilization of an emergency condition; and.
- Post-stabilization care originating in a Hospital emergency room or comparable facility, if approved by Us, provided that We must approve or deny coverage within one hour of a request for approval by the treating Physician or the Hospital emergency room.

2. Requirements for All Emergency Care

To be covered, emergency care must meet all of these conditions:

- You must obtain the services immediately, or as soon as possible, after the emergency condition occurs;
- As soon as possible after the emergency occurs and You seek treatment, You (or someone acting for You) must contact Your PCP for advice and instructions. In any event, You must contact the Plan within 24 hours, unless it is impossible to do so; and
- You must be transferred to the care of Plan Providers as soon as this can be done without harming Your condition. We do not cover services provided by out-of-plan providers after the point at which You can be safely transferred to the care of a Plan Provider.

VALLEY BAPTIST HEALTH PLAN has the right to review the services and the circumstances in which You received them. We will cover the initial medical screening evaluation necessary to determine whether an emergency medical condition exists. After an emergency condition has been stabilized, Your Physician must pre-authorize continued treatment or it may not be covered.

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B. Out-of-Area Urgent Care

1. What is Out-of-Area Urgent Care?

Out-of-area urgent care means medical services that:

- Do not meet the requirements necessary to be considered "Emergency Care" described in this section;
- You urgently need while You are outside of VALLEY BAPTIST HEALTH PLAN's Service Area;
- You could not reasonably have anticipated needing before You left the VALLEY BAPTIST HEALTH PLAN Service Area; and
- Cannot safely be delayed until You are able to come back to the Service Area to obtain care through Your PCP.

In determining whether services provided to You will be covered as out-of-area urgent care, We have the right to review the services and the circumstances in which You received them. If We decide that some or all of the services do not meet the coverage requirements of this section, You will have to pay all charges for the non-covered services.

2. Requirements for All Out-of-Area Urgent Care

To be covered, out-of area urgent care must meet all of these conditions:

- Before receiving treatment for urgent care, You should try to contact Your PCP and explain Your medical circumstances to him or her;
- You must obtain the services immediately after the urgent condition occurs, or as soon as possible afterward. In any event, You (or someone acting for You) must contact Us within 24 hours, unless it is impossible to do so; and
- If You were unable to contact Your PCP before seeking treatment, You (or someone acting for You) must contact Your PCP for advice and instructions as soon as possible after the urgent condition occurs. In any event, You (or someone acting for You) must contact Us within 24 hours, unless it is impossible to do so.

Additionally, You must be transferred to the care of Plan Providers as soon as this can be done without harming Your condition. We do not cover services provided by out-of-plan providers after the point at which You can be safely transferred to the care of a Plan Provider.

FOR IN-AREA URGENT CARE: If You urgently need services while inside the VALLEY BAPTIST HEALTH PLAN Service Area, but Your condition is not serious enough to be a medical emergency, You should first seek care through Your PCP, as You would for Your regular covered care. Please remember that We will not cover urgent care inside the Service Area from an out-of-plan provider.

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C. Services and Copayments

PLEASE REFER TO THE SCHEDULE OF COPAYMENTS FOR COPAYMENT AMOUNTS AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

As long as the requirements described above are satisfied, We will cover the following services:

- Hospital emergency room services, including an initial medical screening examination;
- Services in an outpatient emergency or urgent care center. We will also cover emergency services in a comparable facility;
- Emergency ambulance service to the nearest medical facility able to provide appropriate care. For non-emergency ambulance transport services, see *Section 3, What is Covered; and*
- Any other Covered Health Care Service detailed in *Section 3, What Is Covered*. However, the services must meet all of the conditions described above under this section. Your specific Copayments for these services are outlined in the *Schedule of Copayments*.

If possible, You should make these Copayments to the provider of services at the time the service is rendered, even if the provider is an out-of-plan provider.

D. Payment Procedures

Payment for emergency care received from out-of-plan providers, inside or outside Our Service Area, and out-of-area urgent care is provided in one of two ways:

- We will pay the Usual, Customary and Reasonable (UCR) Amount for care received from out-of-plan providers; or
- We will arrange to pay those providers directly at rates negotiated with the provider by VALLEY BAPTIST HEALTH PLAN.

E. VALLEY BAPTIST HEALTH PLAN Review

We have the right to review all services that were provided to You to determine whether they satisfy all the conditions for coverage of emergency or Out-of-Area urgent care specified above, if permitted by law. If We decide that they did not satisfy one or more of these conditions, We may require You to pay for the services, except that an initial medical screening will be a covered service subject to the applicable Copayment described above. If You disagree with Our decision, You can appeal Our decision by using the procedures described in *Section 8 – Member Complaint & Appeal Procedure*.

PLEASE REFER TO THE SCHEDULE OF COPAYMENTS FOR COPAYMENT AMOUNTS AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

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SECTION 5 – WHAT IS NOT COVERED

It is important that You understand what services are not covered. There are two general rules to remember:

- We cover only the health care services described in Sections 3 and 4 of this document. If a service is not listed in either of those sections it is not covered.
- You must always meet the conditions for coverage described in Sections 1 through Section 4 of this document. Please make sure You meet all of these conditions and follow all of the required procedures. If You do not, We will not pay for the service.

We will not pay for the following services:

1. Cosmetic or other reconstructive procedures (including any related prostheses, except breast prosthesis following mastectomy) that are not medically necessary, unless specifically provided in *Section 3, What Is Covered*. Among the procedures We do not cover are:
 - 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 or reduction mammoplasty if medically necessary);
 - Hair transplants or removal;
 - Peeling or abrasion of the skin;
 - Any procedure that does not repair a functional disorder; and
 - Rhinoplasty and associated surgery.
2. 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.
3. Dental treatments, diagnostics, services, appliances, and supplies. For instance, We do not cover:
 - Dental services, including services for accidental injury;
 - X-rays or exams;
 - Dentures, or dental implants;
 - Dental prostheses, 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;
 - Shortening or lengthening of the mandible or maxillae for members over age 18;
 - Treatment of dental abscess or granuloma;
 - Treatment of gingival tissues (other than for tumors); and
 - Orthodontics, splints, positioners, extracting teeth, or repairing damaged teeth.

