TRS-ActiveCare®

TEACHER RETIREMENT SYSTEM OF TEXAS

ActiveCare 1-HD, 1, 2 and 3 Health Plans

Effective September 1, 2010

# Benefits Booklet

51995.0810

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# Welcome

## Meeting Your Health Care Needs

TRS-ActiveCare assists you and your family in case of illness or injury. The plan covers many health care needs, including preventive care and physician office visits, inpatient and outpatient services, behavioral health, prescription drugs, and more.

This booklet is a guide to your TRS-ActiveCare health benefits. It includes definitions of terms you should know and detailed information about your TRS-ActiveCare plan. Tips on how to use the plan effectively, answers to frequently asked questions, and a comprehensive table of contents to help you locate information you need are also included. If you have questions, call Customer Service at 1-866-355-5999, refer to the website or contact your Benefits Administrator.

## Important Phone Numbers

**Customer Service**
1-866-355-5999
8 a.m. - 8 p.m. (Central Time)
Monday through Friday

**Preauthorization**
1-800-441-9188
6 a.m. - 6 p.m. (Central Time)
Monday through Friday

**Behavioral Health**
1-800-528-7264
8 a.m. - 5 p.m. (Central Time)
Monday through Friday

**BlueCard PPO Access**
1-800-810-BLUE (2583)
24 hours, seven days a week

**Website**
www.trs.state.tx.us/trs-activecare

**Blue Care Connection® Condition Management**
1-800-462-3275

**Special Beginnings® Prenatal Program**
1-888-421-7781

**24/7 Nurseline**
1-800-581-0368

TRS laws and regulations and this online Benefits Booklet are TRS-ActiveCare's official statement about the TRS-ActiveCare program and supersede any other statement or representation made concerning TRS-ActiveCare, regardless of the source of that statement or representation. To the extent that any information in this Benefits Booklet is not consistent with or contradicts TRS laws and rules, the TRS laws and rules control. TRS reserves the right to amend the Benefits Booklet at any time. Generally, such amendments will be reflected in an updated online version of the Benefits Booklet appearing on the TRS website (www.trs.state.tx.us/trs-activecare).

TRS-ActiveCare is administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. Blue Cross and Blue Shield of Texas provides claims payment services only and does not assume any financial risk or obligation with respect to claims. Prescription drug benefits are administered by Medco Health Solutions, Inc. (Medco).

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# Welcome

## Read this first…

- **TRS-ActiveCare is a self-funded health coverage plan, not an insurance policy.** That means the premiums collected must cover the cost of benefits utilized. It's your money...spend it wisely.
- **Do not depend on others to manage your coverage.** You are responsible for the decisions you make and for complying with the TRS-ActiveCare plan rules. If you have questions, refer to the website or call Customer Service.
- **Appeals are handled by the TRS-ActiveCare Grievance Administrator, not the Texas Department of Insurance.** Remember, TRS-ActiveCare is not an insurance policy. See page 68 for more information on appeals.
- **Don't assume anything.** Refer to this booklet or call Customer Service if you have **any** questions about your coverage.

- This plan **does not** pay for every medical or drug expense you may incur. You may be responsible for a share of the cost, so be an informed consumer. Read this booklet carefully. Refer to the website or call Customer Service with questions before you make health care decisions.
- Thousands of prescription drugs are covered by TRS-ActiveCare, but **some exclusions and limitations may apply** under the TRS-ActiveCare plan. Check the website or call Customer Service for specific drug coverage information.
- Some drug therapies may require a conversation between your doctor and Medco, the pharmacy benefit manager for TRS-ActiveCare. You can check on many of these drugs on the TRS-ActiveCare website under "Prescription Management Programs" or call Customer Service.

- If you use a non-network provider, **regardless of the circumstances**, you may have to pay more than the usual deductible and coinsurance amounts.
- Some providers (such as radiologists, pathologists, anesthesiologists, neonatologists, ER physicians, etc.) may work at network hospitals but do not contract with any provider networks. These providers often charge more than TRS-ActiveCare will pay. **You will be responsible for charges exceeding the Blue Cross and Blue Shield of Texas allowable amount.**
- You or your provider must submit and Blue Cross and Blue Shield of Texas must receive all claims for benefits under TRS-ActiveCare within 12 months of the date on which you received the services or supplies. Claims not submitted and received by Blue Cross and Blue Shield of Texas within this 12-month period will not be considered for payment of benefits.

- You **must** complete and submit an enrollment form within the appropriate time period to add coverage for newborns and other new dependents, **even if you already have family or children coverage.**
- You may use prior creditable coverage to offset a preexisting condition waiting period as defined by HIPAA, except any coverage you had that precedes a gap in coverage of 63 or more consecutive days.
- To receive the additional 11 months of COBRA continuation coverage when the Social Security Administration (SSA) determines you are disabled, you must notify your plan administrator (Health Care Service Corporation/Blue Cross and Blue Shield of Texas) before the end of the 18-month period of COBRA continuation coverage.

| ActiveCare 1-HD Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| Deductible (per plan year)<br>Individual<br>Family | $2,400 for employee only<br>$2,400 | |
| Out-of-Pocket Maximum (per plan year; does not include deductible or any charges exceeding the allowable amount)<br>Individual<br>Family | $3,000 for employee only ($5,400 including deductible)<br>$5,000 ($7,400 including deductible) | |
| Lifetime maximum benefit | Unlimited | |
| **Doctor and Lab Services** | | |
| Doctor office visits (includes most injections, diagnostic X-rays and lab tests)<br>Allergy injections<br>Contraceptive devices<br>Office surgery<br>Outpatient surgery<br>Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges)<br>Inpatient doctor visits | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| **Preventive Care** | | |
| When using network physicians, benefits are paid at 100% up to the first $500 per individual, per plan year; remaining charges will be subject to deductible and coinsurance. No copayment is required for preventive care, but covered services under this benefit must be billed by the doctor as "preventive care." Preventive care visits–network or non-network–are limited to one physical exam per plan year for age two and over; one OB/GYN well-woman exam per plan year; and one routine mammogram per plan year. See page 38 for more information. | | |
| Office visit (including lab, X-rays, immunizations)<br>Routine eye exam (one per plan year)<br>Hearing exams<br>Lab and X-ray (when no office visit is billed or services are performed outside the office)<br>Immunizations (when no office visit is billed or services are performed outside the office)<br>Routine mammograms (when no office visit is billed or services are performed outside the office)<br>Routine colonoscopies | First $500: Plan pays 100%<br>Remaining charges: after deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |

| ActiveCare 1-HD Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| **Hospital/Facility Services** | | |
| Inpatient hospital (semi-private room and board or intensive care unit; preauthorization required)<br>Outpatient surgery<br>Outpatient hospital/facilities | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Emergency room care within 48 hours of accident or onset of a medical emergency | After deductible, plan pays 80%; you pay 20% | |
| Emergency room care for all other conditions | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| **Extended Care Services (preauthorization required for all services)** | | |
| Skilled nursing facility ($10,000 plan year maximum; up to $7,000 may be non-network)<br>Home health care ($10,000 plan year maximum; up to $7,000 may be non-network)<br>Hospice ($20,000 lifetime maximum; up to $14,000 may be non-network) | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| **Other Medical Services** | | |
| Physical therapy<br>• Office visit<br>• All other services<br>Chiropractic care (up to $1,500 per plan year)<br>• Office visit<br>• All other services<br>Home Infusion Therapy (preauthorization required) | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Hearing aids (up to $1,000 paid per 36-month period) | After deductible, plan pays 80%; you pay 20% | |
| Durable medical equipment<br>Prosthetics | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Ambulance services (ground or air) | After deductible, plan pays 80% of the allowable amount; you pay the remaining 20% plus any charges exceeding the allowable amount billed by non-network providers | |

| ActiveCare 1-HD Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| **Behavioral Health (Mental Health and Chemical Dependency)** | | |
| Mental Health (preauthorization required for all services) | | |
| Inpatient facility<br>Inpatient physician charges<br>Outpatient/office visit | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Chemical Dependency (preauthorization required for all services) | | |
| Inpatient facility<br>Inpatient physician charges<br>Outpatient<br>Office visit | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| **Serious Mental Illness (preauthorization required for all services)** | | |
| Inpatient facility<br>Inpatient physician<br>Outpatient<br>Office visit | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| **Prescription Drugs** | **Network** | **Non-Network** |
| Deductible (per person, per plan year) | Subject to plan year deductible for all medical and prescription benefits | |
| Retail Short-Term (up to a 30-day supply)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications *(preferred brand/non-preferred brand)*<br>Retail Maintenance (up to a 30-day supply)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications *(preferred brand/non-preferred brand)* | After deductible, plan pays 80%; you pay 20% | You pay 100% of the full cost at the time of purchase, and after the deductible is met, you will be reimbursed 80% of the allowable amount as determined by Medco (Must submit claim to Medco within 12 months of service date to be reimbursed) |
| Mail Order Pharmacy (up to a 90-day supply)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications *(preferred brand/non-preferred brand)*<br>Retail-*Plus* Network (60- to 90-day supply at Retail-*Plus* participating pharmacies)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications *(preferred brand/non-preferred brand)* | After deductible, plan pays 80%; you pay 20% | N/A |

| ActiveCare 1 Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan) Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| Deductible (per plan year)<br>Individual<br>Family | $1,200<br>$3,000 | |
| Out-of-Pocket Maximum (per plan year; does not include deductible or any charges exceeding the allowable amount)<br>Individual<br>Family | $2,000<br>$6,000 | |
| Lifetime maximum benefit | Unlimited | |
| **Doctor and Lab Services** | | |
| Doctor office visits (includes most injections, diagnostic X-rays and lab tests) | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Allergy injections | | |
| Contraceptive devices | | |
| Office surgery | | |
| Outpatient surgery | | |
| Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges) | | |
| Inpatient doctor visits | | |
| **Preventive Care** | | |
| When using network physicians, benefits are paid at 100% up to the first $500 per individual, per plan year; remaining charges will be subject to deductible and coinsurance. No copayment is required for preventive care, but covered services under this benefit must be billed by the doctor as "preventive care." Preventive care visits–network or non-network–are limited to one physical exam per plan year for age two and over; one OB/GYN well-woman exam per plan year; and one routine mammogram per plan year. See page 38 for more information. | | |
| Office visit (including lab, X-rays, immunizations) | First $500: Plan pays 100% Remaining charges: after deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Routine eye exam (one per plan year) | | |
| Hearing exams | | |
| Lab and X-ray (when no office visit is billed or services are performed outside the office) | | |
| Immunizations (when no office visit is billed or services are performed outside the office) | | |
| Routine mammograms (when no office visit is billed or services are performed outside the office) | | |
| Routine colonoscopies | | |

| ActiveCare 1 Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| **Hospital/Facility Services** | | |
| Inpatient hospital (semi-private room and board or intensive care unit; preauthorization required)<br>Outpatient surgery<br>Outpatient hospital/facilities | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Emergency room care within 48 hours of accident or onset of a medical emergency | After deductible, plan pays 80%; you pay 20% | |
| Emergency room care for all other conditions | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| **Extended Care Services (preauthorization required for all services)** | | |
| Skilled nursing facility ($10,000 plan year maximum; up to $7,000 may be non-network)<br>Home health care ($10,000 plan year maximum; up to $7,000 may be non-network)<br>Hospice ($20,000 lifetime maximum; up to $14,000 may be non-network) | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| **Other Medical Services** | | |
| Physical therapy<br>• Office visit<br>• All other services<br>Chiropractic care (up to $1,500 per plan year)<br>• Office visit<br>• All other services<br>Home Infusion Therapy (preauthorization required) | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Hearing aids (up to $1,000 paid per 36-month period) | After deductible, plan pays 80%; you pay 20% | |
| Durable medical equipment<br>Prosthetics | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Ambulance services (ground or air) | After deductible, plan pays 80% of the allowable amount; you pay the remaining 20% plus any charges exceeding the allowable amount billed by non-network providers | |

# Your TRS-ActiveCare Benefits

| ActiveCare 1 Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| **Behavioral Health (Mental Health and Chemical Dependency)** | | |
| **Mental Health (preauthorization required for all services)** | | |
| Inpatient facility<br>Inpatient physician charges<br>Outpatient/office visit | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| **Chemical Dependency (preauthorization required for all services)** | | |
| Inpatient facility<br>Inpatient physician charges<br>Outpatient<br>Office visit | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| **Serious Mental Illness (preauthorization required for all services)** | | |
| Inpatient facility<br>Inpatient physician<br>Outpatient<br>Office visit | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| **Prescription Drugs** | **Network** | **Non-Network** |
| Deductible (per person, per plan year) | Subject to plan year deductible for all medical and prescription benefits | |
| Retail Short-Term (up to a 30-day supply)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications *(preferred brand/non-preferred brand)*<br>Retail Maintenance (up to a 30-day supply)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications *(preferred brand/non-preferred brand)* | After deductible, plan pays 80%; you pay 20% | You pay 100% of the full cost at the time of purchase, and after the deductible is met, you will be reimbursed 80% of the allowable amount as determined by Medco (Must submit claim to Medco within 12 months of service date to be reimbursed) |
| Mail Order Pharmacy (up to a 90-day supply)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications *(preferred brand/non-preferred brand)*<br>Retail-*Plus* Network (60- to 90-day supply at Retail-*Plus* participating pharmacies)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications (preferred *brand/non-preferred brand)* | After deductible, plan pays 80%; you pay 20% | N/A |

# Your TRS-ActiveCare Benefits

| ActiveCare 2 Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| Deductible (per plan year)<br>Individual<br>Family | $500<br>$1,500 | |
| Out-of-Pocket Maximum (per plan year; does not include deductible, copays, or any charges exceeding the allowable amount)<br>Individual<br>Family | $2,000<br>$6,000 | |
| Lifetime maximum benefit | Unlimited | |
| **Doctor and Lab Services** | | |
| Doctor office visits (includes most injections, diagnostic X-rays and lab tests when performed during an office visit) | $30 copay for primary<br>$50 copay for specialist | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Diagnostic X-rays and lab tests (when no office visit is billed or services are performed outside the office) | After deductible, plan pays 80%; you pay 20% | |
| Allergy injections (when no office visit is billed or services are performed outside the office) | | |
| Contraceptive devices (when no office visit is billed or services are performed outside the office) | | |
| Office surgery | | |
| Outpatient surgery | | |
| Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges) | $30 copay for primary<br>$50 copay for specialist<br>(for initial visit only; for delivery, after deductible, plan pays 80% and you pay 20%) | |
| Inpatient doctor visits | After deductible, plan pays 80%; you pay 20% | |

