

Valley TRS-ActiveCare Program Benefits Summary

You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies/evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage. The following is a summary of the Copay amounts You and any Dependents must pay when receiving the services listed below. These services must be performed, prescribed, or directed by Your Primary Care Physician or designated OB/GYN Physician. Please refer to Your Evidence of Coverage for a detailed explanation of covered and non-covered services.

COVERED SERVICE	COPAYMENT
CONTRACT YEAR DEDUCTIBLE	\$250 per Member \$500 per Family
OUT-OF-POCKET MAXIMUM (Does NOT Include Deductible)	\$3,000 per Member \$6,000 per Family
AGGREGATE LIFETIME MAXIMUM	\$2,000,000
INPATIENT SERVICES Inpatient Services Include: <ul style="list-style-type: none"> • Semi-Private Room and Board Charges • Surgical Procedures • Pre-Admission Testing • Physician Hospital Visits • Intensive Care & Coronary Care Units • Operating/Recovering Room • Newborn Delivery Room and Nursery • Physician Services • Skilled Nursing Facility: <i>Limited to 60 days per Contract Year</i> • Chemical Dependency • Acute/Non-Chronic/Short-Term Mental Illness • Serious Mental Illness • Acquired Brain Injury • Autism Spectrum Disorder • Laboratory Tests and X-ray • Reconstructive Surgery 	20% copay – After Deductible
Observation Unit	20% copay – After Deductible
OUTPATIENT SERVICES Outpatient Services Copayment Includes: <ul style="list-style-type: none"> • Facility Charges • Surgical Procedures • Physician Services 	20% copay – After Deductible
Routine Laboratory Tests and X-ray performed in an outpatient setting	No Copay
Diagnostic Test performed in an outpatient setting: <ul style="list-style-type: none"> • MRI • CT Scans 	20% copay – After Deductible

COVERED SERVICE	COPAYMENT
<ul style="list-style-type: none"> Sleep Study Nuclear Stress Tests PET Scan 	
<p>PHYSICIAN OFFICE SERVICES</p> <p>Physician Office Services Copayments Include:</p> <ul style="list-style-type: none"> Physician Office Visits Medications, supplies and materials administered in the office (<i>unless otherwise noted</i>) Second Surgical Opinion <p>Routine Laboratory Tests and X-ray</p> <p>Diagnostic Test performed in a physician's office:</p> <ul style="list-style-type: none"> MRI CT Scans Sleep Study Nuclear Stress Tests PET Scan <p>Allergy Services</p> <ul style="list-style-type: none"> Office Visits Allergy Testing Serum Injection Administration <p>Maternity Care, including Pre- and Post-Natal Obstetrical Care</p> <p>Surgical Procedures performed in the Physician's Office</p>	<p>\$25 per visit to the PCP \$35 per visit to the Specialist</p> <p>No Copay</p> <p>20% copay – After Deductible</p> <p>\$25 per visit to the PCP \$35 per visit to the Specialist</p> <p>20% copay – After Deductible</p> <p>50% copay – After Deductible</p> <p>50% copay – After Deductible</p> <p>No Copay</p> <p>20% copay – After Deductible</p>
<p>PREVENTIVE SERVICES</p> <p>Preventive Services copayments include:</p> <ul style="list-style-type: none"> Annual Routine Physicals Well Baby and Well Child Care Routine Eye, Speech and Hearing Screenings for Children when performed during an office visit Routine Immunizations for (6 and older) Examinations and Testing for the detection of Prostate Cancer <p>Routine Laboratory Tests and X-ray</p> <p>Immunizations for Newborns (birth to 6-years of age)</p> <p>Newborn Child Hearing Screenings (birth to 30-days old)</p> <p>Well Woman Exam including Routine Annual Physicals</p> <p>Preventive Diagnostics and Testing:</p>	<p>\$25 per visit to the PCP \$35 per visit to the Specialist</p> <p>No Copay</p> <p>No Copay</p> <p>No Copay</p> <p>\$25 per visit</p>