The only dental-related coverage We provide under Your Plan is described in Section 3, What Is Covered.
4. Inpatient or outpatient custodial care. Custodial care is care that:
 - Primarily helps with or supports daily living activities (such as, eating, dressing, and eliminating body wastes); or
 - Can be given by people other than trained medical personnel.

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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.

5. Mental health services for the following conditions: attention deficit disorder (ADD); attention deficit hyperactivity disorder (ADHD), however, medication management for the treatment of ADD and ADHD is covered; mental retardation; disruptive behavior disorders; cognitive disorders (except those used for the treatment of acquired brain injury and for rehabilitation of acquired brain injury); delusional disorders; gender identity disorders; personality disorders; senile deterioration, such as progressive dementia of Alzheimer's and Alzheimer's like diseases; sexual disorders; sleep disorders; factitious disorders; impulse control disorders; dissociative disorders and somatoform disorders. Marriage counseling is not a covered health service. Court ordered evaluation, diagnosis, and treatment for mental conditions are excluded unless this Evidence of Coverage would otherwise cover such services. Court ordered testimony is not a Covered Health Service.
6. Reversal of voluntary sterilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF); any costs related to surrogate parenting; infertility services required because of a sex change by the Member or the Member's partner; or any assisted reproductive technology or related treatment that is not specified in *Section 3, What is Covered*.
7. Any and all transplants of organs, cells, and other tissues, except for the Listed Transplants specifically covered under *Section 3, What is Covered*.
8. 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.
9. Health care services for any work-related injury or illness, if any other source of coverage or reimbursement is (or was) available to You for the services. Sources of coverage or reimbursement available to You may include Your employer, a work-related benefit plan maintained by Your employer, and any Workers' Compensation, occupational disease or similar

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program under local, state, or federal law. A source of coverage or reimbursement will be considered available to You even if You waived Your right to payment from that source.

10. 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.
11. Elective, non-therapeutic termination of pregnancy (abortions) including any abortion-inducing medications.
12. All surgical procedures for snoring and sleep apnea.
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. 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.
15. Educational testing and therapy, including the treatment of learning disabilities, motor or language skills, behavioral disorders or services that are educational in nature or are for vocational testing or training.
16. Treatments and evaluations required by employers, insurers, schools, camps, courts, licensing authorities and other third parties. Special medical reports not directly related to treatment. Appearances at court hearings and other legal proceedings.
17. 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.
18. 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) and photo refractive keratectomy (PRK-laser) unless specifically provided in *Section 3, What Is Covered*, or provided by a Rider.
19. Services intended primarily to treat obesity, such as gastric bypasses and balloons, stomach stapling, jaw wiring, vertical banding, weight reduction programs, gym memberships, prescription drugs, or other treatments for obesity (except dietary counseling and nutritional education services for morbid obesity) even if prescribed by a Physician or the Member has medical conditions that might be helped by weight loss.
20. Sex-change surgery and related treatment, including hormone therapy and medical or psychological counseling.
21. Acupuncture, naturopathy, hypnotherapy, and Christian Science Practitioner Services.
22. 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.
23. Anti-smoking treatments and programs, such as nicotine patches.

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24. 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.
25. 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).
26. Charges for missed appointments.
27. Private room accommodations, unless We have pre-approved them for isolation due to infectious disease or immune problem. If a semi-private room is not available, We will cover a private room until a semiprivate room becomes available.
28. 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.

For example, if a Member undergoes non-covered cosmetic surgery, We will not cover pre-operative care, post-operative care, or hospitalization related to the non-covered surgery. Even if the service was covered by another health plan, it will be considered non-covered under this Plan.
29. Special duty nursing, unless considered medically necessary.
30. Nutritional counseling and diet planning, unless We have pre-approved it.
- 31.. Genetic counseling and testing, except medically necessary peri-natal genetic counseling and testing.
32. Biofeedback services, except for the treatment of acquired brain injury and for rehabilitation of acquired brain injury.
33. Implanted neurological stimulators, including but not limited to spinal or dorsal column stimulators for relief of pain, Parkinson's, movement disorders, or seizures.
34. 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.
35. Massage therapy, unless associated with a physical therapy modality provided by a licensed physical therapist.
36. Additional expenses incurred as a result of the Member's failure to follow a Plan Provider's medical orders.
37. The following devices, equipment, and supplies are excluded:
 - Corrective shoes, shoe inserts, arch supports, and orthotic inserts, except as provided for under Diabetic Services;
 - Wigs or prosthetic hair;
 - 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;

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- Environmental control equipment, such as air conditioners, purifiers, humidifiers, dehumidifiers, electrostatic machines, and heat lamps;
 - Institutional equipment, such as air fluidized beds and diathermy machines;
 - Consumable medical supplies, such as over-the counter bandages, dressings, and other disposable supplies, skin preparations, surgical leggings, elastic stockings, JOBST stockings, TED stockings, and stump socks;
 - 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.
38. Sports cords.
39. Hearing aid batteries, temporary or disposable hearing aids, and repair or replacement of hearing aids due to normal wear, loss, or damage.
40. Orthotic devices, except for the treatment of diabetes and those described in *Section 3, What is Covered*.
41. Care not medically necessary as determined by a Plan Provider or Medical Director of VALLEY BAPTIST HEALTH PLAN.
42. Equine or Hippo therapy.
43. Illness or injury incurred as a result of war or any act of war, whether declared or undeclared, whether or not the Member served in the military.
44. Electron Beam Tomography (EBT).

Limitations Due to Certain Conditions

In the event that due to circumstances not within the control of VALLEY BAPTIST HEALTH PLAN, 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 Plan Providers and their personnel, or similar causes, the rendering of Covered Health Services provided under this Evidence of Coverage is delayed or rendered impractical, VALLEY BAPTIST HEALTH PLAN shall make a good faith effort to arrange for an alternative method of providing coverage. In such an event, VALLEY BAPTIST HEALTH PLAN and its Plan Providers shall render Covered Health Services insofar as practical, and according to their best judgment; but VALLEY BAPTIST HEALTH PLAN and Plan 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.