*Note: A specialist is any physician other than a family practitioner, internist, OB/GYN or pediatrician.*

| ActiveCare 2 Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| **Preventive Care** | | |
| Office visit copay includes all preventive care services billed with an office visit by a network doctor. Network services billed without an office visit will be paid at 80%. Covered services under this benefit must be billed by the doctor as "preventive care." Preventive care visits–network or non-network–are limited to one physical exam per plan year for age two and over; one OB/GYN well-woman exam per plan year; and one routine mammogram per plan year. See page 38 for more information. | | |
| Office visit (including lab, X-rays, immunizations)<br>Routine eye exam (one per plan year)<br>Hearing exams | $30 copay for primary<br>$50 copay for specialist | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Lab and X-ray (when no office visit is billed or services are performed outside the office)<br>Immunizations (when no office visit is billed or services are performed outside the office)<br>Routine mammograms (when no office visit is billed or services are performed outside the office) | Plan pays 80%; you pay 20% (deductible waived) | |
| Routine colonoscopies | After $100 copay per visit, plan pays 80%; you pay 20% (deductible waived) | |
| **Hospital/Facility Services** | | |
| Inpatient hospital (semi-private room and board or intensive care unit; preauthorization required)<br>$1,500 maximum copay per plan year for network and non-network benefits combined) | After $100 copay per day ($500 maximum copay per admission), plan pays 80%; you pay 20% after deductible | After $100 copay per day ($500 maximum copay per admission), plan pays 60%; you pay 40% of the allowable amount after deductible |
| Outpatient surgery | After $100 copay per visit, plan pays 80%; you pay 20% after deductible | After $100 copay per visit, plan pays 60%; you pay 40% of the allowable amount after deductible |
| Outpatient hospital/facilities | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Emergency room care within 48 hours of accident or onset of a medical emergency | After $100 copay per visit, plan pays 80%; you pay 20% after deductible (copay waived if admitted) | |
| Emergency room care for all other conditions | After $100 copay per visit, plan pays 80%; you pay 20% after deductible (copay waived if admitted) | After deductible, plan pays 60%; you pay 40% of the allowable amount |

*Note: A specialist is any physician other than a family practitioner, internist, OB/GYN or pediatrician.*

| ActiveCare 2 Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| **Extended Care Services (preauthorization required for all services)** | | |
| Skilled nursing facility ($10,000 plan year maximum; up to $7,000 may be non-network) | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Home health care ($10,000 plan year maximum; up to $7,000 may be non-network) | | |
| Hospice ($20,000 lifetime maximum; up to $14,000 may be non-network) | | |
| **Other Medical Services** | | |
| Physical therapy<br>• Office visit | $30 copay for primary<br>$50 copay for specialist | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| • All other services | After deductible, plan pays 80%; you pay 20% | |
| Chiropractic care (up to $1,500 per plan year)<br>• Office visit | $50 copay for specialist | |
| • All other services | After deductible, plan pays 80%; you pay 20% | |
| Home Infusion Therapy (preauthorization required) | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Hearing aids (up to $1,000 paid per 36-month period) | After deductible, plan pays 80%; you pay 20% | |
| Durable medical equipment | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Prosthetics | | |
| Ambulance services (ground or air) | After deductible, plan pays 80% of the allowable amount; you pay the remaining 20% plus any charges exceeding the allowable amount billed by non-network providers | |

*Note: A specialist is any physician other than a family practitioner, internist, OB/GYN or pediatrician.*

| ActiveCare 2 Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| **Behavioral Health (Mental Health and Chemical Dependency)** | | |
| **Mental Health (preauthorization required for all services)** | | |
| Inpatient facility ($1,500 maximum copay per plan year for network and non-network benefits combined) | After $100 copay per day ($500 maximum copay per admission), plan pays 80%; you pay 20% after deductible | After $100 copay per day ($500 maximum copay per admission), plan pays 60%; you pay 40% of the allowable amount after deductible |
| Inpatient physician charges<br>Outpatient/office visit | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| **Chemical Dependency (preauthorization required for all services)** | | |
| Inpatient facility ($1,500 maximum copay per plan year for network and non-network benefits combined) | After $100 copay per day ($500 maximum copay per admission), plan pays 80%; you pay 20% after deductible | After $100 copay per day ($500 maximum copay per admission), plan pays 60%; you pay 40% of the allowable amount after deductible |
| Inpatient physician charges<br>Outpatient | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Office visit | $30 copay for primary<br>$50 copay for specialist | |
| **Serious Mental Illness (preauthorization required for all services)** | | |
| Inpatient facility ($1,500 maximum copay per plan year for network and non-network benefits combined) | After $100 copay per day ($500 maximum copay per admission), plan pays 80%; you pay 20% after deductible | After $100 copay per day ($500 maximum copay per admission), plan pays 60%; you pay 40% of the allowable amount after deductible |
| Inpatient physician<br>Outpatient | After deductible, plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Office visit | $30 copay for primary<br>$50 copay for specialist | |

*Note: A specialist is any physician other than a family practitioner, internist, OB/GYN or pediatrician.*

| ActiveCare 2 Benefits Summary<br>Prescription Drugs* | Network | Non-Network |
|---|---|---|
| Drug Deductible (per person, per plan year) | $50 | |
| Retail Short-Term (up to a 30-day supply)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications (Preferred brand/Non-preferred brand) | <br>$10 copay<br>$25 copay<br>$45 copay<br>$25 copay / $45 copay | You will be reimbursed the allowable amount as determined by Medco for the amount that would have been charged by a network pharmacy less the required copay after the drug deductible is met (Must submit claim to Medco within 12 months of service date to be reimbursed) |
| Retail Maintenance (after second fill; up to a 30-day supply)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications (Preferred brand/Non-preferred brand) | <br>$15 copay<br>$35 copay<br>$60 copay<br>$35 copay / $60 copay | |
| Mail Order Pharmacy Service (up to a 90-day supply)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications (Preferred brand/Non-preferred brand) | <br>$20 copay<br>$62.50 copay<br>$112.50 copay<br>$62.50 copay / $112.50 copay | N/A |
| Retail-*Plus* Network (60- to 90-day supply at Retail-*Plus* participating pharmacies)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications (Preferred brand/Non-preferred brand) | <br>$20 copay<br>$62.50 copay<br>$112.50 copay<br>$62.50 copay / $112.50 copay | N/A |

** If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug. This amount does not count toward the $50 drug deductible.*

| ActiveCare 3 Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| Deductible (per plan year) | | |
| Individual | None | $500 |
| Family | None | $1,500 |
| Out-of-Pocket Maximum (per plan year; does not include deductible, copays, or any charges exceeding the allowable amount) | | |
| Individual | $1,000 | $3,000 |
| Family | N/A | N/A |
| Lifetime maximum benefit | Unlimited | $1,000,000 |
| **Doctor and Lab Services** | | |
| Doctor office visits (includes most injections, diagnostic X-rays and lab tests when performed during an office visit) | $20 copay for primary<br>$30 copay for specialist | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Diagnostic X-rays and lab tests (when no office visit is billed or services are performed outside the office) | Plan pays 80%; you pay 20% | |
| Allergy injections (when no office visit is billed or services are performed outside the office) | | |
| Contraceptive devices (when no office visit is billed or services are performed outside the office) | | |
| Office surgery | | |
| Outpatient surgery | | |
| Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges) | $20 copay for primary<br>$30 copay for specialist<br>(for initial visit only; for delivery, plan pays 80% and you pay 20%) | |
| Inpatient doctor visits | Plan pays 80%; you pay 20% | |

*Note: A specialist is any physician other than a family practitioner, internist, OB/GYN or pediatrician.*

| ActiveCare 3 Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| **Preventive Care** | | |
| Office visit copay includes all preventive care services billed with an office visit by a network doctor. Network services billed without an office visit will be paid at 80%. Covered services under this benefit must be billed by the doctor as "preventive care." Preventive care visits–network or non-network–are limited to one physical exam per plan year for age two and over; one OB/GYN well-woman exam per plan year; and one routine mammogram per plan year. See page 38 for more information. | | |
| Office visit (including lab, X-rays, immunizations) | $20 copay for primary<br>$30 copay for specialist | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Routine eye exam (one per plan year) | | |
| Hearing exams | | |
| Lab and X-ray (when no office visit is billed or services are performed outside the office) | Plan pays 80%; you pay 20% | |
| Immunizations (when no office visit is billed or services are performed outside the office) | | |
| Routine mammograms (when no office visit is billed or services are performed outside the office) | | |
| Routine colonoscopies | After $100 copay per visit, plan pays 80%; you pay 20% | |
| **Hospital/Facility Services** | | |
| Inpatient hospital (semi-private room and board or intensive care unit; preauthorization required; $1,500 maximum copay per plan year for network and non-network benefits combined) | After $100 copay per day ($500 maximum copay per admission), plan pays 80%; you pay 20% | After $100 copay per day ($500 maximum copay per admission), plan pays 60%; you pay 40% of the allowable amount after deductible |
| Outpatient surgery | After $100 copay per visit, plan pays 80%; you pay 20% | After $100 copay per visit, plan pays 60%; you pay 40% of the allowable amount after deductible |
| Outpatient hospital/facilities | Plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Emergency room care within 48 hours of accident or onset of a medical emergency | After $100 copay, plan pays 80%; you pay 20% (copay waived if admitted) | |
| Emergency room care for all other conditions | After $100 copay, plan pays 80%; you pay 20% (copay waived if admitted) | After deductible, plan pays 60%; you pay 40% of the allowable amount |

*Note: A specialist is any physician other than a family practitioner, internist, OB/GYN or pediatrician.*

| ActiveCare 3 Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| **Extended Care Services (preauthorization required for all services)** | | |
| Skilled nursing facility ($10,000 plan year maximum; up to $7,000 may be non-network) | Plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Home health care ($10,000 plan year maximum; up to $7,000 may be non-network) | | |
| Hospice ($20,000 lifetime maximum; up to $14,000 may be non-network) | | |
| **Other Medical Services** | | |
| Physical therapy<br>• Office visit | $20 copay for primary<br>$30 copay for specialist | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| • All other services | Plan pays 80%; you pay 20% | |
| Chiropractic care (up to $1,500 per plan year)<br>• Office visit | $30 copay for specialist | |
| • All other services | Plan pays 80%; you pay 20% | |
| Home Infusion Therapy (preauthorization required) | Plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Hearing aids (up to $1,000 paid per 36-month period) | Plan pays 80%; you pay 20% | |
| Durable medical equipment | Plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Prosthetics | | |
| Ambulance services (ground or air) | Plan pays 80% of the allowable amount; you pay the remaining 20% plus any charges exceeding the allowable amount billed by non-network providers | |

*Note: A specialist is any physician other than a family practitioner, internist, OB/GYN or pediatrician.*

| ActiveCare 3 Benefits Summary<br>General Provisions | Network | Non-Network (Including ParPlan)<br>Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
|---|---|---|
| **Behavioral Health (Mental Health and Chemical Dependency)** | | |
| **Mental Health (preauthorization required for all services)** | | |
| Inpatient facility ($1,500 maximum copay per plan year for network and non-network benefits combined) | After $100 copay per day ($500 maximum copay per admission), plan pays 80%; you pay 20% | After $100 copay per day ($500 maximum copay per admission), plan pays 60%; you pay 40% of the allowable amount after deductible |
| Inpatient physician charges<br>Outpatient/office visit | Plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| **Chemical Dependency (preauthorization required for all services)** | | |
| Inpatient facility ($1,500 maximum copay per plan year for network and non-network benefits combined) | After $100 copay per day ($500 maximum copay per admission), plan pays 80%; you pay 20% | After $100 copay per day ($500 maximum copay per admission), plan pays 60%; you pay 40% of the allowable amount after deductible |
| Inpatient physician charges<br>Outpatient | Plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Office visit | $20 copay for primary<br>$30 copay for specialist | |
| **Serious Mental Illness (preauthorization required for all services)** | | |
| Inpatient facility ($1,500 maximum copay per plan year for network and non-network benefits combined) | After $100 copay per day ($500 maximum copay per admission), plan pays 80%; you pay 20% | After $100 copay per day ($500 maximum copay per admission), plan pays 60%; you pay 40% of the allowable amount after deductible |
| Inpatient physician<br>Outpatient | Plan pays 80%; you pay 20% | After deductible, plan pays 60%; you pay 40% of the allowable amount |
| Office visit | $20 copay for primary<br>$30 copay for specialist | |

*Note: A specialist is any physician other than a family practitioner, internist, OB/GYN or pediatrician.*

| ActiveCare 3 Benefits Summary<br>Prescription Drugs* | Network | Non-Network |
|---|---|---|
| Drug Deductible (per person, per plan year) | $50 | |
| Retail Short-Term (up to a 30-day supply)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications (Preferred brand/Non-preferred brand) | <br>$10 copay<br>$25 copay<br>$40 copay<br>$25 copay / $40 copay | You will be reimbursed the allowable amount as determined by Medco for the amount that would have been charged by a network pharmacy less the required copay after the drug deductible is met (Must submit claim to Medco within 12 months of service date to be reimbursed) |
| Retail Maintenance (after second fill; up to a 30-day supply)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications (Preferred brand/Non-preferred brand) | <br>$15 copay<br>$35 copay<br>$55 copay<br>$35 copay / $55 copay | |
| Mail Order Pharmacy Service (up to a 90-day supply)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications (Preferred brand/Non-preferred brand) | <br>$20 copay<br>$62.50 copay<br>$100 copay<br>$62.50 copay / $100 copay | N/A |
| Retail-*Plus* Network (60- to 90-day supply at Retail-*Plus* participating pharmacies)<br>• Generic<br>• Preferred brand<br>• Non-preferred brand<br>• Specialty medications (Preferred brand/Non-preferred brand) | <br>$20 copay<br>$62.50 copay<br>$100 copay<br>$62.50 copay / $100 copay | N/A |

** If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug. This amount does not count toward the $50 drug deductible.*

# How Your Medical Plan Works

## Allowable Amount

The allowable amount is the maximum amount of benefits Blue Cross and Blue Shield of Texas will pay for eligible expenses you incur under TRS-ActiveCare. Blue Cross and Blue Shield of Texas has established an allowable amount for medically necessary services, supplies and procedures provided by providers that have contracted with Blue Cross and Blue Shield of Texas or any other Blue Cross and/or Blue Shield Plan and providers that have not contracted with Blue Cross and Blue Shield of Texas or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a provider that does not contract with Blue Cross and Blue Shield of Texas, you will be responsible for any difference between the allowable amount and the amount charged by the non-contracting provider.

**Exception:** If you are treated by a non-network provider in a network hospital during the first 48 hours of your emergency, benefits will be paid at the network level based on the billed amount instead of the allowable amount. Ambulance services will be limited to the allowable amount.

You will also be responsible for charges for services, supplies and procedures limited or not covered under TRS-ActiveCare, deductibles, any applicable coinsurance, out-of-pocket maximum amounts, and copay amounts.

How is the allowable amount determined?

**For hospitals and facility other providers, physicians, and professional other providers contracting with Blue Cross and Blue Shield of Texas in Texas or any other Blue Cross and Blue Shield Plan –** The allowable amount is based on the terms of the provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

**For hospitals and facility other providers, physicians, and professional other providers not contracting with Blue Cross and Blue Shield of Texas in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting allowable amount) –** The non-contracting allowable amount for TRS-ActiveCare coverage will be 50% of the provider's billed charges. Participants receiving services from a non-contracting provider will be responsible for the difference between the non-contracting allowable amount and the non-contracting provider's billed charge. **The difference between the non-contracting allowable amount and the non-contracting provider's billed charge may be a substantial amount of money.**

**For multiple surgeries –** The allowable amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest allowable amount plus a determined percentage of the allowable amount for each of the other covered procedures performed.

**For procedures, services, or supplies provided to Medicare recipients –** The allowable amount will not exceed Medicare's limiting charge.