COVERED SERVICE	COPAYMENT
<ul style="list-style-type: none"> • Screening mammograms including Digital, X-ray and Ultrasound • Screening for the detection of Colorectal Cancer (<i>If other procedures are needed during the screening, additional Copayments, Deductible, Coinsurance will apply.</i>) • Cardiovascular Disease Testing: <i>Limited to a benefit maximum of \$200, once every 5 years.</i> • Bone Mass Measurement 	<p>No Copay</p> <p>No Copay</p> <p>No Copay</p> <p>No Copay</p>
<p>OUTPATIENT BEHAVIORAL HEALTH SERVICES</p> <p>Outpatient Behavioral Health Services include:</p> <ul style="list-style-type: none"> • Acute/Non-Chronic/Short-Term Mental Health Services • Chemical Dependency Services • Serious Mental Illness • Autism Spectrum Disorder • Acquired Brain Injury 	<p>\$25 per visit to the PCP</p> <p>\$35 per visit to the Specialist</p>
<p>FAMILY PLANNING AND INFERTILITY SERVICES</p> <p>Family Planning and Counseling</p> <p>Infertility Services</p> <ul style="list-style-type: none"> • Diagnostic testing to determine cause of infertility • Medical services for artificial insemination • Infertility Drugs are not covered. <p>Contraceptive Devices, Implants and Injections including:</p> <ul style="list-style-type: none"> • Diaphragm • IUD • Subdermal Contraceptive Implants & Removal • Depo-Provera™ Injections <p><u>STERILIZATION PROCEDURES</u> (Vasectomy & Tubal Ligation)</p> <ul style="list-style-type: none"> • When performed in an Outpatient Facility • When performed in the Physician's Office • When performed in an Inpatient Facility 	<p>\$25 per visit to the PCP</p> <p>\$35 per visit to the Specialist</p> <p>50% of the Allowable Amount – After Deductible; applies to all office visits and services.</p> <p>20% of the Allowable Amount for all charges – After Deductible. Applies to materials, procedures, and services.</p> <p>20% copay – After Deductible</p> <p>20% copay – After Deductible</p> <p>See Inpatient Services</p>
<p>DIABETIC SERVICES</p> <p>Diabetic Self-Management Education</p> <p>Insulin and Diabetic Insulin</p> <ul style="list-style-type: none"> • 30 Day Supply <ul style="list-style-type: none"> ○ 1st tier - Generic Drugs ○ 2nd tier - Brand name drugs on drug list ○ 3rd tier - Brand name drugs not on drug list • Mail Order (up to 90- day supply) <ul style="list-style-type: none"> ○ 1st tier - Generic Drugs ○ 2nd tier - Brand name drugs on drug list ○ 3rd tier - Brand name drugs not on drug list 	<p>\$25 per visit to the PCP</p> <p>\$35 per visit to the Specialist</p> <p>\$10 per prescription</p> <p>\$30 per prescription</p> <p>\$60 per prescription</p> <p>\$30 per prescription</p> <p>\$90 per prescription</p> <p>\$180 per prescription</p>

COVERED SERVICE	COPAYMENT
Test Strips	20% per item
Other Diabetic Supplies and Equipment (30 Day Supply)	20% per item
EMERGENCY ROOM SERVICES	
Emergency Room	20% copay – After Deductible. Emergency room Copay is waived if admitted to Hospital
Minor Emergency/Urgent Care Center	\$75 copay
Ambulance	20% per ambulance trip – After Deductible
OTHER HEALTH CARE SERVICES	
Limited Accidental Dental Care and Medically Related Oral Surgeries: <i>Limited to \$10,000 Contract Year Maximum Benefit</i>	\$25 per visit to the PCP – After Deductible \$35 per visit to the Specialist – After Deductible
Therapy Services: <ul style="list-style-type: none"> • Rehabilitation Therapy • Speech Therapy • Occupational Therapy • Physical Therapy 	20% copay – After Deductible
Hospice Care: <i>Lifetime Maximum of \$10,000</i>	No Copay – After Deductible
Spinal Manipulation: <i>Limited to 10 visits per Contract Year</i>	20% copay – After Deductible
Pain Management Services	Included in the Physician Office Services, Outpatient Services/Surgery, or Inpatient Services copayment.
Durable Medical Equipment (DME) and Medical Supplies: <i>DME is limited to \$4,000 per Contract Year. DME used in the treatment of diabetes, oxygen and monitoring devices are not included in the \$4,000 maximum.</i>	20% of the Allowable Amount per piece of equipment or supply – After Deductible.
Medical Supplies	20% of the Allowable Amount per piece of equipment or supply – After Deductible.
Prosthetics: External Devices: <i>Lifetime Maximum of \$10,000 per Device/Limb</i>	20% of the Allowable Amount per device – After Deductible
Orthotics: <i>Lifetime Maximum of \$10,000</i>	20% of the Allowable Amount per device – After Deductible
Internal Implantable Devices	20% of the Allowable Amount per device – After Deductible
Dialysis Services (<i>Inpatient & Outpatient</i>)	Included in the Physician Office Services, Outpatient Services/Surgery, or Inpatient Services copayment.
Organ Transplant Services (<i>Inpatient & Outpatient</i>)	Included in the Physician Office Services, Outpatient Services/Surgery, or Inpatient Services copayment.

COVERED SERVICE	COPAYMENT
Drugs associated with the following: <ul style="list-style-type: none"> • Cancer Chemotherapy; • Anti-Rejection/Immunosuppressant Therapy; and • Radiation Therapy 	20% copay – After Deductible
Chemotherapy/Radiation Therapy (<i>Administration & Supplies only</i>)	Included in the Physician Office Services, Outpatient Services/Surgery, or Inpatient Services copayment.
Home Infusion Medications (<i>excluding “self-injectable” drugs</i>)	20% copay – After Deductible
Amino Acid-Based Elemental Formulas	20% copay – After Deductible
Hearing Aids	Coverage is limited to a maximum of \$500 per ear once every 36 months – After Deductible.
Home Health Services <ul style="list-style-type: none"> • Includes treatment of covered illness or injury in your home • EXCLUDES speech, physical, and occupational therapy 	\$35 per visit – After Deductible
ALL OTHER HEALTH CARE SERVICES	20% copay – After Deductible