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SECTION 6 – TERMINATION OF COVERAGE

A. Termination of Coverage

Your coverage may be terminated for any of the following reasons:

1. For a Member, in the case of:

- Nonpayment of amounts due, including any applicable Copayments, under this, Evidence of Coverage may be canceled after not less than 30 days written notice; except that no written notice will be required for failure to pay premiums;
- Fraud or intentional material misrepresentation, coverage may be canceled after not less than 15 days written notice; subject, however, to the incontestability provisions outlined in *Section 9, Miscellaneous Provisions*;
- Fraud in the use of services or facilities, coverage may be canceled after not less than 15 days written notice;
- Failure to meet eligibility requirements, coverage will be canceled immediately, subject to continuation of coverage and conversion privileges, if applicable;
- Misconduct detrimental to safe Plan operations and the delivery of services, coverage may be canceled immediately;
- Failure of the enrollee and a Plan Physician to establish a satisfactory patient/provider relationship, provided We have made a good faith effort to provide the Member with the opportunity to select an alternative Plan Provider, and further provided that We have notified the Member in writing at least 30 days in advance that We consider such Member's patient/provider relationship to be unsatisfactory and specified the changes that are necessary in order to avoid termination, and thereafter the Member has failed to make such changes, then coverage may be canceled at the end of the 30 days; and
- Failure of the Subscriber and/or covered Dependent to reside, live, or work in the Service Area, coverage may be canceled immediately. This provision only applies if coverage is terminated uniformly without regard to any health status-related factor of Members. Coverage for a child who is the subject of a medical support order cannot be canceled solely because the child does not reside, live or work in the Service Area.

2. For a Group, in the case of:

- Termination of the Contract shall be governed by Article I.B.13 of the RFP and by the terms of the Contractual Agreement.
- In the event that the Plan does not receive payment as provided by Section III b. of the Contractual Agreement, for a period of more than sixty (60) days, the Plan may terminate the Contract. Other than as provided in this section, the Plan shall have no right to terminate the Contract.

B. Termination of Benefits

Upon the effective date of a termination of coverage, the Member or Group, shall not be entitled to any further benefits hereunder after such effective date. Neither VALLEY BAPTIST HEALTH PLAN nor any Plan Provider shall have any further obligation to provide services or facilities pursuant to this benefit Plan. Members whose Group has not terminated may be eligible for continuation of coverage benefits as described below.

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C. Continuation of Coverage

Upon termination of coverage, You may be eligible for continuation coverage, if either of the following provisions applies.

1. COBRA

Under the provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272), You may have the right to continue coverage under the Health Plan beyond the date it would otherwise terminate.

2. State Continuation of Coverage

Upon completion of coverage under COBRA or if Your Group is not required to offer COBRA, You have the option to elect State Continuation of Coverage. If You no longer meet eligibility requirements, have been continuously covered under the Group contract for at least three consecutive months prior to the contract ending and have not been terminated for cause, then You may elect State Continuation of Coverage. You must submit a completed application to Us within 31 days following the later of:

- The effective date of termination of Group coverage;
- The effective date of termination of COBRA coverage; or
- The date You are given notice of the right of continuation by the employer.

You must submit the premium payments applicable for such continuation membership within the 31-day period. If You fail to meet any of these conditions for continuation, then You shall not be eligible to elect continuation anytime after the 31-day period.

The effective date of such continuation coverage shall be the date of termination of Group coverage. Continuation is permitted for a maximum of six months. The Premium rate will be 102% of the Group premium charged to the employer. The Premium must be paid in advance to the employer on a monthly basis.

Continuation of the coverage may not terminate until the earliest of:

- Six months after the date continuation of coverage is effective;
- The date You fail to make timely premium payments;
- The date on which You are covered for similar benefits under another group or individual health plan;
- The date on which the Group coverage terminates in its entirety; or
- Similar benefits are provided or available to You, pursuant to or in accordance with the requirements of any state or federal law.

Thirty days prior to the end of the six months of continuation contract, We will notify You that You may be eligible for coverage under the Health Insurance Risk Pool, as provided under Article 3.77, Texas Insurance Code.

This continuation of coverage will be to the extent necessary to comply with provisions of the applicable statute. Contact Your Participating Entity for verification of eligibility and procedures to follow.

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D. Continuation of Coverage for Certain Dependents

If coverage under this Evidence of Coverage ends as the result of a Subscriber's death, retirement or divorce, a Dependent's coverage can continue. The Dependent must have been covered under the plan for at least one year, unless the Dependent is an infant less than one year of age. You must apply for this continuation coverage within 60 days of the event establishing eligibility for continuation.

Continuation is not available when coverage terminates due to any of these circumstances:

- The Evidence of Coverage is canceled; or
- The Dependent fails to make timely Premium payments.

Continuation ends at the earliest of:

- Three years after the date that the coverage would have ended;
- The Dependent fails to make timely premium payments;
- The Dependent becomes eligible for coverage under any other group plan providing similar benefits; or
- The coverage is canceled.

The premium rate will be the group premium charged to the employer and may include a five-dollar administrative fee. The premium must be paid in advance to Your employer on a monthly basis.

E. Refunds

If Your coverage is terminated, premium payments received on Your behalf that apply to periods after the effective date of termination of coverage shall be pro rata refunded to Your Group within 30 days after We have actual knowledge of Your termination. Upon the making of such refund to the Group, neither VALLEY BAPTIST HEALTH PLAN nor any Plan Provider shall have any further liability under this benefit Plan with respect to the refunded amount. Any claims for refunds must be made within 60 days from the effective date of termination of a Member's coverage, or such right to a refund shall be deemed to have been waived by the Member and the applicable Group.