## Predetermination of Benefits

As participants in TRS-ActiveCare, you and your covered dependents are entitled to a review by the Blue Cross and Blue Shield of Texas Medical Division to determine the medical necessity of any proposed medical procedure. It will inform you in advance if Blue Cross and Blue Shield of Texas considers the service to be medically necessary and, therefore, eligible for benefits. To have a predetermination conducted, have your physician provide Blue Cross and Blue Shield of Texas a letter of medical necessity and any pertinent medical records supporting this position. After a decision is reached, you and your physician will be notified in writing. **Predetermination is not a guarantee of payment.** Benefits are always subject to other applicable requirements, such as preexisting conditions, limitations and exclusions, payment of premium, and eligibility at the time care and services are provided.

## Continuity of Care

In the event a participant is under the care of a network provider at the time such provider stops participating in the network and at the time of the network provider's termination, the participant has *special circumstances* such as a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) is past the 24th week of pregnancy and is receiving

treatment in accordance with the dictates of medical prudence, Blue Cross and Blue Shield of Texas will continue providing coverage for that provider's services at the network benefit level, subject to the allowable amount for covered services.

*Special circumstances* means a condition such that the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the participant. *Special circumstances* shall be identified by the treating physician or health care provider, who must request that the participant be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the participant of any amounts for which the participant would not be responsible if the physician or provider were still a network provider.

The continuity of coverage will not extend for more than ninety (90) days, or more than nine (9) months if the participant has been diagnosed with a terminal illness, beyond the date the provider's termination from the network takes effect. However, for participants past the 24th week of pregnancy at the time the provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care and the follow-up check-up within the first six (6) weeks of delivery.

## Freedom of Choice

Each time you need medical care, you can choose to:

| See a Network Provider | See a Non-Network Provider | |
|---|---|---|
| | ParPlan Provider | Non-Network Provider that is not a contracting provider |
| • You receive the higher level of benefits (network benefits)<br>• You are not required to file claim forms<br>• You are not balance billed; network providers will not bill for costs exceeding the Blue Cross and Blue Shield of Texas allowable amount for covered services<br>• Your provider will preauthorize necessary services | • You receive the lower level of benefits (non-network benefits)<br>• You are not required to file claim forms in most cases; ParPlan providers will usually file claims for you<br>• You are not balance billed; ParPlan providers will not bill for costs exceeding the Blue Cross and Blue Shield of Texas allowable amount for covered services<br>• In most cases, ParPlan providers will preauthorize necessary services | • You receive non-network benefits (the lower level of benefits)<br>• You are required to file your own claim forms (must be filed within 12 months of the date of service)<br>• You may be billed for charges exceeding the allowable amount for covered services<br>• You must preauthorize necessary services |

| Network vs. Non-Network Providers | | |
|---|---|---|
| | Network | Non-Network (Including ParPlan) |
| If you need to… | You pay lower out-of-pocket costs if you choose network care | Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
| Visit a doctor or specialist<br>*A "specialist" is any physician other than a family practitioner, internist, OB/GYN or pediatrician* | • Visit any network doctor or specialist<br>• Pay the office visit copay (not applicable for ActiveCare 1-HD or ActiveCare 1)<br>• Pay any coinsurance and deductible<br>• Your doctor cannot charge more than the allowable amounts for covered services | • Visit any licensed doctor or specialist<br>• Pay for the office visit<br>• File a claim and get reimbursed for the visit minus any coinsurance and deductible<br>• Your costs will be based on allowable amounts; the non-network doctor you receive services from may require you to pay any charges over the allowable amounts |
| Receive preventive care | • Visit any network doctor or specialist<br>• Pay the preventive care copay (not applicable for ActiveCare 1-HD or ActiveCare 1)<br>• Pay any coinsurance and deductible<br>• Your doctor cannot charge more than the allowable amounts for covered services | • Visit any licensed doctor or specialist<br>• Pay for the preventive care visit<br>• File a claim and get reimbursed for the visit minus any coinsurance and deductible<br>• Your costs will be based on allowable amounts; the non-network doctor you receive services from may require you to pay any charges over the allowable amounts |
| Receive emergency care | • Call 911 or go to any hospital or doctor immediately; you will receive network benefits for emergency care<br>• Pay any copay (waived if admitted)<br>• Pay any coinsurance and deductible (see emergency care on page 32)<br>• Call the preauthorization number on your ID card within 48 hours | |
| Be admitted to the hospital | • Your network doctor will preauthorize your admission<br>• Go to the network hospital<br>• Pay any copay, coinsurance and deductible | • You, a family member, your doctor or the hospital must preauthorize your admission<br>• Go to any licensed hospital<br>• Pay any coinsurance and deductible each time you are admitted<br>• Your costs will be based on allowable amounts; the non-network doctor you receive services from may require you to pay any charges over the allowable amounts |

| Network vs. Non-Network Providers | | |
|---|---|---|
| | Network | Non-Network (Including ParPlan) |
| If you need to… | You pay lower out-of-pocket costs if you choose network care | Payment for non-network services is limited to the allowable amount. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount. |
| Receive behavioral health or chemical dependency services | • Call the behavioral health number on your ID card first to authorize all care<br>• See a network doctor or health care professional, or go to any network hospital or facility<br>• Pay any coinsurance and deductible | • Call the behavioral health number on your ID card first to authorize all care<br>• See any licensed doctor or health care professional, or go to any licensed hospital or facility<br>• Pay any coinsurance and deductible<br>• Your costs will be based on allowable amounts; the non-network doctor you receive services from may require you to pay any charges over the allowable amounts |
| File a claim | Claims will be filed for you | You may need to file the claim yourself (claims must be filed within 12 months of the date of service) |
| Get prescription drugs | ActiveCare 1-HD and ActiveCare 1<br>• Take prescription to a network retail pharmacy or use Medco's mail order service<br>• Pay the required coinsurance and deductible<br>ActiveCare 2 and ActiveCare 3<br>• Take prescription to a network retail pharmacy or use Medco's mail order service<br>• Pay the required prescription drug deductible and copay | ActiveCare 1-HD and ActiveCare 1<br>• Take prescription to any licensed pharmacy<br>• Pay the total cost of the drug<br>• File a claim with Medco and get reimbursed the amount that would have been charged by a network pharmacy *less* any coinsurance and deductible (claims must be filed within 12 months of the date of service)<br>ActiveCare 2 and ActiveCare 3<br>• Take prescription to any licensed pharmacy<br>• Pay the total cost of the drug<br>• File a claim with Medco and get reimbursed the amount that would have been charged by a network pharmacy *less* the required prescription drug deductible and copay (claims must be filed within 12 months of the date of service) |

# How Your Medical Plan Works

### What is a ParPlan provider?

ParPlan providers have agreed to accept the Blue Cross and Blue Shield of Texas allowable amount and/or negotiated rates for covered services. When using ParPlan providers, you are covered at the non-network level and, in most cases, will not have to file your own claims. However, you will also not be responsible for any billed amount that exceeds the allowable amount unless you make a special agreement with your provider for non-covered services.

### What happens if a non-network provider is used?

When you seek care from a network doctor or hospital, your TRS-ActiveCare PPO plan pays a larger portion of your health care costs than it pays for services by a non-network provider. When you receive care outside the network, you still have coverage, but you may pay more of the cost, including any charges exceeding allowable amount. For example, with ActiveCare 2, if a non-network doctor bills $100 for a covered service and the allowable amount is $50, assuming your deductible is already met, you would pay $70 ($50 x 40% coinsurance = $20 plus the $50 exceeding the allowable amount). In this example, if a network doctor is used, you would pay $10 ($50 x 20% coinsurance).

### What happens if care is not available from a network provider?

If care is not available from a network provider as determined by Blue Cross and Blue Shield of Texas, and Blue Cross and Blue Shield of Texas preauthorizes your visit to a non-network provider **prior to the visit**, network benefits will be paid. Otherwise, non-network benefits will be paid, and the claim will have to be resubmitted for review and adjustment, if appropriate.

Note: Even if approved by Blue Cross and Blue Shield of Texas, non-network providers paid at the network level may bill you for any charges exceeding the allowable amount for covered services. You are responsible for these charges, which may be substantial. For example, if a non-network doctor bills $10,000 for a covered service and the allowable amount is $5,000, assuming your deductible is met, you would pay $6,000 ($5,000 x 20% preauthorized network coinsurance = $1,000 plus the $5,000 exceeding the allowable amount).

### Need to locate a network or ParPlan doctor or hospital?

Log onto www.trs.state.tx.us/trs-activecare and click on Medical Benefits, then Provider Locator. You can always call Customer Service at 1-866-355-5999 to confirm network status.

## Use of Non-Contracting Providers

When you choose to receive services, supplies, or care from a provider that does not contract with Blue Cross and Blue Shield of Texas (a non-contracting provider), you receive non-network benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the non-contracting allowable amount. The non-contracted provider is not required to accept the non-contracting allowable amount as payment in full and may balance bill you for the difference between the non-contracting allowable amount and the non-contracting provider's billed charges. You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies and procedures limited or not covered under TRS-ActiveCare and any applicable deductibles, coinsurance amounts, and copayment amounts.

## Preauthorization Requirements

TRS-ActiveCare requires advance approval (preauthorization) by Blue Cross and Blue Shield of Texas for certain services. Preauthorization establishes in advance (or within 48 hours following an emergency hospital admission) the medical necessity of certain care and services covered under TRS-ActiveCare. Preauthorization ensures that care and services will not be denied on the basis of medical necessity. However, preauthorization does not guarantee payment of benefits. Benefits are always subject to other applicable requirements, such as preexisting conditions, limitations and exclusions, payment of premium, and eligibility at the time care and services are provided.

The following types of services require preauthorization:

- All inpatient admissions;
- Treatment of all mental health care, chemical dependency and serious mental illness;
- Extended care, such as in a skilled nursing facility, through home health care or through hospice; and
- Home infusion therapy.

Care should also be preauthorized if you or your doctor wants to:

- Extend your hospital stay beyond the approved days (you or your doctor must call for an extension before your approved stay ends); or
- Transfer you to another facility or to or from a specialty unit within the facility.

Your doctor will not be required to obtain preauthorization from Blue Cross and Blue Shield of Texas for prescribing a length of stay less than 48 hours (or 96 hours) for maternity care. If you require a longer stay, your doctor must seek an extension for the additional days by obtaining preauthorization from Blue Cross and Blue Shield of Texas.

Note: You must request preauthorization to use a non-network provider to receive the network level of benefits. **Preauthorization for medical necessity of services does not guarantee the network level of benefits.** Even if approved by Blue Cross and Blue Shield of Texas, non-network providers paid at the network level may bill for charges exceeding the allowable amount for covered services. You are responsible for these charges, which may be substantial. For example, if a non-network doctor bills $10,000 for a covered service and the allowable amount is $5,000, assuming your deductible is met, you would pay $6,000 ($5,000 x 20% preauthorized network coinsurance = $1,000 plus the $5,000 exceeding the allowable amount).

**What happens if services are not preauthorized?**
Blue Cross and Blue Shield of Texas will review the medical necessity of your treatment prior to the final benefit determination. If the treatment or service is not medically necessary, benefits will be denied. There is a $250 penalty for failure to preauthorize a medically necessary admission to a non-network hospital. The penalty will be deducted from any benefit payment that may be due for the admission. The penalty is in addition to the deductible or out-of-pocket maximum.

## How to Preauthorize

**Medical:** Network providers will preauthorize services for you.

*If you do not use a network provider for your medical care, you are responsible for preauthorization by calling Blue Cross and Blue Shield of Texas at* ***1-800-441-9188****.* (The preauthorization telephone number also appears on your TRS-ActiveCare ID card.) This phone call is important. There is a $250 penalty for failure to preauthorize a medically necessary admission to a non-network hospital. You, your provider, or a family member may call. The call should be made between 6 a.m. and 6 p.m. (Central Time) Monday through Friday. Calls made after working hours, on weekends, or holidays will be recorded and returned the next working day.

**Mental health care, chemical dependency and serious mental illness:** Preauthorization for mental health care, chemical dependency and serious mental illness should be obtained by calling **1-800-528-7264** between 8 a.m. and 5 p.m. (Central Time). All mental health care, chemical dependency and serious mental illness–network and non-network, inpatient and outpatient–should be preauthorized.

**Is there a time limit for preauthorizing hospital admissions?**
All inpatient admissions should be preauthorized at least two working days before admission, or, in the case of an emergency, within 48 hours after admission.

## How to Request or Replace an ID Card

Plan participants will receive two ID cards – one from Blue Cross and Blue Shield of Texas for the medical benefits and a separate card from Medco for the pharmacy/prescription drug benefits. To request additional cards or to replace lost or damaged cards, call Customer Service at 1-866-355-5999, or log on to Blue Access for Members through the TRS-ActiveCare website to order medical ID cards online, or the www.medco.com website to order cards for your prescription drug benefits. There is no charge for ID cards.

## Accessing the BlueCard Program for Health Care Outside Texas

Your benefits travel with you. Your TRS-ActiveCare ID card features the Blue Cross and Blue Shield symbols and the PPO-in-a-suitcase logo telling providers that you are part of the BlueCard program. This means you and your covered dependents have access to Blue Cross and Blue Shield network providers throughout the United States and around the world. Follow these steps to receive the network (highest) level of benefits offered under your plan while traveling or away from home.

| If you need to: | |
|---|---|
| Locate the nearest network doctors and hospitals | Refer to your TRS-ActiveCare ID card and call BlueCard Access at 1-800-810-BLUE (2583) |
| Be admitted to a hospital and/or preauthorize care | Refer to your TRS-ActiveCare ID card and call **1-800-441-9188** to preauthorize care for medical or **1-800-528-7264** to preauthorize care for behavioral health (mental health and chemical dependency) |
| Receive medical attention | Pay any applicable deductible, copayment or coinsurance amount and pay for any non-covered services |
| File a claim<br>(Claims must be filed within 12 months of the date of service) | BlueCard (network) providers will file your claims for you. BlueCard providers have also agreed to accept Blue Cross and Blue Shield's allowable amount for covered services and will not balance bill you for any costs exceeding the allowable amount.<br>If you do **not** use a BlueCard provider for care, **you must pay the doctor or hospital at the time of service and obtain proof of payment (itemized receipt).** Then, you will need to complete and submit a claim form, along with your proof of payment, to receive any applicable reimbursement for covered expenses. The claim form is available online at www.bcbstx.com/trs.<br>Non-network benefits will apply toward covered expenses when using a non-network provider. This means your out-of-pocket expenses will be higher. You will pay 40 percent of the allowable amount after your deductible and the plan will pay 60 percent up to the Blue Cross and Blue Shield of Texas allowable amount. The non-network provider may bill you for any charges exceeding the allowable amounts, and **any charges over the allowable amount will be your responsibility to pay.** |

For more information, see the notice on page 86 regarding other Blue Cross and Blue Shield's separate financial arrangements with providers.

