

FirstCare Health Plans TRS ActiveCare Program

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 09/01/2016-08/31/2017

Coverage for: Member/Family | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.firstcare.com or by calling 1-800-884-4901.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$500 person/\$1,500 family Doesn't apply to preventive care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes. \$100 per member /\$300 per family for prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the <i>specific</i> deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. \$6,000 person/\$12,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. See www.firstcare.com or call 1-800-884-4901 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services .

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Adult: \$20 co-pay Pediatric: \$0 co-pay (Age 0-19)	Not covered.	Deductible does not apply to service provided by a Participating Provider.
	Specialist visit	\$60 co-pay/visit.	Not covered.	Deductible does not apply to service provided by a Participating Provider.
	Other practitioner office visit	\$60 co-pay/visit for chiropractor.	Not covered.	—————none—————
	Preventive care/screening/immunization	No charge.	Not covered.	Deductible does not apply to service provided by a Participating Provider.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for routine tests. 25% co-pay for non-routine outpatient diagnostic tests.	Not covered.	Deductible does not apply to service provided by a Participating Provider.
	Imaging (CT/PET scans, MRIs)	\$250 co-pay.	Not covered.	Services that are not pre-authorized will be denied.

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.firstcare.com .	Tier 1	\$0 co-pay/ prescription (retail & mail order).	Not covered.	Prescription Drug Deductible waived for Tier 1 and Tier 2 drugs. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Tier 2	\$15 co-pay/prescription (retail & mail order).	Not covered.	
	Tier 3	\$40 co-pay/prescription (retail & mail order).	Not covered.	
	Tier 4	\$100 co-pay/prescription (retail & mail order)	Not covered.	
	Tier 5	20% co-pay.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% co-pay.	Not covered.	—————none—————
	Physician/surgeon fees	25% co-pay.	Not covered.	—————none—————
If you need immediate medical attention	Emergency room services	\$500 co-pay/vist.	\$500 co-pay/visit.	If services are obtained inside the service area from an out-of-network provider, or if the provider is not an Out-of-Area Wrap Network contracted provider, then the Member may be billed for the balance between billed charges and Non-Participating Provider Reimbursement (NPPR) if payment is made at NPPR. Deductible does not apply to Urgent Care services provided by a Participating Provider .
	Emergency medical transportation	25% co-pay.	Not covered.	
	Urgent care	\$75 co-pay/visit.	\$75 co-pay/visit, if outside service area. Not Covered, if inside service area.	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% co-pay.	Not covered.	Services that are not pre-authorized will be denied.
	Physician/surgeon fee	25% co-pay.	Not covered.	Services that are not pre-authorized will be denied.

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$25 co-pay/office visit. 25% co-pay for other outpatient service.	Not covered.	Deductible does not apply to Participating Provider office visit. Some services that are not pre-authorized will be denied.
	Mental/Behavioral health inpatient services	25% co-pay.	Not covered.	Services that are not pre-authorized will be denied.
	Substance use disorder outpatient services	\$25 co-pay/office visit. 25% co-pay for other outpatient service.	Not covered.	Deductible does not apply to Participating Provider office visit. Some services that are not pre-authorized will be denied.
	Substance use disorder inpatient services	25% co-pay.	Not covered.	Services that are not pre-authorized will be denied.
If you are pregnant	Prenatal and postnatal care	\$25 co-pay. (Initial Visit)	Not covered.	Deductible does not apply to service provided by a Participating Provider.
	Delivery and all inpatient services	25% co-pay.	Not covered.	Services that are not pre-authorized will be denied.

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If you need help recovering or have other special health needs	Home health care	25% co-pay.	Not covered.	Limited to <u>60 Visits</u> per plan year. Services that are not pre-authorized will be denied.
	Rehabilitation services	25% co-pay.	Not covered.	Limited to <u>35 Visits</u> per plan year per each service Services that are not pre-authorized will be denied.
	Habilitation services	Not covered.	Not covered.	Services that are not pre-authorized will be denied.
	Skilled nursing care	25% co-pay.	Not covered.	Limited to <u>30 Days</u> per plan year. Services that are not pre-authorized will be denied.
	Durable medical equipment	25% co-pay.	Not covered.	Services that are not pre-authorized will be denied.
	Hospice service	25% co-pay.	Not covered.	Services that are not pre-authorized will be denied.
If your child needs dental or eye care	Eye exam	Not covered.	Not covered.	—————none—————
	Glasses	Not covered.	Not covered.	—————none—————
	Dental check-up	Not covered.	Not covered.	—————none—————

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult and Child)
- Glasses
- Habilitation
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult and Child)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (Limited to 10 Visits per plan year).

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800-884-4901. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Customer Service at 1-800-884-4901, or contact the Texas Department of Insurance; Mail Code 111-1A; 333 Guadalupe; P.O. Box 149091; Austin, TX 78714; (855) 839-2427 (855-TEX-CHAP); www.texashealthoptions.com; chap@tdi.state.tx.us

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-884-4901.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,800
- Patient pays \$1,740

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$500
Co-pays	\$40
Co-insurance	\$1,000
Limits or exclusions	\$200
Total	\$1,740

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,120
- Patient pays \$1,280

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$1,200
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$1,280

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include [premiums](#).
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network [providers](#). If the patient had received care from out-of-network [providers](#), costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how [deductibles](#), [co-payments](#), and [co-insurance](#) can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your [providers](#) charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the [premium](#) you pay. Generally, the lower your [premium](#), the more you'll pay in out-of-pocket costs, such as [co-payments](#), [deductibles](#), and [co-insurance](#). You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.