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SECTION 7 – COORDINATION OF BENEFITS, ON-THE-JOB INJURY & SUBROGATION

If any benefits to which a Member is entitled under this Evidence of Coverage are also covered under any other Health Care Plan, the benefits payable under another Health Care Plan include the benefits that would have been payable had claim been duly made therefore. This provision does not apply to individual coverage.

A. Coordination of Benefits

If a Member is eligible to receive benefits under another Health Care Plan that duplicates benefits provided under this Evidence of Coverage, VALLEY BAPTIST HEALTH PLAN will coordinate Our benefits with the other Health Care Plan(s) according to the Coordination of Benefits rules outlined below. VALLEY BAPTIST HEALTH PLAN may seek reimbursement from any Health Care Plan(s) for the cost of services provided. However, We will not seek reimbursement that exceeds this Plan's financial responsibility. It is the Member's responsibility to ensure that all procedures are properly authorized in advance by VALLEY BAPTIST HEALTH PLAN and to provide VALLEY BAPTIST HEALTH PLAN with information that will assist Us in determining Coordination of Benefit obligations.

The rules establishing the order of benefit determination between VALLEY BAPTIST HEALTH PLAN and any other Health Care Plan covering the Member on whose behalf a claim is made are as follows:

- Whenever a health care Plan does not contain a Coordination of Benefits provision, that health care plan must be primary. The primary Health Care Plan pays benefits before the secondary health care plan pays. When VALLEY BAPTIST HEALTH PLAN is determined to be the secondary plan based on the Coordination of Benefits rules described in this section, then VALLEY BAPTIST HEALTH PLAN will be liable only for the amount due under the secondary plan rules, regardless of whether or not payment is actually made by the primary plan.
- Whenever a health care plan contains a Coordination of Benefits provision, benefits will be determined according to the Rules of Coordination below.
- When a VALLEY BAPTIST HEALTH PLAN Member has other coverage that is primary, VALLEY BAPTIST HEALTH PLAN will provide secondary coverage only when those services are pre-authorized through Our Medical Services Department. It is the Member's responsibility to contact the Customer Services Department to assure prior authorization has been obtained for any referral to a Physician, a health care professional, or a facility.

B. Rules of Coordination

Rules establishing the order of benefit determination as to a Member's claim for the purposes of this section are as follows:

1. Non-Dependent/Dependent

The benefits of the health care plan which covers the Member as a Subscriber are determined before those of the health care plan which covers the Member as a Dependent except, if the Member is also a Medicare beneficiary and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- Secondary to the health care plan covering the Member as a Dependent; and
- Primary to the health care plan covering the Member as other than a Dependent (for example, a retired employee), then the benefits of the health care plan covering the Member as a Dependent are determined before those of the health care plan covering that Member as other than a Dependent.

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2. Dependent Child/Parents Not Separated or Divorced

Except as stated below, when this health care plan and another health care plan cover the same child as a Dependent of different persons, called parents:

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

However, if the other health care plan does not have the rule described immediately above, but instead has a rule based on gender of the parent, and if, as a result, the health care plans do not agree on the order of benefits, the rule in the other health care plan will determine the order of benefits.

3. Dependent Child/Separated or Divorced

If two or more health care plans cover a Member as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- First, the health care plan of the parent with custody of the child;
- Then, the health care plan of the spouse of the parent with custody; and
- Finally, the health care plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the health care plan of that parent has actual knowledge of those terms, the benefits of that health care plan are determined first. The Health Care Plan of the other parent shall be the secondary health care plan. This paragraph does not apply with respect to any claim paid or provided before the entity has that actual knowledge.

4. Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the health care plans covering the child shall follow the order of benefit determination rules outlined above in the Dependent Child/Parents Not Separated or Divorced provision.

5. Active/Inactive Employee

The benefits of a health care plan which covers a Member as an employee who is neither laid off nor retired, are determined before those of a health care plan which covers that Member as a laid off or retired employee or as that employee's Dependent. If the other health care plan does not have this rule, and if, as a result, the health care plans do not agree on the order of benefits, this rule is ignored.

6. Continuation Coverage

If a Member whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another health care plan, the following shall be the order of benefit determination:

- The benefits of a Health Care Plan covering the Member as a Subscriber (or as that Subscriber's Dependent); and
- The benefits under the continuation coverage.

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If the other health care plan does not have the rule described above, and if, as a result, the health care plans do not agree on the order of benefits, this rule is ignored.

7. Longer/Shorter Length of Coverage

If none of the above rules determine the order of benefits, the benefits of the health care plan that covered a Subscriber or Member longer are determined before those of the health care plan that covered that Member for the shorter term.

8. Rules of Coordination for Members 65 or Older

Rules establishing the order of benefit determination for Members age 65 or older or Members with end-stage renal disease are as follows:

- For the Subscriber and the Subscriber's spouse, the benefits of this Evidence of Coverage shall be determined before the benefits of Medicare if the Member is actively employed;
- For Members who have become entitled to Medicare benefits solely on the basis of being diagnosed as having end-stage renal disease the benefits of this Evidence of Coverage shall be determined in accordance with Medicare guidelines.
- The benefits of Medicare Part A and Part B shall be determined before the benefits of this Evidence of Coverage:
 - a. When a Member is no longer actively employed and the Member and/or the Member's spouse are enrolled in Medicare;
 - b. When a Member is no longer actively employed and the Member and/or the Member's spouse are age 65 or older and do not elect Medicare coverage; and
 - c. When a Subscriber is actively employed by an employer with fewer than 20 employees and the Subscriber or Subscriber's spouse is enrolled in Medicare.

When Medicare benefits are primary, claims must be filed with Medicare first for determination of benefits. VALLEY BAPTIST HEALTH PLAN remains secondary, even when Medicare benefits have been exhausted. The Member is responsible for sending the Medicare explanation of benefits form to VALLEY BAPTIST HEALTH PLAN for determination of benefits under this Evidence of Coverage.

9. Employer Providers

Benefits, which are provided directly through a specified provider of an employer, shall in all cases be primary before the benefits of this Evidence of Coverage.