**Does TRS-ActiveCare provide benefits for medical services outside the United States?**
Yes. Through the BlueCard Worldwide program, you have access to hospitals on almost every continent and to a broad range of medical assistance services when you travel or live outside the United States. BlueCard Worldwide provides the following services:

- Provider location
- Referral information
- Medical monitoring
- Wire transfers/overseas mailing
- Translation
- Coverage verification
- Currency conversion

If you need to locate a doctor or hospital, or need medical assistance, call BlueCard Access at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. A medical assistance coordinator, in conjunction with a medical professional, will arrange hospitalization, if necessary. Network benefits will apply for inpatient care at BlueCard Worldwide hospitals.

In an emergency, go directly to the nearest hospital.

Call Blue Cross and Blue Shield of Texas for preauthorization, if necessary. (Refer to the phone number on the back of your TRS-ActiveCare ID card. The preauthorization phone number is different than the BlueCard Access number above.)

In most cases, you will not need to pay for inpatient care at BlueCard Worldwide hospitals in advance. The hospital should submit your claim. You will, however, be responsible for the usual out-of-pocket expenses (non-covered services, deductible, copayment, and coinsurance amounts).

If you do not use a BlueCard Worldwide provider for care, you must pay the doctor or hospital at the time of service and obtain proof of payment (itemized receipt). Then, you will need to complete an international claim form and send it, along with your proof of payment, to the BlueCard Worldwide Service Center in order to receive any applicable reimbursement for covered expenses. The claim form is available online at www.bcbs.com. Non-network benefits will apply towards covered expenses.

Remember that bills from foreign providers differ from billing in the United States. The bills may be missing the provider's name and address, in addition to other critical information. It is very important that you fill out the BlueCard Worldwide claim form completely and attach your bills from the foreign provider. Missing information will delay or prevent claims processing.

## What the Medical Plan Covers

The following medical expenses are covered by TRS-ActiveCare. The descriptions have been alphabetized for quick reference. Covered services may be subject to other plan limitations.

**Refer to the specific Benefits Summary for the TRS-ActiveCare plan you selected on pages 6-18 of this booklet for more detailed information, including the applicable copay, deductible and coinsurance.**

### Acquired Brain Injury

Benefits for eligible expenses incurred for medically necessary treatment of an acquired brain injury will be determined on the same basis as treatment for any other physical condition. Acquired brain injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior. Eligible expenses include:

- Cognitive communication therapy – *Services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
- Cognitive rehabilitation therapy – *Services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits;
- Community reintegration services – *Services* that facilitate the continuum of care as an affected individual transitions into the community;
- Neurobehavioral testing – An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;
- Neurobehavioral treatment – Interventions that focus on behavior and the variables that control behavior;
- Neurocognitive rehabilitation – *Services* designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
- Neurocognitive therapy – *Services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
- Neurofeedback therapy – *Services* that utilizes operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;
- Neurophysiological testing – An evaluation of the functions of the nervous system;
- Neurophysiological treatment – Interventions that focus on the functions of the nervous system;
- Neuropsychological testing – The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment – Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Post-acute transition services – *Services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration. This shall include coverage for reasonable expenses related to periodic reevaluation of an individual covered under the plan who:
  - Has incurred an acquired brain injury
  - Has been unresponsive to treatment and
  - Becomes responsive to treatment at a later date
- Psychophysiological testing – An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment – Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation – The process(es) of restoring or improving a specific function.

Note: *Service* means the work of testing, treatment, and providing therapies to an individual with an acquired brain injury. *Therapy* means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury. Treatment for an acquired brain injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

# How Your Medical Plan Works

## Allergy Care

Coverage is provided for testing and treatment for medically necessary allergy care. Allergy injections are not considered immunizations for purposes of the TRS-ActiveCare preventive care benefit.

## Ambulance Services

TRS-ActiveCare provides coverage for professional local ground ambulance or air ambulance transportation services received at the time of an emergency and when determined to be medically necessary by Blue Cross and Blue Shield of Texas. There are no benefits available for ambulance services unless a patient is transported to the nearest hospital equipped and staffed to treat the condition. Payment for ambulance services will be limited to the allowable amount.

### What does medically necessary mean?

Supplies and services are covered only if they are medically necessary. This means that the services and supplies must be:

- Essential to and provided for diagnosis or treatment of a medical condition
- Proper for the symptoms, diagnosis or treatment of a medical condition
- Performed in the proper setting or manner required for a medical condition
- Within the standards of generally accepted health care practice as determined by Blue Cross and Blue Shield of Texas, and
- The most economical supplies or levels of service appropriate for safe and effective treatment.

Medically necessary charges do not include charges for:

- A service or supply that is provided only as a convenience
- Repeated tests that are not needed, even if ordered by a doctor
- Services which are experimental, investigational, and/or unproven, or
- All other non-covered services and supplies.

Medical necessity is determined by Blue Cross and Blue Shield of Texas. A determination of medical necessity does not guarantee payment unless the service is covered by the TRS-ActiveCare plan. Decisions regarding medical necessity are guided by current medical policies that may be viewed at www.trs.state.tx.us/trs-activecare.

## Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by the participant's physician in a treatment plan recommended by that physician are available for a covered dependent child from birth but who has not yet reached the age of ten.

An individual providing services prescribed under the physician's treatment plan must be a health care practitioner:

- who is licensed, certified, or registered by an appropriate agency of the state of Texas;
- whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- who is certified as a provider under the TRICARE military health system.

For purposes of this section, generally recognized services may include services such as:

- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

After the dependent child reaches the age of ten, eligible expenses, as otherwise covered under TRS-ActiveCare, will be available. All contractual provisions will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

## Chemical Dependency Treatment (preauthorization required)

Chemical dependency is the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance. All chemical dependency treatment–inpatient and outpatient, network or non-network–must be preauthorized.

Inpatient treatment of chemical dependency must be provided in a chemical dependency treatment center. Benefits for the medical management of acute, life-threatening intoxication (toxicity) in a hospital will be available on the same basis as any other illness.

## Chiropractic Care

TRS-ActiveCare pays benefits for services (including occupational therapy) and supplies provided by or under the direction of a Doctor of Chiropractic. There is a $1,500 maximum benefit per person, per plan year.

## Clinical Trials

Benefits are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

- Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- National Institutes of Health;
- United States Food and Drug Administration;
- United States Department of Defense;
- United States Department of Veterans Affairs; or
- An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Benefits are not available for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.

## Cosmetic, Reconstructive, or Plastic Surgery

For cosmetic, reconstructive or plastic surgery, TRS-ActiveCare covers only the following services if medically necessary:

- Treatment for correction of defects due to accidental injury while covered under TRS-ActiveCare. (The condition that the accident occurs while the participant is covered by TRS-ActiveCare does not apply to initial enrollees and new hires.)
- Reconstructive surgery following cancer surgery.
- Treatment and surgery to correct a congenital defect in a newborn.
- Surgery to correct a congenital defect in a dependent child (other than a newborn child) under age 19. This does not include breast surgery.
- Reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.
- Reconstructive surgery on a dependent child under age 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.
- Reduction mammoplasty.

Benefits for eligible expenses will be the same as for the treatment of any other sickness as shown on the Benefits Summary for the specific TRS-ActiveCare plan you selected.

## Dental Services and Covered Oral Surgery

TRS-ActiveCare is **not** a dental plan. You should consult your employer regarding dental coverage they may offer or make available to employees. General dental services, including removal of impacted and non-impacted wisdom teeth, are not covered by TRS-ActiveCare, even as a result of a medical condition or as a precursor to an approved medical procedure.

When medically necessary as determined by Blue Cross and Blue Shield of Texas and prescribed by your doctor, covered oral surgery is limited to:

- Excision of non-dental related neoplasms, including benign tumors and cysts, and all malignant and premalignant lesions and growths;
- Incision and drainage of facial abscess;
- Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses;
- Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) due to accident, trauma, congenital defects and developmental defects or a pathology;
- Services provided to a newborn for treatment or correction of a congenital defect;
- Correction of damage caused solely by external violent accidental injury to healthy natural teeth and supporting tissues, if the accident occurs while the participant is covered by TRS-ActiveCare. (The condition that the accident occurs while the participant is covered by TRS-ActiveCare does not apply to initial enrollees and new hires.) Services must be received within 24 months of the date of the accident. An injury sustained as a result of biting or chewing is not considered to be an accidental injury; and
- Orthognathic surgery (except for services due to a congenital defect for plan participants age 19 or older).

Facility and related services, when medically necessary, are covered for participants who are unable to undergo treatment in a dental office or under local anesthesia due to a documented physical, mental, or medical reason (preauthorization required). The dental-related services are not covered.

## Diabetic Management Services

TRS-ActiveCare covers expenses associated with the treatment of diabetes for individuals diagnosed with insulin-dependent or non-insulin-dependent diabetes, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels. Covered items include:

### Diabetic Equipment

- Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind; up to $100 every 12 calendar months)
- Insulin pumps and necessary accessories (infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin, and other required disposable supplies) and
- Podiatric appliances, including up to two pairs of therapeutic footwear per plan year, for the prevention of complications associated with diabetes.

### Diabetic Supplies

- Test strips for blood glucose monitors
- Lancets and lancet devices
- Visual reading and urine test strips and tablets which test for glucose, ketones and protein
- Insulin and insulin analog preparations
- Incretins and amylin analogs
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Biohazard disposable containers
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- Glucagon emergency kits or GlucaGen HypoKits

**Note:** All diabetic supplies listed above, along with blood glucose monitors (including noninvasive glucose monitors and monitors for the blind), will be covered under the prescription drug program, administered by Medco Health Solutions, Inc.

### Diabetic Management Services/Diabetes Self-Management Training Programs

Includes initial and follow-up instruction concerning:

- The physical cause and process of diabetes;
- Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
- Prevention and treatment of special health problems for the diabetic patient;
- Adjustment or lifestyle modifications; and
- Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Training will include the development of an individualized management plan that is created for and in collaboration with the patient (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and diabetes supplies.

## Disease/Condition Management

TRS-ActiveCare provides voluntary disease/condition management programs designed specifically for participants who have been diagnosed with asthma, diabetes, congestive heart failure, coronary artery disease, metabolic syndrome (high blood pressure, high cholesterol), low back pain, or end stage renal disease. Lifestyle management programs are also available to address weight management and smoking cessation. When you enroll in one of the programs, you'll receive helpful information about your condition, at no out-of-pocket cost to you.

The programs work collaboratively with your health plan, doctor and you to identify the best way to manage your condition more effectively. Enrolling in a program can help:

- Decrease the intensity and frequency of your symptoms
- Enhance your self-management skills
- Reduce (or decrease) missed days at work
- Enrich your quality of life

Claims, lab results, pharmacy data, preauthorization prior to hospitalization, predictive modeling, health risk assessments, self referral and/or a physician referral are some of the sources used to determine if you may be a candidate for enrollment in a disease/condition management program. As you know, your physician plays an important role in treating your condition and Blue Cross and Blue Shield of Texas will notify your physician by letter and/or contact you directly to invite you to enroll in one of the programs.

Each program addresses your specific needs, based on the severity of your condition, complications and risk factors. If the severity of your condition is mild, you will receive:

- Coverage for targeted preventive screenings
- Seasonal mailings with educational materials related to your condition

- Annual contact calls to encourage medication compliance
- Tools to help you better self-manage your condition

If the symptoms of your chronic condition are moderate to severe, your program will be tailored to provide you with:

- Personalized self-management planning
- Regularly scheduled monitoring by a registered nurse
- 24-hour-a-day telephone access to a specialty nurse
- An audio library of topics related to your condition, available by telephone around-the-clock
- Assistance in getting selected condition-specific durable medical equipment for monitoring your chronic condition covered under your health plan
- Home health visits and social service consultation, if needed

**Please be assured your health care information is kept confidential and will not be released to your employer.** Blue Cross and Blue Shield of Texas disease/condition management programs are fully compliant with federal and state privacy regulations. Such regulations permit a health plan and its contracted business associates (such as a pharmacy benefits manager and a disease management program) to use and disclose individuals' health information for purposes of *health care operations*, as long as the various parties agree to keep the information protected and to use it only for the specified purposes. *Health care operations* includes population-based activities relating to improving health or reducing health care costs, plus contacting patients with information about treatment alternatives. Regulators have determined that disease management activities are part of *health care operations*, and patient authorization is not required.

To enroll or ask questions about disease/condition management programs, call **1-800-462-3275.** See page 49 to read about disease/condition management programs and Therapeutic Resource Centers available through your pharmacy benefits administered by Medco.

### Durable Medical Equipment

TRS-ActiveCare covers the rental (or purchase at the discretion of Blue Cross and Blue Shield of Texas) of therapeutic supplies and rehabilitative equipment required for therapeutic use, such as a standard wheelchair, crutches, walker, bedside commode, hospital-type bed, suction machine, artificial respirator, or similar equipment.

Equipment to alleviate pain or provide patient comfort (for example, over-the-counter splints or braces, air conditioners, humidifiers, dehumidifiers, air purifiers, physical fitness and whirlpool bath equipment, personal hygiene protection and home air fluidized beds) is **not** covered, even if prescribed by your doctor.

# How Your Medical Plan Works

## Emergency Care

Your TRS-ActiveCare plan covers medical emergencies wherever they occur. In case of emergency, call 911 or go to the nearest emergency room.

- **Inpatient care:** If you are admitted to a network hospital, network providers will preauthorize your hospital admission and you will receive the network level of benefits. If you are admitted to a non-network hospital, the hospital admission must be preauthorized within 48 hours by calling 1-800-441-9188. If the non-network hospital admission is not preauthorized, there is a $250 penalty, and benefits will be paid at the non-network level. If the admission to the non-network hospital was medically necessary and due to an accident or emergency, you can contact Blue Cross and Blue Shield of Texas to appeal the original decision and request payment at the network level of benefits. **Note:** If you are treated by a non-network provider in a network hospital during the first 48 hours of your emergency, benefits will be paid at the network level based on the billed amount instead of the allowable amount. Payment for ambulance services will be limited to the allowable amount.
- **Outpatient care:** Network level of benefits are available for treatment received within the first 48 hours following an accident or medical emergency (even in a non-network facility). Treatment received after 48 hours of an onset of an accident or medical emergency in a non-network facility will be paid at the non-network level of benefits. Non-network providers may bill you for any charges exceeding the non-contracting allowable amount.

### What is an emergency?

An emergency is the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate care could result in:

- Placing the person'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.

### Doctor, Retail Clinic, Urgent Care or ER?

Sometimes it's easy to know when you should go to an emergency room (ER), such as when you have severe chest pain or unstoppable bleeding. At other times, it isn't always clear. Where do you go when you have an ear infection, or are generally not feeling well? You have various options for receiving in-network treatment. Know when to use each to help save time and money.

| Care Option | Relative Cost* | Description |
|---|---|---|
| **Doctor's Office**<br>*Office hours vary* | Lower out-of-pocket cost to you than an urgent care visit | Your doctor's office is generally the best place to go for non-emergency care such as health exams, colds, flu, sore throats, minor injuries, aches and pains. |
| **Retail Health Clinic**<br>*Example: MinuteClinic (CVS)*<br>*Similar to retail store hours* | Lower out-of-pocket cost to you than an urgent care visit | Walk-in clinics are often located in stores and pharmacies to provide convenient, low-cost treatment for minor medical problems like ear infections, athlete's foot, bronchitis and some vaccinations. |
| **Urgent Care Provider**<br>*Hours generally include evenings, weekends and holidays* | Lower cost than an ER visit | Urgent care centers provide care when your doctor is not available, and you don't have a true emergency. For example, they can treat sprained ankles, fevers, and minor cuts and injuries. |
| **Emergency Room (ER)**<br>*24 hours, seven days a week* | Highest out-of-pocket cost to you | An emergency means you could die, lose the use of a limb or organ, or otherwise place your health in serious jeopardy if you don't get care quickly. For serious, life-threatening conditions, you need emergency care. *For medical emergencies, call 911 or your local emergency services first.* |

* The relative costs described here are for network providers. Your costs for out-of-network providers may be significantly higher. Visit **bcbstx.com/trs** for more information or to find a provider.

### 24/7 Nurseline

**888-315-9473**

*Available 24 hours a day, seven days a week; bilingual nurses available.* The 24/7 Nurseline can help:

- Decide if a situation is an emergency
- Answer health-related questions
- Understand your condition

### Family Planning
Covered services include:
- Insertion and removal of an intrauterine device (IUD)
- Fitting a diaphragm
- Vasectomy
- Tubal ligation
- Insertion or removal of birth control device implanted under the skin.

Oral contraceptives and other items requiring a prescription, such as contraceptive patches, Estring and Seasonale, etc., are included under the TRS-ActiveCare prescription drug benefit.

### Hearing Aids
Benefits are available for hearing aids, including fittings and molds, up to $1,000 per 36-month period. Hearing aids must be paid for in advance and claims for covered expenses must be submitted to Blue Cross and Blue Shield of Texas for reimbursement. TRS-ActiveCare does not cover replacement for loss, damage or functional defect. Hearing aid repair and batteries are also not covered.

### Home Health Care (preauthorization required)
TRS-ActiveCare covers medically necessary services and supplies provided in the patient's home during a visit from a home health agency as part of a physician's written home health care plan. Coverage includes:
- Part-time or intermittent nursing care by a registered nurse (RN), advanced practice nurse (APN), or licensed vocational nurse (LVN)
- Part-time or intermittent home health aide services for patient care
- Physical, occupational, speech, and respiratory therapy services provided by licensed therapists, and
- Supplies and equipment routinely provided by the home health agency.

Home health care benefits are not provided for food or home-delivered meals, social casework or homemaker services, transportation, or services provided primarily for custodial care.

### Home Infusion Therapy (preauthorization required)
TRS-ActiveCare covers the administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous (IV) or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home infusion therapy includes:
- Drugs and IV solutions
- Pharmacy compounding and dispensing services
- All equipment and ancillary supplies necessitated by the defined therapy
- Delivery services
- Patient and family education, and
- Nursing services.

Over-the-counter products which do not require a prescription, including standard nutritional formulations used for enteral nutrition therapy, are **not** covered.

### Hospice Care (preauthorization required)
TRS-ActiveCare covers services provided by a hospice to patients confined at home or in a hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

The following services are covered for *home* hospice care:
- Part-time or intermittent nursing care by a registered nurse (RN), advanced practice nurse (APN) or licensed vocational nurse (LVN)
- Part-time or intermittent home health aide services for patient care
- Physical, respiratory, and speech therapy by licensed therapists, and
- Homemaker and counseling services, including bereavement counseling.

Covered *facility* hospice care includes:
- All usual nursing care by a registered nurse (RN), advanced practice nurse (APN), or licensed vocational nurse (LVN)
- Room and board and all routine services, supplies and equipment provided by the hospice facility
- Physical, speech and respiratory therapy services by licensed therapists, and
- Counseling services routinely provided by the hospice facility, including bereavement counseling.

### Hospital Admission (preauthorization required)
TRS-ActiveCare covers room and board (up to the hospital's semiprivate room rate), general nursing care, and other hospital services and supplies. It does not cover personal items such as telephones and television rental.

Note: Any charge for room and board in a private room over the semiprivate room rate is not covered unless medically necessary, as determined by Blue Cross and Blue Shield of Texas.

### Infertility Services

Testing for problems of infertility is covered. Coverage is also provided for prescription fertility drugs under the TRS-ActiveCare prescription drug benefit.

Note: Services or supplies provided for, in preparation for, or in conjunction with in vitro fertilization and artificial insemination are **not** covered. See page 41 for additional exclusions.

### Lab and X-Ray Services

Medically necessary laboratory and radiographic procedures, services and materials, including diagnostic X-rays, X-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests, and therapeutic radiology services are covered when ordered by a provider.

Network providers are responsible for referring patients to network labs, imaging centers or an outpatient department of a network hospital for medically necessary lab and X-ray services that are not available in a provider's office. However, you should always remind your provider that you will receive a higher level of benefits offered under your plan when using network providers.

If care is not available from a network provider as determined by Blue Cross and Blue Shield of Texas and Blue Cross and Blue Shield of Texas preauthorizes your visit to a non-network provider **prior to the visit**, network benefits will be paid. Otherwise, non-network benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate. If a non-network provider is used, the participant will be responsible for any expenses exceeding the allowable amount.

In some situations, a provider or facility will refer the results of lab tests and X-rays to a radiologist or pathologist for a professional interpretation of the results. Since participants have little or no control over this referral, all professional interpretations for lab and X-ray will be paid at the network level of benefits whether performed by a network or non-network provider. However, if a non-network provider is used, the participant will be responsible for any expenses exceeding the allowable amount.

**What happens if lab and X-ray work are performed outside the doctor's office, or the lab work and X-rays are sent to another location for interpretation?**

ActiveCare 1-HD and ActiveCare 1: If the lab and X-ray services performed outside the doctor's office are for preventive care, they will be paid at 100% of the allowable amount up to a $500 maximum per plan year when using network physicians. Charges over the $500 maximum will be subject to deductible and coinsurance (plan pays 80%; you pay 20%). Lab and X-ray services due to non-preventive diagnoses will also be subject to deductible and coinsurance.

ActiveCare 2: For lab and X-ray services performed outside the doctor's office, the plan pays 80% of the allowable amount and you pay 20% for covered services when using network physicians for preventive care. Lab and X-ray services due to non-preventive diagnoses will be subject to deductible and coinsurance.

ActiveCare 3: For lab and X-ray services performed outside the doctor's office, the plan pays 80% of the allowable amount and you pay 20% for covered services when using network physicians.

**Are non-network specialists such as anesthesiologists, radiologists and pathologists covered at the network level of benefits if the hospital or surgeon is in the network?**

These services will be paid at the network benefits level. However, payment for non-network services is limited to the allowable amount, and you are responsible for any charges billed by the provider which exceed the allowable amount, except for emergency care services (see page 32).

## Maternity Care

TRS-ActiveCare covers maternity-related expenses for employees and covered dependents.

Maternity care includes diagnosis of pregnancy, pre- and post-natal care and delivery (including delivery by Caesarean section). TRS-ActiveCare covers inpatient care for the mother and newborn child in a health care facility for a minimum of 48 hours following an uncomplicated vaginal delivery and for a minimum of 96 hours following an uncomplicated delivery by Caesarean section. Inpatient hospital expenses incurred by the mother for delivery of a child will not include charges for routine well-baby nursery care of the newborn child during the mother's hospital admission for the delivery. These charges will be considered expenses of the child and will be subject to the benefit provisions and benefit maximums described in the Benefits Summary of the specific TRS-ActiveCare plan you selected.

Benefits for eligible expenses incurred for treatment of *complications of pregnancy* will be determined on the same basis as treatment for any other sickness. Complications of pregnancy means: (1) conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but *shall not include* false labor, occasional spotting, physician−prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre−eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and (2) non−elective Caesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Note: TRS-ActiveCare includes a free voluntary comprehensive prenatal program–Special Beginnings–that helps mothers take better care of themselves and their babies. The program assesses pregnancy risk level and provides close monitoring through a series of calls from an experienced obstetrical nurse from pregnancy through six weeks after delivery. To enroll or ask questions about the program, call toll-free: **1-888-421-7781**.

**How are doctor's charges for maternity care covered?**

ActiveCare 1-HD and ActiveCare 1: Maternity care is subject to the applicable deductible and coinsurance.

ActiveCare 2 and ActiveCare 3: You pay the office visit copay for your initial visit. For the duration of your pregnancy, you pay your applicable deductible and coinsurance.

**How is a newborn child covered under TRS-ActiveCare?**

To add coverage for the newborn, you must sign, date and submit an *Enrollment Application and Change Form* to your Benefits Administrator **within 60 days after the date of birth**. However, you have up to one year after the newborn's date of birth to add the newborn to coverage if you have employee and family or employee and child(ren) coverage with TRS-ActiveCare at the time of the newborn's birth and at the time of enrollment. If the application is submitted after the enrollment period for the newborn child, the request to add coverage will be denied–even if there would be no change in premium. Note: You do not have to wait for the newborn's Social Security number to be issued before you submit an *Enrollment Application and Change Form*. Enroll the newborn and re-submit another form after the Social Security number has been issued.

TRS-ActiveCare automatically provides coverage for a newborn child of a covered employee for the first 31 days after the date of birth, but this coverage ends unless the newborn is added to the employee's coverage.

Newborn grandchildren are not covered automatically. If eligible, the grandchild must be added to the employee's coverage for benefits. An eligible grandchild must primarily reside in the employee's household and must be a dependent of the employee for federal income tax purposes.

# How Your Medical Plan Works

## Medical-Surgical Expenses

TRS-ActiveCare provides coverage for medical-surgical expenses for you and your covered dependents. These include:

- Services of physicians and professional other providers
- Services of a certified registered nurse-anesthetist (CRNA)
- Diagnostic X-ray and laboratory procedures except for C-Reactive Protein testing
- Radiation therapy
- Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. For information on coverage for amino acid-based elemental formulas, refer to the prescription drug program on page 51.
- Medically necessary treatment for symptoms of Autism Spectrum Disorder
- Anesthetics and its administration, when performed by someone other than the operating physician or professional other provider
- Oxygen and its administration provided the oxygen is actually used
- Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the participant
- Prosthetic appliances, required for the alleviation or correction of conditions arising out of accidental injury occurring or illness commencing after the participant's effective date of coverage under TRS-ActiveCare, excluding all replacements of such devices other than those necessitated by growth to maturity of the participant
- Services or supplies used by the participant during an outpatient visit to a hospital, a therapeutic center, or a chemical dependency treatment center, or scheduled services in the outpatient treatment room of a hospital
- Certain diagnostic procedures, including, but not limited to bone scan, cardiac stress test, CT scan, MRI, myelogram, ultrasound
- Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes
- Injectable drugs, administered by or under the direction or supervision of a physician or professional other provider
- Telemedicine services other than by telephone or facsimile

Services and supplies for medical-surgical expense must be furnished by or at the direction or prescription of a physician or professional other provider. A service or supply is furnished at the direction of a physician or professional other provider if the listed service or supply is:

- provided by a person employed by the directing physician or professional other provider;
- provided at the usual place of business of the directing physician or professional other provider; and
- billed to the patient by the directing physician or professional other provider

## Mental Health Care (preauthorization required)

TRS-ActiveCare covers charges for inpatient and outpatient mental health care for:

- Diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association,* as revised or any other diagnostic coding system used by Blue Cross and Blue Shield of Texas, whether or not the cause of the disease, disorder or condition is physical, chemical or mental in nature or origin
- Diagnosis or treatment of any symptom, condition, disease or disorder by a provider, or any person working under the supervision of a provider, when the eligible expense is:
  - Individual psychotherapy
  - Psychoanalysis
  - Psychological testing and assessment
  - For administering or monitoring of psychotropic drugs
  - Hospital visits or consultations in a facility providing such care
- Electroconvulsive treatment
- Psychotropic drugs (covered under your pharmacy benefits)

All mental health care–inpatient and outpatient, network or non-network–must be preauthorized. Refer to the Benefits Summary of the TRS-ActiveCare plan you selected for day or visit limitations that apply.

Medically necessary mental health care in a psychiatric day treatment facility, a crisis stabilization unit or facility, or a residential treatment center for children and adolescents, in lieu of hospitalization, will be considered inpatient hospital expense at a mental health facility.

### Organ and Tissue Transplants (preauthorization required)

Organ and tissue transplants (bone marrow, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung) and related services and supplies are covered if the:

- Transplant is not experimental/investigational in nature
- Donated human organs or tissue or an FDA-approved artificial device are used
- Recipient or donor is a participant under TRS-ActiveCare (Benefits are also available to the donor who is not a participant under TRS-ActiveCare)
- Transplant procedure is preauthorized
- Recipient meets all of the criteria established by Blue Cross and Blue Shield of Texas in its written medical policy guidelines, and
- Recipient meets all of the protocols established by the hospital in which the transplant is performed

Covered services and supplies include:

- Evaluation of organs or tissues including, but not limited to, the determination of tissue matches
- Removal of organs or tissues from living or deceased donors
- Transportation and short-term storage of donated organs and tissues

Covered services and supplies related to an organ or tissue transplant include, but are not limited to, X-rays, laboratory testing, chemotherapy, radiation therapy, and complications arising from such transplant.

Services and supplies not covered by TRS-ActiveCare include:

- Living and/or travel expenses of the recipient or live donor
- Donor search and acceptability testing of potential live donors
- Expenses related to maintenance of life for purposes of organ or tissue donation
- Purchase of the organ or tissue
- Organs or tissue (xenograft) obtained from another species

### Orthotics

TRS-ActiveCare covers orthopedic braces (*i.e.,* an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets; and physician-prescribed, -directed, or -applied dressings, bandages, trusses, and splints which are custom-designed for the purpose of assisting the function of a joint.

Non-covered items include, but are not limited to, an orthodontic or other dental appliance (except as allowed for accidental injury under covered oral surgery on page 29); splints or bandages provided by a physician in a non-hospital setting or purchased over-the-counter for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace; specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or effect changes in the foot; or foot alignment, arch supports, elastic stockings and garter belts.

Maintenance and repairs to orthotics resulting from accident, misuse or abuse are the participant's responsibility.

### Outpatient Facility Services

TRS-ActiveCare covers the following services provided through a hospital outpatient department or a free-standing facility when medically necessary:

- Radiation therapy
- Chemotherapy
- Dialysis
- Rehabilitation services
- Outpatient surgery

# How Your Medical Plan Works

## Preventive Care

TRS-ActiveCare encourages preventive care and maintenance of good health. Covered services under this benefit must be billed by the provider as "preventive care." Preventive care benefits include, but are not limited to:

- Routine physical exams (limited to one physical exam per plan year for persons age two and over and one well-woman exam per plan year; benefits are not available for routine physical exams performed on in inpatient basis, except for the initial examination of a newborn child)
- Routine mammograms (one per plan year)
- Immunizations (injections for allergies are not considered immunizations)
- Well baby exams (after newborn's initial examination and discharge from the hospital)
- Vision exams (one per plan year)
- Hearing exams
- Prostate (PSA) screenings
- Colorectal cancer screenings
- Osteoporosis screenings
- Bone density screenings
- Routine colonoscopy

## More about Your Preventive Care Benefits

### Benefits for the Prevention and Detection of Osteoporosis

If a participant is a *qualified individual*, as defined below, benefits will be determined on the same basis as for any other illness as shown on the *Benefits Summary*. Benefits are provided for medically accepted bone mass measurement for the detection of low bone mass and/or to determine the participant's risk of osteoporosis and fractures associated with osteoporosis.