10. Military Providers

Services and benefits for military personnel for which a Member is legally entitled and for which facilities are reasonably available, shall in all cases be primary before the benefits of this Evidence of Coverage, if we approve such services in advance. Otherwise, no benefits will be payable.

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11. Release of Information

For purposes of this Evidence of Coverage, VALLEY BAPTIST HEALTH PLAN may, subject to applicable confidentiality requirements set forth in this Evidence of Coverage, release to or obtain from any insurance company or other organization necessary information to implement these Coordination of Benefit provisions. Any Member claiming benefits under this Evidence of Coverage must furnish to VALLEY BAPTIST HEALTH PLAN all information deemed necessary by it to implement these Coordination of Benefits provisions.

12. Recovery of Payments

Whenever payments have been made by VALLEY BAPTIST HEALTH PLAN with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment required in accordance with the Coordination of Benefits provisions of this section, then VALLEY BAPTIST HEALTH PLAN shall have the right to recover such payment to the extent of such excess from among one or more of the following as VALLEY BAPTIST HEALTH PLAN shall determine:

- Any person or persons to, or for, or with respect to whom such payments were made; and
- Any insurance company or companies (or any other organization or organizations) to which such payments were made.

13. On-The-Job Injury/Illness

In the event services are provided or payments are made by VALLEY BAPTIST HEALTH PLAN for work-related injuries or illnesses sustained by a Member and such services are determined to be covered by a Workers' Compensation System or any other insurance, VALLEY BAPTIST HEALTH PLAN shall have the right to recover Usual, Customary and Reasonable (UCR) Amounts for such services so provided or the payments made by VALLEY BAPTIST HEALTH PLAN from such third party payer. It is understood that coverage under this Evidence of Coverage is not in lieu of, and shall not affect, any benefits or requirements for coverage under an applicable Workers' Compensation System(s) or under any other applicable insurance coverage.

14. Subrogation

If We provide services to a Member or such Member's Dependent, due directly or indirectly to the act or omission of another person or entity, then We shall be entitled to receive and shall be fully subrogated to all rights of recovery acquired by or accruing to such Member (or Dependent) but only up to 100% of the dollar amounts paid for such benefits provided by Us and Our costs of recovery (including, but not limited to, court costs and reasonable attorney fees). Our rights become effective as to all third parties and their insurers upon the giving of written notice to such third parties, their insurers or attorneys. It is agreed that, by receipt of such benefits from Us, such Member (or Dependent) shall be legally considered to have assigned all first and prior rights of recovery to Us and to have agreed to cooperate and help Us obtain such recovery by settlement or judgment. We shall have the right to intervene in any action brought by the Member (or Dependent) against any third party alleged to be responsible for the Member's (or Dependent's) illness or injury, in order to protect and prosecute Our rights to recovery. It is further agreed that, should the Member (or Dependent) receive any payment applicable to such assigned rights of recovery of VALLEY BAPTIST HEALTH PLAN, that reimbursement shall be immediately made to VALLEY BAPTIST HEALTH PLAN by the Member (or Dependent).

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SECTION 8 – MEMBER COMPLAINT AND APPEAL PROCEDURE

A *Complaint* means any dissatisfaction expressed by You, or anyone acting on Your behalf, orally or in writing to Us with any aspect of Our operation, including but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of an Adverse Determination, the denial, reduction or termination of a service for reasons not related to medical necessity, the way a service is provided or disenrollment decisions. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the Member and does not include a Plan Provider's or Member's oral or written dissatisfaction or disagreement with an Adverse Determination. A Complaint filed concerning dissatisfaction or disagreement with an Adverse Determination constitutes an appeal of that Adverse Determination.

A. Complaint Procedure

If You notify Us orally or in writing of a Complaint, We will not later than the fifth business day after the date of the receipt of the Complaint, send to You a letter acknowledging the date We received Your Complaint. If the Complaint was received orally, We will enclose a one-page Complaint form clearly stating that the Complaint form must be returned to Us for prompt resolution.

Complaints should be directed to the Customer Services Department at (800) 829-6440 or in writing to:

VALLEY BAPTIST HEALTH PLAN
ATTN: Coordinator of Complaints & Appeals
1901 West Loop 289, Suite 9
Lubbock, Texas 79407

After receipt of the written Complaint or one-page Complaint form from You, We will investigate and send You a letter with Our resolution. The total time for acknowledging, investigating and resolving Your Complaint will not exceed 30 calendar days after the date We receive Your Complaint.

Your Complaint concerning an emergency or denial of continued stay for hospitalization will be resolved in one business day of receipt of Your Complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

You may use the Appeals Process to resolve a dispute regarding the resolution of Your Complaint.

B. Complaint Appeal Procedure

If the Complaint is not resolved to Your satisfaction, You have the right either to appear in person before a Complaint appeal panel where You normally receive health care services, unless another site is agreed to by You, or to address a written appeal to the Complaint appeal panel.

We shall send an acknowledgment letter to You not later than the fifth business day after the date of receipt of the request for appeal.

We shall appoint members to the Complaint Appeal Panel, which shall advise Us on the resolution of the dispute. The Complaint Appeal Panel shall be composed of an equal number of Our staff, Physicians or other providers, and Members.

Not later than the fifth business day before the scheduled meeting of the panel, unless You agree otherwise, We shall provide to You or Your designated representative:

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- Any documentation to be presented to the panel by Our staff;
- The specialization of any Physicians or providers consulted during the investigation; and
- The name and affiliation of each of Our representatives on the panel.

You or designated representative is entitled to:

- Appear in person before the Complaint appeal panel;
- Present alternative expert testimony; and
- Request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

Written notification of Our final decision on the appeal will be provided no later than the 30th calendar day after the date We received the appeal. The notice of final decision will address the specific medical determination, clinical basis and contractual criteria used to reach the final decision. The notice will also include the toll-free telephone number and address of the Texas Department of Insurance.