*Qualified individual* means a participant who is:

- Postmenopausal and not receiving estrogen replacement therapy
- An individual with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures
- An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or effectiveness of approved osteoporosis drug therapy

### Benefits for Screening Tests for Hearing Impairment

Benefits are available for a covered dependent child for a screening test for hearing loss from birth through the date the child is 30 days old and for necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months. No deductible applies.

### Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits will be determined on the same basis as for other medical-surgical expenses as shown on the *Benefits Summary*, for each woman enrolled in TRS-ActiveCare for eligible expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

### Immunizations

Benefits are available for immunizations, including, but not limited to the following:

- Diphtheria
- Hemophilus influenzae type B
- Hepatitis B
- HPV
- Measles
- Mumps
- Pertussis
- Polio
- Rubella
- Shingles
- Tetanus
- Varicella
- Any other immunization that is required by law for the child

Injections for allergies are not considered immunizations under this benefit provision.

## Professional Services

Covered services must be medically necessary as determined by Blue Cross and Blue Shield of Texas and provided by a licensed doctor or by other covered health providers. See box below. Benefits for services for diagnosis and treatment of illness or injury are available on an inpatient or an outpatient basis or in a provider's office.

## Prosthetic Devices

TRS-ActiveCare provides coverage for medically necessary artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of:

- An absent body organ (including contiguous tissue), or
- The function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses)

TRS-ActiveCare provides coverage for prosthetic appliances, including replacements necessitated by growth to maturity of the participant.

For purposes of this definition, a wig or hairpiece is not considered a prosthetic appliance. Maintenance and repairs to prosthetic devices resulting from accident, misuse or abuse are the participant's responsibility.

**Who are covered health providers?**

TRS-ActiveCare provides benefits for services provided only by the following providers:

- Advanced Practice Nurse (APN)
- Doctor of Chiropractic
- Doctor of Dentistry
- Doctor of Medicine
- Doctor of Optometry
- Doctor of Osteopathy
- Doctor of Podiatry
- Doctor in Psychology
- Licensed Audiologist
- Licensed Chemical Dependency Counselor
- Licensed Dietician
- Licensed Hearing Instrument Fitter and Dispenser
- Licensed Marriage and Family Therapist
- Licensed Clinical Social Worker
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Licensed Professional Counselor
- Licensed Speech-Language Pathologist
- Licensed Surgical Assistant
- Nurse First Assistant (NFA)
- Physician Assistant (PA)
- Psychological Associates who work under the supervision of a Doctor in Psychology

## Rehabilitation Services (Physical, Speech and Occupational Therapies)

TRS-ActiveCare covers rehabilitation services and physical, speech and occupational therapies that are medically necessary, meet or exceed treatment goals for a participant, and are provided on an inpatient or outpatient basis or in the provider's office. For a physically disabled person, treatment goals may include maintenance of function or prevention or slowing of further deterioration.

## Serious Mental Illness (preauthorization required)

Benefits for the treatment of serious mental illness will be provided on the same basis as any other illness. Serious mental illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:*

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

Medically necessary care for serious mental illness in a psychiatric day treatment facility, a crisis stabilization unit or facility, or a residential treatment center for children and adolescents, in lieu of hospitalization, will be considered inpatient hospital expense at a mental health facility.

## Skilled Nursing Facility (preauthorization required)

TRS-ActiveCare covers care in a skilled nursing facility and pays benefits for:

- Room and board up to the semiprivate room rate
- Routine medical services, supplies, and equipment provided by the skilled nursing facility
- General nursing care by a registered nurse (RN), advanced practice nurse (APN), or licensed vocational nurse (LVN)
- Physical, occupational, speech therapy, and respiratory therapy services by a licensed therapist

## Transitional Care

*Transitional care applies only to initial enrollees as of the date the district/entity begins participating in TRS-ActiveCare; transitional care does not apply to new hires.*

If you or a covered dependent are undergoing a course of medical treatment at the time of enrolling in ActiveCare 1-HD, 1, 2 or 3 and your doctor is **not** in the PPO network, ongoing care with the current doctor may be requested for a period of time. Transitional care benefits may be available if being treated for any of the following conditions by a non-network doctor:

- Pregnancy (third trimester or high risk)
- Newly diagnosed cancer
- Terminal illness
- Recent heart attack
- Other ongoing acute care

Transitional care benefits are subject to approval. To request transitional care benefits, complete a *Transitional Benefits/Release of Patient Information Form* available from your Benefits Administrator or on the website. Instructions for submitting the request to Blue Cross and Blue Shield of Texas are on the form. If the transitional care request is approved, you or your covered dependent may continue to see the non-network doctor and receive the network level of benefits from the selected TRS-ActiveCare plan. If the transitional care request is denied, you may still continue to see your current doctor, but benefits will be paid at the non-network level.

*If your doctor is in the network, you do not have to complete a Transitional Benefits/Release of Patient Information Form.*

# What the Medical Plan Does Not Cover

## Limitations and Exclusions

In addition to the limitations and exclusions set out in the description of What the Medical Plan Covers, beginning on page 27, TRS-ActiveCare does not cover medical expenses for the following:

- As determined by Blue Cross and Blue Shield of Texas, services or supplies that are not medically necessary or any experimental/investigational and/or unproven services or supplies
- Charges resulting from the failure to keep a scheduled visit with a physician or other professional provider, for the completion of any forms, or for the acquisition of medical records
- Vision services or supplies, including but not limited to, orthoptics, vision training, vision therapy, radial keratotomy, contact lenses or the fitting of contact lenses, eyeglasses, photoreflective keratotomy, INTACS and LASIK
- Cosmetic, reconstructive, or plastic surgery except as allowed on page 29
- General dental services, including dental appliances (except for appliances as allowed for accidental injury under covered oral surgery on page 29)
- Any items of medical/surgical expense incurred for dental surgery except as allowed on page 29
- Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses,or the cutting and trimming of toenails in the absence of severe systemic disease
- Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain
- Services or supplies provided for obesity or weight reduction, except for medically necessary treatment of morbid obesity as determined by Blue Cross and Blue Shield of Texas
- Services or supplies provided for bariatric surgery except for medically necessary bariatric procedures performed at designated Blue Distinction Centers for Bariatric Surgery
- Services or supplies provided for injuries sustained as a result of war, declared or undeclared, or any act of war or while on active or reserve duty in the armed forces of any country or international authority
- Services or supplies provided for treatment or related services to the temporomandibular joint (TMJ), except for medically necessary diagnostic/surgical treatment
- Services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment, whether or not benefits are or could be provided under Workers' Compensation
- Items for patient convenience or comfort as determined by Blue Cross and Blue Shield of Texas
- Any charge for room and board in a private room over the semiprivate room rate is not covered unless medically necessary, as determined by Blue Cross and Blue Shield of Texas
- Dietary and nutritional services and supplies except for: an inpatient nutritional assessment program provided in and by a hospital and approved by Blue Cross and Blue Shield of Texas, diabetic management services that are provided by a physician and approved by Blue Cross and Blue Shield of Texas, medically necessary dietary supplements required for the treatment of Phenylketonuria (PKU) or other heritable diseases, medically necessary treatment for symptoms of Autism Spectrum Disorder, or amino acid-based elemental formulas (a prescription order is required)
- Services or supplies provided before the participant's effective date of coverage or after the expiration date of coverage
- Charges that would not be made if you did not have health coverage or charges that you are not legally required to pay
- Services or supplies provided by a person, entity, facility or hospital that has not been approved as a network or non-network provider by Blue Cross and Blue Shield of Texas
- Room and board charges during a hospital admission for diagnostic or evaluative procedures, unless Blue Cross and Blue Shield of Texas determines that inpatient status is medically necessary
- Marriage and family therapy/counseling, self-therapy, or therapy as a part of training
- Travel services and accommodations, whether or not recommended or prescribed, except ambulance services
- Services or supplies provided for, in preparation for, or in conjunction with: sterilization reversal (male or female); transsexual surgery; sexual dysfunction, in vitro fertilization; or promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, transuterine tubal insemination, gamete intra-fallopian

transfer, pronuclear oocyte state transfer, zygote intra-fallopian transfer, and tubal embryo transfer
- Abortion, unless the participant's life would be endangered by continuing the pregnancy, there is a diagnosed fetal anomaly, or the pregnancy is caused by a criminal act such as rape or incest
- Transplant procedures which Blue Cross and Blue Shield of Texas considers experimental and/or investigational in nature
- Medical social services, bereavement counseling (except as part of a preauthorized hospice treatment plan), or vocational counseling
- Environmental sensitivity, clinical ecology , or inpatient allergy testing or treatment
- Chelation therapy except for treatment of acute metal poisoning
- Prescription drugs or medicines that are covered under a separate prescription drug program with its own limitations and exclusions
- Acupuncture, intersegmental traction, surface EMGs, spinal manipulation under anesthesia, and muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph, and Dynatron
- Any occupational therapy services which do not consist of traditional physical therapy modalities and are not part of a rehabilitation program designed to restore lost or impaired body functions
- Any portion of a charge for a service or supply that is in excess of the allowable amount as determined by Blue Cross and Blue Shield of Texas, except for emergency services provided by a non-network provider in a network facility within 48 hours of an accident or medical emergency (see page 32)
- Any services or supplies not specifically defined as eligible expenses, unless pre-approved through case management by Blue Cross and Blue Shield of Texas
- Services or supplies for custodial care as determined by Blue Cross and Blue Shield of Texas
- Services or supplies provided by a person who is related to the participant by blood or marriage, such as, but not limited to spouse, child, sibling or self.
- Over-the-counter products, which do not require a prescription
- Any services or supplies provided for treatment of adolescent (up to age 18) behavior disorders, including conduct disorders and opposition disorders.
- Services for smoking cessation or nicotine addiction. (Supplies may be covered through the prescription drug benefit)
- Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

**What does "non-covered" mean?**

**Non-covered services/care** are those services such as tests, visits, and procedures that are not a covered benefit, or are excluded by Blue Cross and Blue Shield of Texas medical policy and/or done in anticipation of, or preparation for, any of the following:

- Excluded tests, visits, treatments, medications, and procedures
- Treatments, medications, procedures, and/or tests that are considered to be not medically necessary services
- Unproven, investigative/experimental treatments
- Management of complications, a condition following the consequence of a disease, or undesired results that are a direct consequence of excluded tests, visits, treatments, medications, and procedures.

Examples would include complications related to breast implants placed for cosmetic reason, scars or unsatisfactory results of cosmetic surgery, or complications related to non-covered surgeries.

Blue Cross and Blue Shield of Texas medical policies are **subject to change without notice at any time.** Participants and providers should verify the status of any relevant medical policy immediately before services are provided. Current medical policies are available on the TRS-ActiveCare or Blue Cross websites, or by calling Customer Service.

# What the Medical Plan Does Not Cover

**What are preexisting conditions?**

Preexisting conditions are conditions for which you or your dependent received medical advice, diagnosis, care, or for which treatment was recommended or received during the six months before your effective date of coverage under TRS-ActiveCare.

If you or a dependent has a preexisting condition before your medical coverage starts, TRS-ActiveCare may deny benefits for that condition until you have been covered 12 months by TRS-ActiveCare.

The preexisting condition provision does not apply to:

- A newborn child (special rules apply to newborns; see box on page 35 for more information)
- A person who was covered for 12 months under creditable coverage
- Pregnancies
- Conditions resulting from domestic violence
- Genetic information without a diagnosis of a specific condition

All other terms and provisions, limitations and exclusions apply to all employees and covered dependents even if a preexisting condition exclusion does not apply for the reasons above.

**Does TRS-ActiveCare coverage have preexisting condition limitations or exclusions?**

For ActiveCare 1-HD, 1, 2 and 3, preexisting condition exclusions do not apply to employees that initially enroll when the district/entity begins participating in TRS-ActiveCare or to new hires who enroll within 31 days after their actively-at-work date. If you were covered by TRS-ActiveCare at any point in time since the program's inception in 2002, and have been hired by a different participating district/entity (or rehired by same participating district/entity), preexisting limitation exclusions may apply. Prior creditable coverage may be used to offset a preexisting condition waiting period as defined by HIPAA, unless followed by a gap in coverage of 63 or more consecutive days. A 12-month preexisting condition waiting period may apply to employees or dependents enrolling in ActiveCare 1-HD, 1, 2 or 3 due to:

- A special enrollment event
- A future plan enrollment period as determined by TRS
- A transfer to another participating district/entity (or rehired by same participating district/entity) if the employee or any covered dependent has any remaining preexisting waiting period or a gap in coverage of 63 or more consecutive days.

# How Your Prescription Drug Program Works

The pharmacy benefits for the ActiveCare 1-HD, 1, 2 and 3 plans are administered by Medco Health Solutions, Inc. (Medco).

## ActiveCare 1-HD and ActiveCare 1

Your prescription drug deductible is included in your medical deductible.

### Network Retail Pharmacy Services

Participating network retail pharmacies will accept your TRS-ActiveCare ID card and charge you the lesser of the negotiated Medco price or the usual and customary cost for up to a 30-day supply of your prescription. After your plan year deductible is met, you will pay 20% of the price of the prescription until the out-of-pocket maximum is satisfied.

Your retail pharmacy service is most convenient when you need a medication for a **short period**. For example, if you need an antibiotic to treat an infection, you can go to one of the many pharmacies that participate in the TRS-ActiveCare program and get your medication on the **same day**. You may save money by using Medco participating network pharmacies for your short-term prescriptions.

### Medco By Mail Pharmacy Service

By using Medco By Mail Pharmacy Service (Medco By Mail), you can receive up to a **90-day supply** of covered medication. After your plan year deductible is met, you will pay 20% of the price of the prescription until the out-of-pocket maximum is satisfied.

Medco By Mail offers you convenience and potential cost savings. If you need medication on an ongoing or long-term basis, such as medication to treat asthma or diabetes, you can ask your doctor to prescribe up to a **90-day supply** for home delivery, plus refills for up to one year.

## ActiveCare 2 and ActiveCare 3

There is a $50 deductible, per person, per plan year for prescription drugs.

### Network Retail Pharmacy Services

Participating network retail pharmacies will accept your TRS-ActiveCare ID card and charge you the lesser of the usual and customary cost or the appropriate copay for up to a 30-day supply of your prescription. Your retail pharmacy service is, typically, most convenient when you need a medication for a **short period**. For example, if you need an antibiotic to treat an infection, you can go to one of the many pharmacies that participate in TRS-ActiveCare program and get your medication on the **same day**.

### Long-Term Medications and Medco By Mail Pharmacy Service

Obtaining your long-term prescriptions through mail order could mean significant savings for you. If you do not use Medco By Mail for your long-term prescriptions, you may be required to pay more for these medications.

**Here's how it works:** The first two times you buy your long-term prescription at a participating retail pharmacy, you pay your usual retail pharmacy copayment. After that, you will pay a higher cost for your long-term prescription.