C. Adverse Determination Appeal Procedure

In the event of an Adverse Determination, notification will include:

- The principal reasons for the Adverse Determination.
- The clinical basis for the Adverse Determination.
- A description or source of the screening criteria that were utilized as guidelines in making the determination.
- Notification of the right to appeal an Adverse Determination to an Independent Review Organization.
- Notification of the procedures for appealing an Adverse Determination to an Independent Review Organization.
- Notification to the Member who has a Life-Threatening condition of the Member's right to an immediate review by an Independent Review Organization and the procedure to obtain that review.

You, a person acting on Your behalf or Your Physician or Plan Provider may appeal an Adverse Determination orally or in writing.

We shall send an acknowledgment letter to You not later than the fifth business day after the date of receipt of the request for appeal. We will outline a list of documents that You must submit for review by the utilization review agent.

Investigation and resolution of appeals relating to ongoing emergencies or denials of continued stays for hospitalization shall be conducted in accordance with the medical immediacy of the case but in no event to exceed one business day after Your request for appeal.

Due to the ongoing emergency or continued Hospital stay, and at Your request, We shall provide a review by a Physician or provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

The Physician or provider reviewing the appeal may interview You or Your designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within three days.

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Written notification of Our final decision on the appeal will be provided no later than the 30th calendar day after the date We received the appeal. If the appeal is denied the written notification shall include a clear and concise statement of:

- The clinical basis for the appeal's denial.
- The specialty of the Physician making the denial.
- Notice of Your right to seek review of the denial by an Independent Review Organization and the procedures for obtaining that review.

D. Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve Complaints through Our Complaint system process and who are dissatisfied with the resolution, may report an alleged violation to:

**Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104**

The commissioner shall investigate a Complaint against Us to determine compliance within 60 days after the Texas Department of Insurance's receipt of the Complaint and all information necessary for the Department to determine compliance. The commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

- Additional information is needed;
- An on-site review is necessary;
- We, the Physician or provider, or You do not provide all documentation necessary to complete the investigation; or
- Other circumstances beyond the control of the Texas Department of Insurance occur.

E. Appeals to an Independent Review Organization (IRO)

In a circumstance involving a Life-Threatening condition, You are entitled to an immediate appeal to an Independent Review Organization and are not required to comply with procedures for an internal review of Our Adverse Determination.

We shall permit any party whose appeal of an Adverse Determination is denied by Us to seek review of that determination by an Independent Review Organization assigned to the appeal as follows:

- We shall provide to You, Your designated representative, or Your provider of record, information on how to appeal the denial of an Adverse Determination to an Independent Review Organization.
- We must provide such information to You, Your designated representative, or Your provider of record at the time of the denial of the appeal.
- We shall provide to You, Your designated representative, or Your provider of record the prescribed form.
- You, Your designated representative, or Your provider of record must complete the form and return it to Us to begin the independent review process.
- In Life-Threatening situations, You, Your designated representative, or Your provider of record may contact Us by telephone to request the review and provide the required information.

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The appeal process does not prohibit You from pursuing other appropriate remedies including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places Your health in serious jeopardy.

VALLEY BAPTIST HEALTH PLAN will not take any retaliatory action, such as refusing to renew or canceling coverage, against You or Your Group because You, the Group, or any person acting on Your or Your Group's behalf, has filed a Complaint against VALLEY BAPTIST HEALTH PLAN or appealed a decision made by VALLEY BAPTIST HEALTH PLAN.

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SECTION 9 – MISCELLANEOUS PROVISIONS

Entire Evidence of Coverage

This booklet, the applicable Group Enrollment Agreement of Your Group, and Your (including Your Dependents, if any) enrollment form(s) constitute the entire contract between VALLEY BAPTIST HEALTH PLAN and You (and Your covered Dependents), as well as Your Group, and as of the effective date of Your coverage, this Evidence of Coverage supersedes all other agreements.

Cancellation

Except as otherwise provided herein, VALLEY BAPTIST HEALTH PLAN will not have the right to cancel Your coverage if the following requirements are met:

- The Group Enrollment Agreement of Your Group remains in full force and effect;
- You and Your Dependents, if any, remain eligible for coverage in accordance with this Evidence of Coverage and the applicable requirements of Your Group; and
- All applicable premiums have been paid in accordance with this Contract.

Authority

No agent or employee of VALLEY BAPTIST HEALTH PLAN is authorized to change the form or content of this Evidence of Contract other than to make necessary and proper insertions in blank spaces. Any changes to the form or content of this Evidence of Coverage may only be made through proper endorsement signed by an authorized officer of VALLEY BAPTIST HEALTH PLAN. No agent, employee, or other person, except an authorized officer of VALLEY BAPTIST HEALTH PLAN, has the authority to waive any terms, provisions, conditions or restrictions of this Evidence of Coverage.

Authorization to Examine Health Records

You and Your Dependents, if any, expressly consent to and expressly authorize, to the fullest extent permitted by applicable law, any and all Physicians and health care providers who provide care to any of You to permit the examination and copying of any portion of such provider's medical and other records pertaining to any of You by VALLEY BAPTIST HEALTH PLAN, upon request by VALLEY BAPTIST HEALTH PLAN without need of further authorization from any of You.

Notice of Claim

It is not expected that You will make payment for Covered Health Services, other than required Copayments. However, if You pay for Covered Health Services in addition to the required Copayment(s), You must file a claim with Us within 90 days from the date You incurred Covered Health Services, unless You can document as soon as reasonably possible after the 90-day period, to Our satisfaction, good cause why such claim could not be filed within such 90-day period. Provided, however, reimbursement shall not be allowed if a claim is made beyond one year from the date such Covered Health Services were first incurred. We will provide forms for the submission of written proof of payment. You may contact Our Customer Services Department at (800) 829-6440.

Payment of Claims

Payment of claims to the Member will be handled as follows:

Not later than the 15th day after We receive of a claim from You, We will:

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- Acknowledge receipt of the claim;
- Commence any investigation of the claim; and
- Request information, statements and forms from You as deemed necessary. Additional requests may be made during the course of the investigation.