With Medco By Mail, you can get up to a 90-day supply of your prescription and make just one copayment. If you fill your prescription at a retail pharmacy, however, you could pay a higher amount for the same 90-day supply (three 30-day fills). Please see charts on page 45 for the copay amounts. If you need medication on an ongoing or long-term basis, such as medication to treat asthma or diabetes, you can ask your doctor to prescribe up to a **90-day supply** for mail order, plus refills for up to one year. When using Medco By Mail to fill a prescription for less than a 90-day supply, the full mail order copay still applies.

You should continue to get all your short-term drugs, such as antibiotics, at a retail pharmacy and pay your usual copayment.

Note: Certain long-term medications are not subject to the above conditions. Insulin and diabetic supplies, for example, may be purchased at retail with no increase in copay on the third or subsequent fills. A listing of drugs that *are* subject to the conditions above may be found at www.trs.state.tx.us/trs-activecare.

### Retail-*Plus* Network

In compliance with SB 0704, 81st (r) Texas Legislature, TRS-ActiveCare will make available through Medco a retail maintenance network effective September 1, 2010. Retail pharmacies who choose to participate in this network will be able to dispense a 60- to 90-day supply of medication. Please contact Medco customer service for more information on pharmacies that may choose to participate in the Retail-*Plus* network.

# How Your Prescription Drug Program Works

## Prescription Drug Formulary

ActiveCare 2 and ActiveCare 3 plans include a formulary, which is a list of drugs indicating preferred and non-preferred status. Each covered drug is Food and Drug Administration (FDA) approved and is also reviewed by an independent group of doctors and pharmacists for safety and efficacy. TRS-ActiveCare encourages the use of the preferred drugs on this list to help control rising prescription drug costs.

### ActiveCare 2 Pharmacy Benefit Copays (after $50 deductible per person, per plan year)

| Short-term drugs (such as antibiotics) | | | | |
|---|---|---|---|---|
| | | You pay | You pay | You pay |
| Where | When | Generic drug | Preferred brand-name drug | Non-preferred brand-name drug |
| Participating Retail Pharmacy | Anytime a medication is prescribed for short-term use | $10 per prescription filled for up to a 30-day supply | $25 per prescription filled for up to a 30-day supply | $45 per prescription filled for up to a 30-day supply |
| Medco By Mail | Not advisable for short-term drugs | Not advisable for short-term drugs | Not advisable for short-term drugs | Not advisable for short-term drugs |
| **Long-term drugs (those you take for three months or more, such as those used to treat high blood pressure or high cholesterol)** | | | | |
| | | You pay | You pay | You pay |
| Where | When | Generic drug | Preferred brand-name drug | Non-preferred brand-name drug |
| Participating Retail Pharmacy | First 2 times you purchase each prescription drug | $10 per prescription filled for up to a 30-day supply | $25 per prescription filled for up to a 30-day supply | $45 per prescription filled for up to a 30-day supply |
| Participating Retail Pharmacy | Beginning with the 3rd time you purchase each prescription drug | $15 per prescription filled for up to a 30-day supply | $35 per prescription filled for up to a 30-day supply | $60 per prescription filled for up to a 30-day supply |
| Medco By Mail | Anytime you purchase a prescription drug | $20 per prescription filled for up to a 90-day supply | $62.50 per prescription filled for up to a 90-day supply | $112.50 per prescription filled for up to a 90-day supply |

### ActiveCare 2

- Participating network retail pharmacies will accept your TRS-ActiveCare ID card and charge you the lesser of the usual and customary cost or the appropriate copay for up to a 30-day supply of your prescription.
- If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug.
- When using Medco By Mail to fill a prescription for less than a 90-day supply, the full mail order copay still applies.
- Remember: You should continue to purchase short-term drugs, such as antibiotics, at a participating retail pharmacy.
- Specialty medications can be categorized as preferred or non-preferred. Refer to page 50 for additional information on specialty medications.
- For copayment information for non-network pharmacies, see the Benefits Summaries on pages 6 to 18.
- If you need more information, visit www.trs.state.tx.us/trs-activecare, or call Customer Service at 1-866-355-5999, select option “2” for member services, then option “1” for prescription benefit information.

# How Your Prescription Drug Program Works

## ActiveCare 3 Pharmacy Benefit Copays (after $50 deductible per person, per plan year)

| Short-term drugs (such as antibiotics) | | | | |
|---|---|---|---|---|
| | | You pay | You pay | You pay |
| Where | When | Generic drug | Preferred brand-name drug | Non-preferred brand-name drug |
| Participating Retail Pharmacy | Anytime a medication is prescribed for short-term use | $10 per prescription filled for up to a 30-day supply | $25 per prescription filled for up to a 30-day supply | $40 per prescription filled for up to a 30-day supply |
| Medco By Mail | Not advisable for short-term drugs | Not advisable for short-term drugs | Not advisable for short-term drugs | Not advisable for short-term drugs |
| **Long-term drugs (those you take for three months or more, such as those used to treat high blood pressure or high cholesterol)** | | | | |
| | | You pay | You pay | You pay |
| Where | When | Generic drug | Preferred brand-name drug | Non-preferred brand-name drug |
| Participating Retail Pharmacy | First 2 times you purchase each prescription drug | $10 per prescription filled for up to a 30-day supply | $25 per prescription filled for up to a 30-day supply | $40 per prescription filled for up to a 30-day supply |
| Participating Retail Pharmacy | Beginning with the 3rd time you purchase each prescription drug | $15 per prescription filled for up to a 30-day supply | $35 per prescription filled for up to a 30-day supply | $55 per prescription filled for up to a 30-day supply |
| Medco By Mail | Anytime you purchase a prescription drug | $20 per prescription filled for up to a 90-day supply | $62.50 per prescription filled for up to a 90-day supply | $100 per prescription filled for up to a 90-day supply |

### ActiveCare 3

- Participating network retail pharmacies will accept your TRS-ActiveCare ID card and charge you the lesser of the usual and customary cost or the appropriate copay for up to a 30-day supply of your prescription.
- If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug.
- When using Medco By Mail to fill a prescription for less than a 90-day supply, the full mail order copay still applies.
- Remember: You should continue to **purchase short-term drugs, such as antibiotics, at a participating retail pharmacy.**
- Specialty medications can be categorized as preferred or non-preferred. Refer to page 50 for additional information on specialty medications.
- For copayment information for non-network pharmacies, see the Benefits Summaries on pages 6 to 18.
- If you need more information, visit www.trs.state.tx.us/trs-activecare, or call Customer Service at **1-866-355-5999**, select option "2" for member services, then option "1" for prescription benefit information.

**Can prescription drug copayments be used to satisfy the plan year deductible and out-of-pocket maximum?**
**ActiveCare 1-HD and ActiveCare 1:** Yes. The cost of your prescription drugs will apply to your medical plan year deductible and out-of-pocket maximum.
**ActiveCare 2 and ActiveCare 3:** No. Your prescription drug copayments do **not** apply to your medical plan year deductible or out-of-pocket maximum. There is a separate $50 per person per plan year deductible for prescription drugs that must be satisfied before copayments apply.

# How Your Prescription Drug Program Works

## ActiveCare 2 and ActiveCare 3: Applying the Prescription Drug Deductible

Example 1: Claim cost less than $50 deductible

| | Total Cost | Deductible Applied | You Pay | Deductible Remaining |
|---|---|---|---|---|
| First Fill | $37 | $37 | $37 | $13 |
| Next Fill | $37 | $13 | $13 + copay | $0 |

Example 2: Claim cost more than $50 deductible

| | Total Cost | Deductible Applied | You Pay | Deductible Remaining |
|---|---|---|---|---|
| First Fill | $100 | $50 | $50 + copay | $0 |
| Next Fill | $100 | $0 | copay | $0 |

- Once the deductible is satisfied, you pay the applicable copay
- Member-paid cost differences between a brand-name drug and a generic equivalent do not apply to the deductible

**Get the information you need online.**
Visit the link to Medco through the website at www.trs.state.tx.us/trs-activecare to compare costs of generic vs. brand-name drugs, calculate mail-order savings, access medication information and more. First-time visitors should take a minute to register to access all the benefits of the site–be sure to have your ID number and a recent prescription number handy when you register.

# How Your Prescription Drug Program Works

### What is the difference between long-term and short-term drugs?

Long-term drugs are those you take on an ongoing basis (three months or more), such as those used to treat high blood pressure or high cholesterol. Short-term drugs include antibiotics and other medications that you take for short periods of time. You can view a list of long-term (or "maintenance") medications on the Medco link at www.trs.state.tx.us/trs-activecare.

### How long does it take to get my medications when I use Medco By Mail?

First-time orders that you mail to Medco will be delivered to you within seven to 11 days after you mail in the order. If your doctor faxes your prescription, you will receive your medications within five to eight days after your doctor faxes the order.

### What if I need to speak with a pharmacist?

Just call toll-free 1-866-355-5999, select option "2" for member services, then option "1" for prescription benefit information. Medco-registered pharmacists are available for medication consultations 24 hours a day, seven days a week.

### Can I still use a participating retail pharmacy?

Yes. You should go to a participating retail pharmacy for medications that you take on a short-term basis, such as antibiotics, and you will pay your participating retail pharmacy copayment. If you prefer, you can continue to receive long-term drugs from a participating retail pharmacy. However, unless you fill a 60- to 90-day supply at a Retail-*Plus* Network participating pharmacy, you will pay more for each long-term drug at a participating retail pharmacy after the second time you fill the prescription.

### What about drug interactions?

The prescription drugs that you get through Medco By Mail, as well as those purchased from a participating retail pharmacy, are checked for potential drug interactions. If Medco By Mail ever has a question about your prescription, a Medco pharmacist will contact your doctor prior to dispensing the medication. If your doctor decides to change the prescription, Medco will send a notification letter to you and to your doctor.

### What is a compound and how does a compound claim process?

A compound is a prescription that requires a pharmacist to mix two or more drugs. Claims for compound medications may be submitted in two ways:

1. The participating retail pharmacy may submit the claim electronically to the PBM. The participant will pay a copayment at the time of service. The PBM will reimburse the pharmacy.
2. If the patient utilizes a non-network pharmacy or utilizes a network pharmacy that will not file the electronic claim, the participant must file a direct claim to the Medco. The participant will be responsible for any cost differences between the pharmacy charge and the plan reimbursement.

In order for a direct claim to be processed, the participant must send the Medco an itemized list of ingredients with a receipt and fully completed claim form. The claim and/or receipt must include:

1. The amount charged by the pharmacy;
2. The total volume or quantity of the compound (such as the number of capsules or the number of milligrams); and
3. The valid National Drug Code (NDC) for each ingredient.

### What happens if I am covered by TRS-ActiveCare and also have Medicare Part D coverage for prescription drugs?

You cannot use your TRS-ActiveCare ID card and your Medicare Part D benefit for the same prescription. Choose the card that offers the best benefit for your prescription.

### Medicare Beneficiaries and Medicare Part D

Medicare Part D provides Medicare benefits for prescription drugs to those Medicare beneficiaries who enroll in Part D. Medicare Part D is an *optional* benefit and is available only to individuals who have Medicare Part A and/or Part B. TRS-ActiveCare coverage will not be affected by enrollment in Medicare Part D for these individuals. That is, your TRS-ActiveCare coverage will continue. The TRS-ActiveCare plan you have may influence your decision on whether or not to enroll in Medicare Part D. TRS-ActiveCare 1-HD, 1, 2, and 3 plans are considered to be creditable coverage in accordance with CMS guidelines. The Centers for Medicare & Medicaid Services (CMS) administers Medicare and a link to their website is available on the TRS-ActiveCare page of the TRS website: www.trs.state.tx.us.

# How Your Prescription Drug Program Works

## Personalized Medicine

### What is Medco's Personalized Medicine Program?

New genetic tests have been developed to help doctors prescribe the most appropriate drug and dosage for each patient's condition. The Personalized Medicine Program gives you the full benefit of these advances. If you are using a medication covered by the Personalized Medicine Program—such as warfarin for a heart condition or tamoxifen for breast cancer—a pharmacist will contact your doctor to see if it is appropriate for you to participate in the program. If your doctor agrees, you will then be contacted by a pharmacist to let you know that the testing is available. If you agree to participate, you will receive a cheek swab test that you can administer on your own. It's as simple as rubbing a swab on your cheek and mailing it back in an envelope. The results will be sent to your doctor and to a specially trained Medco pharmacist who can help your doctor interpret the results of the test. Of course, your doctor decides which drug and dose is right for you.

The Personalized Medicine Program is available to you at no additional cost, and it requires no action on your part. To find out more, contact Medco Member Services.

### Can you describe Medco's Therapeutic Resource Centers and Specialist Pharmacists and the value they bring?

Medco has invented and implemented a model of advanced pharmacy practice that was developed to improve health while lowering the total cost of care for clients and members. We refer to this advanced pharmacy practice model as **Medco Therapeutic Resource Centers®**. Medco is the only pharmacy network capable of delivering this practice model, due to our scale, sophisticated information technology systems, and resources to train and credential pharmacists in specific areas of expertise.

### Specialist Pharmacists Revolutionize Personalized Care

Medco Therapeutic Resource Centers are designated by 14 condition areas, such as Diabetes and Hepatitis, and are staffed by highly trained and accredited pharmacists who are experts in those specific conditions. Specialist pharmacists are Medco's key differentiating element, providing excellence in member care and addressing clients' needs for cost solutions, member engagement, and customized and responsive service. Our specialist pharmacist practice serves the needs of members with like conditions and treatments and provides members and their physicians with advanced clinical support. Collectively, the Medco specialist pharmacists serve all of the members with chronic conditions; i.e., the very members who *account for more than 90% of pharmacy costs and 70% of medical costs*.

### Optimized Pharmacy Practice Improves Savings and Compliance

Each specialist pharmacist works continuously to better understand the needs of the members under their care. Our specialist pharmacists may engage members to discuss medication issues and explore new approaches to improving care. The focus of this work is on members with important gaps in their pharmacy care or at risk for complications. Members are eligible for inclusion, regardless of whether they use retail or mail. When specialist pharmacists evaluate prescriptions, they look for cost and safety issues, identify and address issues with members and their physicians, and counsel those who have questions and special needs. After prescriptions are evaluated, and all issues are resolved, the prescriptions are routed to one of Medco's fully automated dispensing pharmacies for fulfillment. Members benefit from the expertise of the specialist pharmacists and they and their physicians are better engaged in making more cost effective treatment decisions.

### Tailored Services Benefit Both Members and Clients

Medco's fully supports members by dedicating entire pharmacies to members with like conditions and medication needs and staffing these specialist practices with pharmacists specializing in the members' conditions and treatments. Specialist pharmacists not only can help improve the care of members, but their actions can result in substantial annual savings to clients, by eliminating unnecessary medications or suggesting cost-effective alternatives, and when medical complications are avoided. Medco specialist pharmacists are better equipped to make appropriate recommendations to members and physicians and improve clinical results at an overall lower cost by helping increase the generic dispensing rate, formulary compliance, and mail penetration, encouraging better utilization management, and reducing or avoiding medical costs.

# How Your Prescription Drug Program Works

## The Generic Drug Advantage

**Important:** *For both mail order and the retail pharmacy, if you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug.*

Generic drugs may have unfamiliar names, but they are safe and effective. Be assured that generic drugs and their brand-name counterparts:

- Have the same active ingredients and
- Are manufactured according to the same strict federal regulations.