Not later than the 15th day after receipt of all requested items and information, VALLEY BAPTIST HEALTH PLAN will:

- Notify You of the acceptance or rejection of the claim and the reason if rejected; or
- Notify You that additional time is needed and state the reason. Not later than the 45th day after the date of notification of the additional time requirement, We shall accept or reject the claim.
- Claims will be paid no later than the fifth day after notification of acceptance of the claim.

Legal Action

No action at law or in equity shall be brought to recover under this Evidence of Coverage prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of this Evidence of Coverage, nor shall such action be brought at all unless brought within three years from the expiration of the time within which notice of claim is required by this Evidence of Coverage.

Notice

Any notice required by or given involving this Evidence of Coverage may be given by personal delivery, by telephone facsimile transmission, by overnight delivery service or by United States mail, first class, postage prepaid, addressed as follows:

**VALLEY BAPTIST HEALTH PLAN
12940 N Highway 183
Austin Texas 78750**

and if to a Member, at the last address specified in the corporate records of VALLEY BAPTIST HEALTH PLAN.

Interpretation of this Evidence of Coverage

The laws of the State of Texas shall be applied to the interpretation and construction of this Evidence of Coverage. Any provision contained in this Evidence of Coverage not in conformity with the Texas Health Maintenance Organization Act as amended and codified as the Texas Insurance Code, Chapter 20A, or other applicable Texas laws shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Act and such other applicable Texas laws.

Assignment

This Evidence of Coverage is not assignable by You, Your Dependents, if any, or Your Group without the written consent of VALLEY BAPTIST HEALTH PLAN. Likewise, the coverage and benefits provided by this Evidence of Coverage are not assignable without the written consent of VALLEY BAPTIST HEALTH PLAN.

Gender

The use of any gender in this Evidence of Coverage shall be deemed to include and reference the other genders, and likewise, use of the singular tense shall be deemed to include the plural and visa versa.

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Modifications

This Evidence of Coverage shall be subject to amendment, modification, or termination as required by law or regulatory order without the consent of the Group or any Member; otherwise, this Evidence of Coverage can be amended, modified, or terminated by the mutual written agreement of VALLEY BAPTIST HEALTH PLAN and the Group without the consent of any Member.

Clerical Error

Clerical error, whether made by the Group or VALLEY BAPTIST HEALTH PLAN, in keeping records pertaining to the coverage of Members under this Evidence of Coverage will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Headings and Captions

The headings and captions used in this Evidence of Coverage are provided for purposes of reference and convenience only and shall not be used in continuing or interpreting this Evidence of Coverage.

Incontestability

All statements made by the subscriber on the enrollment application shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of the subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel, or non-renew an enrollee's coverage or reduce benefits unless:

- It is in a written enrollment application signed by the subscriber; and
- A signed copy of the enrollment application is or has been furnished to the subscriber or the subscriber's personal representative.

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SECTION 10 – DEFINITIONS

This section provides definitions for some of the terms used in this document.

Adverse Determination: A determination by a utilization review agent or health maintenance organization that the health care services furnished or proposed to be furnished to a Member are not medically necessary.

Allowable Amount: The maximum amount We determine to be eligible for consideration of payment for a particular Covered Health Service, supply, or procedure.

Ancillary Provider: A provider with whom a PCP may be required to consult and/or coordinate regarding referrals for certain Covered Health Services on behalf of a Member.

Complaint: See *Section 8, Member Complaint and Appeal Procedure* for a complete definition and description.

Copayment: The amount You are required to pay to a Plan Provider or other authorized provider in connection with the provision of Covered Health Services. The Copayment amounts are indicated in the Schedule of Copayments.

Covered Health Services: Those medical and health care services and items specified and defined in the Schedule of Copayments as being covered services but only when such services and items are medically necessary and when they are performed, prescribed, directed, or authorized in accordance with VALLEY BAPTIST HEALTH PLAN's policies and procedures and this Evidence of Coverage.

Crisis Stabilization Unit: A 24-hour residential program that is usually short-term in nature and provides intensive supervision and highly structured activities to persons who are demonstrating an acute psychiatric crisis of moderate to severe proportions.

Dependent: A Member of a Subscriber's family who meets the eligibility requirements specified in *Section 2.B., Eligibility and Enrollment*, and who has become enrolled as a Member in VALLEY BAPTIST HEALTH PLAN through the Subscriber's Group.

Diabetic Equipment: Includes equipment used to treat diabetes, such as blood glucose monitors, including monitors designed for use by blind individuals; insulin pumps and associated appurtenances; insulin infusion devices; shoe inserts and podiatric appliances for the prevention of complications associated with diabetes.

Diabetes Self-Management Training: (i) Training provided after the initial diagnosis of diabetes, including nutritional counseling and proper use of Diabetic Equipment and Supplies; (ii) additional training authorized on the diagnosis of a significant change in Your symptoms or condition that requires changes to Your self-management regime; and (iii) periodic or episodic continuing education training as warranted by the development of new techniques and treatments for diabetes.

Diabetic Supplies: Includes supplies to treat diabetes such as, test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.

Evidence of Coverage: The term used to describe this document along with any attachments and Your Enrollment Form, which constitute Your contract with VALLEY BAPTIST HEALTH PLAN.

VALLEY BAPTIST HEALTH PLAN is the registered service mark and trade name of the health Plan.

Grace Period: A period of 31 days after a Premium Due Date, during which premiums may be paid to VALLEY BAPTIST HEALTH PLAN without lapse of Your coverage and that of Your Dependents, if any, under an Evidence of Coverage. If payment is not received within the 31 days, coverage will be canceled and You will be responsible for any cost of services received during the Grace Period.

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Group: The Teachers Retirement System of Texas who has entered into a contract on behalf of the Texas School Employees Uniform Group Health Coverage Program (TRS-ActiveCare) with VALLEY BAPTIST HEALTH PLAN, and through which, You and Your Dependents, if any, have enrolled in the health Plan.

Hospital: An acute care institution licensed by the State of Texas as a Hospital, which is primarily engaged, on an inpatient basis, in providing medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, under supervision of a staff of Physicians and with 24-hour a day nursing and Physician service; provided, however, it does not include a nursing home or any institution or part thereof which is used principally as a custodial facility.

Independent Review Organization (IRO): An organization selected as provided under Article 21.58C, Insurance Code

Injectable Drugs or Medications: Drugs used *intramuscular* (in the muscle) *intrathecal* (in the spine); *intraarticular* (in the joint); *intravenous* (in the vein); or *subcutaneous* (under the skin), and must be administered by a professional health care provider and that the FDA has not recognized as appropriate for self-administration. Injectable medications *do not include* allergy serums, immunizations, or insulin and are covered as a basic medical benefit. Refer to Your Schedule of Copayments for details.

Life-Threatening: A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medical Director: A Physician designated by VALLEY BAPTIST HEALTH PLAN to monitor appropriate provision of medically necessary Covered Health Services to Members in accordance with their applicable Evidences of Coverage.

Member: A person who has enrolled in VALLEY BAPTIST HEALTH PLAN as a Subscriber or Dependent, and is eligible to receive Covered Health Services.

Out-of-Pocket Maximum: Amounts for which You and each Dependent are responsible during a Contract Year. This amount will not be more than 200% of the total annual premium cost which is required to be paid by You or on Your behalf. Your Copayments count toward the Out-of-Pocket Maximum amount. The Out-of-Pocket Maximum *does not* include charges for non-covered services, prescription drug Copayments, and any amounts owed over the Usual, Customary and Reasonable (UCR) Amount. You are responsible for contacting Us when you have reached Your Out-Of-Pocket Maximum.

Participating Entity: An entity participating in the TRS-ActiveCare Program including a school district; another educational district whose employees are members of the retirement system; a regional education service center; and a charter school that meets the requirements of Insurance Code Article 3.50-7. An entity is considered to be participating in the TRS-ActiveCare program on and after the first date coverage becomes effective for its employees.

Participating Mail Service Pharmacy: A pharmacy providing prescription service by mail that has contracted with the Health Plan to provide such services.

Plan Enrollment Period: A 31-day period established by TRS and VALLEY BAPTIST HEALTH PLAN from time to time, but not less frequently than once in any Plan Year, during which eligible persons in such Group may enroll in VALLEY BAPTIST HEALTH PLAN.

Physician: Any Physician who is duly licensed and qualified to practice within the scope of a medical practice license issued under the laws of the State of Texas or in which state treatment is received.

Plan Provider: A Physician, medical group, Hospital or other health care provider who has contracted with VALLEY BAPTIST HEALTH PLAN to provide Covered Health Services to Members of Your Plan. For more information on the network of Plan Providers available to You, check the provider directory We give to You, ask Your PCP or call Us. Please remember that the list of Plan

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Providers in the directory is subject to change, so You may want to call Our Customer Services Department at (800) 829-6440 for the most current provider information or go to the VALLEY BAPTIST HEALTH PLAN link at www.trs.state.tx.us/trs-activecare.

Plan Year - A Plan Year begins on the first day of September and ends on the last day of the following August.

Plan, Your Plan, the Plan: This is the coverage of health care services available to You under the terms of this Evidence of Coverage.

Primary Care Physician (PCP): The Physician who is responsible for coordinating the health care services You receive under Your Plan, including referring You to specialists and other services. At the time of enrollment, You must select a PCP, or one will be assigned for You. Usually, PCPs are general practitioners, family practitioners, internists or pediatricians. Sometimes Physicians who practice in a particular office of a participating medical group, rather than an individual Physician, may serve as Your PCP. However, if You suffer from a chronic illness that is disabling or Life-Threatening, You may apply to the Plan Medical Director to have a participating specialist Physician designated as Your PCP. Your application to the Medical Director must include the following:

- A written certification of medical need signed by You and the participating specialist who would serve as Your PCP
- Any additional information specified by the Medical Director; and
- A written statement from the participating specialist indicating that he or she is willing to accept responsibility for the coordination of all Your health care needs.

If Your request is denied, that denial may be appealed through Our Member appeal process. If Your request is approved, the effective date for the participating specialist to be Your PCP is the first day of the month following that approval. Under state law, such designations cannot be made retroactively.

For the names of PCPs, please see Your Provider Directory or contact Our Customer Services Department at (800) 829-6440 or go to the VALLEY BAPTIST HEALTH PLAN link at www.trs.state.tx.us/trs-activecare.

Psychiatric Day Treatment Facility: A facility that provides treatment for not more than eight hours in any 24-hour period after which the Member is allowed to leave. The Joint Commission on Accreditation of Healthcare Organizations must accredit such facility.

Residential Treatment Center for Children and Adolescents: A child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children.

Self-Injectable Drugs: Injectable medications recognized by the FDA as appropriate for self-administration, regardless of the Member's ability to self-administer.

Service Area: This is the geographical area that VALLEY BAPTIST HEALTH PLAN is authorized by law to serve. VALLEY BAPTIST HEALTH PLAN's Service Area map is provided in this booklet.

Subscriber: A covered employee of a group who meets all applicable eligibility requirements of *Section 2, Eligibility and Enrollment* and whose enrollment form and applicable premium payment have been received in accordance with the enrollment requirements of this Evidence of Coverage.

Telemedicine: The use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. The term does not include services performed using a telephone or facsimile machine. Health care services will not be excluded based solely on the fact that they were provided through telemedicine and not provided through a face-to-face consultation.

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Toxic Inhalant: A volatile chemical under Chapter 484, Texas Health and Safety Code, or abusable glue or aerosol paints under Section 485.001, Texas Health and Safety Code.

TRS-ActiveCare Program: The Texas School Employees Uniform Group Health Coverage Program established by Insurance Code article 3.50-7.

Usual, Customary and Reasonable (UCR) Amount means costs that do not exceed negotiated schedules of payments developed by Us that are accepted by Participating Providers within a geographic area specified by Us as payment in full.

Us, We or Our means VALLEY BAPTIST HEALTH PLAN.

You or Your means a covered Member.