Generic drugs may differ in color, size, or shape, but the FDA requires that they have the same strength, purity, and quality as the brand-name alternatives.

Prescriptions filled with generic drugs often have lower copayments. Therefore, you may be able to get the same health benefits at a lower cost. You should ask **your doctor or pharmacist whether a generic version of your medication is available and whether it would be right for you.** By using a generic drug, you will receive a high-quality medication that may reduce your expenses.

**If your retail pharmacy offers a price that is less than your plan's retail copayment, you will always pay the lesser amount.** Certain retail pharmacies that participate in Medco's network offer a low, "usual and customary" price for some medications. You will pay either this price or your plan's retail copayment, whichever is less.

**You should still use your Medco prescription drug ID card if you fill a prescription in a pharmacy that has a generic promotion program (i.e. Wal-Mart $4 generic program).** Even if you're purchasing a generic drug at retail pharmacy that has a generic promotion program, please present your prescription drug ID card to the pharmacist. Otherwise, we will not be able to check your prescription for potential interactions with your other medications. It also ensures that your payment will be applied to your plan's deductible or out-of-pocket maximum (if applicable).

**The best thing you can do is research your options.** Prices to vary by retail store. Find out whether any of the medications that you're taking is on a generic program list. If they *are* on the list, review your plan's copayments and see whether you could save even more money.

## Exclusions from Pharmacy Benefits

Examples of, but not a complete listing of, categories that are excluded are:

- Non-federal legend drugs
- Ostomy supplies
- Allergy serums
- Blood or blood plasma products
- Implantable contraceptives
- Experimental drugs
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g. Rogaine, Propecia) or for cosmetic purposes only (e.g. Renova, Vaniqua)
- Retin-A/Avita for use by individuals age 35 and over

Note: Other drugs may be excluded under the plan. To find out if your drug is excluded under TRS-ActiveCare, follow the links to the Medco website under the "Medical Pharmacy Benefits" page at www.trs.state.tx.us/trs-activecare. There, you can look up the drug by name (online registration required).

## Prescription Limitations

Under state law, TRS must require prior authorization before certain drugs are dispensed under TRS-ActiveCare. Some drugs or therapeutic classes of drugs may have limitations based upon accepted clinical guidelines, dosage limitations, recommended standards of care and/or shelf life stability limits.

Consult the www.trs.state.tx.us/trs-activecare website for an updated list of these managed drug classes. These programs include:

- **Traditional Prior Authorization:** Certain medications require review and authorization from your physician prior to dispensing.
- **Smart Prior Authorization:** Certain medications require review and authorization by your physician if you have a prescription for more than the usually allowed quantity or dose of medication over time, or in cases when evidence of prior therapy in a step approach is not found.
- **Quantity Per Dispensing Event:** Sets dispensing quantity limits per copayment on a few categories of drugs.
- **Dose Optimization:** Voluntary program that seeks to educate patients and physicians on optimizing dosing of multiple lower strength medications into higher strengths where clinically appropriate.

### Dietary and Nutritional Services

Medco provides coverage for amino acid-based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- Severe food protein-induced enterocolitis syndromes;
- Eosinophilic disorders, as evidenced by the results of biopsy; and
- Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

A written order (prescription) from your health care practitioner is required.

## Specialty Pharmacy (Accredo)

Medco provides specialty pharmacy services for patients with certain complex and chronic conditions through its wholly owned subsidiary, Accredo Health Group, Inc. (Accredo), with locations throughout the United States. Accredo offers comprehensive therapy management solutions, including:

- Reimbursement services to review the patient's coverage and coordinate payment from the health plan and/or patient, as appropriate.
- Confidential and convenient delivery with packaging and handling protocols designed so medication arrives with integrity intact.
- Clinical services to assist the patient—under the supervision of his/her physician—in implementing the prescribed course of treatment.
- Compliance programs to promote patient persistency and help the patient improve his/her quality of life.
- Toll-free access to National Customer Support Center which provides patients with access to specialty-trained pharmacists and registered nurses 24 hours a day, 7 days a week
- Expedited, scheduled delivery of your medications at no additional charge
- Registered nurses available for in-home medication administration, when clinically appropriate and as your plan allows
- Necessary supplies, such as needles and syringes, provided with your medications
- Refill reminder calls

Accredo focuses on infused, injectable, and oral drugs that are very expensive and often have restrictions as determined by the FDA. These specialty drugs may be difficult to self-administer, have a potential for adverse reactions, and require temperature control or other specialized handling.

### What is a specialty drug?

Accredo defines specialty drugs as medications that typically cost $500 or more per dose or $6,000 or more per year* and have one or more of the following characteristics:

- Complex therapy for complex disease
- Specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy
- Unique patient compliance and safety monitoring requirements
- Unique requirements for handling, shipping, and storage
- Potential for significant waste due to the high cost of the drug

*Exceptions to the price threshold may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a specialty drug. In addition, a follow-on-biologic or generic product will be considered a specialty drug if the innovator drug is a specialty drug.

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they're administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

### Are there any limitations on where I can get my specialty medication?

You can obtain drugs designated by Medco as specialty drugs using either your retail or mail order benefit. If you choose to receive specialty drugs from a mail order pharmacy, you must use Accredo as your pharmacy. The exception to this would be for certain products that are available through only one or two U.S. pharmacies. For those products, you will be directed to a pharmacy that can fill your prescription.

# How Your Prescription Drug Program Works

**How to Get Your Prescriptions Filled**

**Retail Pharmacies**

Filling short-term prescriptions can be fast and easy when you use a retail network pharmacy. These pharmacies will accept your ID card and charge you the appropriate copayment when you fill a prescription covered by TRS-ActiveCare. **To find out whether a pharmacy participates in TRS-ActiveCare:**

- Ask your pharmacist
- Visit the website at www.trs.state.tx.us/trs-activecare and use the online pharmacy locator
- Call 1-866-355-5999 and use the automated pharmacy locator.

**Medco By Mail**

With the mail order pharmacy service:

- Your medications are dispensed by a mail order pharmacy and **shipped to your home**.
- Medications are shipped by standard delivery at **no additional cost to you**. (Express shipping is available for an added charge.)
- You can order and track your prescriptions online through the Medco link at www.trs.state.tx.us/trs-activecare, or you can telephone your order to Medco toll-free at 1-800-473-3455.
- Registered pharmacists are available around the clock for medication consultations.

There are two easy ways to get started with Medco By Mail.

### Option 1 — Mail in your prescription:

**Step 1:** Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to one year (as appropriate). Make sure you have a two-week supply on hand while you wait for your mail order prescription to arrive.

**Step 2:** Mail the new prescription using Medco's order form and envelope. Order forms are available on the TRS website at www.trs.state.tx.us/trs-activecare, or you may call Customer Service at 1-866-355-5999, selecting option "2" for member services, then option "1" for prescription benefit information. You may pay for your mail order by credit card, check, or money order. Your prescription will arrive within seven to 11 days after your order is received.

### Option 2 — Have your doctor fax your prescription:

**Step 1:** Follow Step 1 in the Mail section above.

**Step 2:** Provide your doctor with your ID number (located on your TRS-ActiveCare ID card), and ask him or her to call 1-888-327-9791 for instructions on how to use Medco's fax service. You will be billed later. Your prescription will arrive within five to eight days after your doctor faxes the order.

### For Specialty Medications — Call our specialty pharmacy:

**Step 1:** Simply call our specialty pharmacy toll-free at **1-800-501-7260** between 8:00 a.m. and 8:00 p.m., eastern time, Monday through Friday.

**Step 2:** We'll contact your doctor and start the arrangements to transition pharmacies so you can continue receiving the medications you need.

**Step 3:** We'll call you back to arrange for expedited delivery of your medications at a time that is convenient for you.

*OR — Have your doctor call:*

**Step 1:** Provide your doctor with your member ID number (shown on your TRS-ActiveCare ID card) and ask him or her to call 1- 800- 987-4904. We'll work with your doctor to help make the transition smooth for you.

**Step 2:** We'll call you back to arrange for expedited delivery of your medications at a time that is convenient for you.

# Plan Provisions

## Employee Eligibility

**Who can enroll in TRS-ActiveCare?**

To be eligible for TRS-ActiveCare, you must be employed by a participating district/entity and be either an active, contributing TRS member or employed 10 or more regularly scheduled hours each week. You are **not** eligible for TRS-ActiveCare coverage if you are:

- Receiving health care coverage as an employee or retiree under the State University Employees Uniform Insurance Benefits Act. Example: A school employee who has UT SELECT coverage as an employee with The University of Texas System.
- Receiving health care coverage as an employee or retiree under the Texas Employees Group Benefits Act. Example: A school employee who has HealthSelect coverage as an employee with ERS.
- A TRS retiree receiving, or who declined 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 district/entity, he or she can be covered as a **dependent** of an eligible employee.

Employees covered as dependents by a higher education or state program may also be covered under TRS-ActiveCare as an employee.

* If a TRS retiree has returned to work and has never been eligible for TRS-Care, he or she would be eligible for TRS-ActiveCare coverage, as long as the retiree meets all the TRS-ActiveCare eligibility requirements.

Under Section 22.004(k), Texas Education Code, an employee who is participating in TRS-ActiveCare is entitled to continue participating in TRS-ActiveCare if the employee resigns after the end of the instructional year. TRS Rule §41.38, Texas Administrative Code, will be applied by TRS-ActiveCare in determining the appropriate termination date of TRS-ActiveCare coverage.

**Who is eligible for TRS-ActiveCare coverage?**

Teachers, administrative personnel, permanent substitutes, bus drivers, librarians, crossing guards, cafeteria workers, and high school or college students are all eligible for coverage, provided no exception applies, if they are employees, not volunteers, and are either active, contributing TRS members or are employed for 10 or more regularly scheduled hours each week.

True on-call substitutes, independent contractors, and volunteers are not employees and are therefore not eligible for TRS-ActiveCare coverage.

## Eligible Dependents

You may also enroll your eligible dependents at the same time you enroll for coverage. Eligible dependents include:

- A spouse (including a common law spouse)
- An unmarried (including divorced) child under the age of 25, such as:
  - A natural or adopted child
  - A stepchild
  - A foster child
  - A child under the legal guardianship of the employee
- Another child in a regular parent-child relationship with the employee, meaning:
  - The child's primary residence is the household of the employee;
  - The employee provides at least 50% of the child's support;
  - Neither of the child's natural parents resides in that household; and
  - The employee has the legal right to make decisions regarding the child's medical care
- An unmarried grandchild whose primary residence is the household of the employee and who is a dependent of the employee for federal income tax purposes.
- An unmarried child of a covered employee, regardless of age, may be eligible for dependent coverage if the child is either mentally or physically incapacitated to such an extent as to be dependent on the employee on a regular basis as determined by TRS and the child meets other requirements as determined by TRS.

Note: Siblings over age 25 or parents are not the children of an employee and do not meet the definition of an eligible dependent. **It is against the law to elect coverage for an ineligible person. Violations may result in prosecution and/or expulsion from the TRS-ActiveCare program for up to five years.**

If an employee and spouse both work for a participating district/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 district/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 district/entity. If the child is not a contributing TRS member, the child may be covered as a dependent.

**Unmarried (Including Divorced) Children under the Age of 25**
An employee may enroll an unmarried child under the age of 25 who meets TRS-ActiveCare eligibility requirements for dependent coverage. If a married child under the age of 25 obtains a divorce and the employee wants to enroll the child after the initial enrollment period in TRS-ActiveCare, the employee must submit an *Enrollment Application and Change Form* within 31 days after the date of the divorce. Coverage for the child will be effective on the first of the month following the date of the divorce.

This same policy applies to children who obtain an annulment of their marriage and who meet the other TRS-ActiveCare eligibility requirements.

The employee will be responsible for any increase in premium that results from enrolling the child.

## Making Changes/Special Enrollment Events

**TRS-ActiveCare is a self-funded government health plan that has elected to be exempt from the Special Enrollment provisions of the Health Insurance Accountability and Portability Act of 1996 (HIPAA). Therefore, the only special enrollment events recognized by TRS-ActiveCare are those specifically noted in this Benefits Booklet.**

You may be able to enroll yourself and change the dependents you cover during a plan year if you have a special enrollment event such as:

- You legally marry (a common law marriage is not considered a special enrollment event unless there is a certificate of common law marriage filed with an authorized federal or state government agency)
- You divorce (if the divorce results in a loss of other coverage)
- A child is born, adopted, or is placed with you for adoption such that you have a legal obligation to support that child
- A court orders you to provide health coverage for your child (does not apply to court-ordered coverage for an ex-spouse or a spouse's children; also, you will not be able to enroll yourself for employee coverage as a result of such an order)
- Your school district receives an insurance enrollment notification letter from the Texas Health and Human Services agency, stating that you and/or dependent(s) qualify for the Health Insurance Premium Reimbursement program (HIPP), available for Medicaid recipients (the type of coverage and premium amount must match the information provided in the notification letter)
- You involuntarily lose other health insurance coverage (and you originally declined TRS-ActiveCare coverage in writing because of coverage under another health benefit plan), or
- An eligible dependent involuntarily loses other health insurance coverage (and you originally declined TRS-ActiveCare dependent coverage in writing because of coverage under another health benefit plan). The dependent can only enroll if you are already covered by TRS-ActiveCare.

Note: Voluntary terminations of other coverage, such as dropping coverage due to premium or benefit changes, including spousal surcharges or coverage restrictions, are not special enrollment events.

The change in coverage must be consistent with the family status change. For example, if you get married, you can change from employee-only coverage to employee and spouse coverage. The cost of coverage may change based on the selected coverage category.

**Changes in employee and/or dependent coverage must be made within 31 days after the special enrollment event.** (Special rules apply to newborns; see box on page 35 for more information.) If you do not request the appropriate changes during the applicable special enrollment period, the changes cannot be made until the next plan enrollment period or if applicable, another special enrollment event. A preexisting condition exclusion period may apply. An employee may submit a certificate of creditable coverage to offset a preexisting condition waiting period. If the certificate of creditable coverage reveals a gap in coverage exceeding 63 days, it cannot be counted toward the preexisting condition waiting period.

Even if you have a special enrollment event, change employment to another participating district/entity or leave and become re-employed by your same district/entity, you **may not make plan changes** during a plan year unless specifically permitted by TRS rules. An employee may not add dependents during the plan year unless there is a special enrollment event. If coverage is dropped during the plan year, an individual will **not** be eligible to re-enroll in TRS-ActiveCare until the next plan enrollment period even if there is a

special enrollment event, including a loss of other coverage.

Refer to the Effective Date of Coverage chart on page 57 for more information on special enrollment events, when coverage begins and when premium is due.

Note: The COBRA election period is separate from the TRS-ActiveCare enrollment period(s). For example, you have 60 days to elect COBRA coverage with a prior employer, but you must elect TRS-ActiveCare coverage within 31 days of the loss of coverage.

**What is a special enrollment event?**
An event as defined by the TRS-ActiveCare plan design that may provide a special enrollment period for individuals and dependents when there is a loss of other coverage or a gain of additional dependents.

**Can dependents be added throughout the plan year?**
An employee may be able to add eligible dependents during a plan year if the employee has a qualified status change or special enrollment event. Such events include marriage, divorce, birth or adoption of a child, or a loss of coverage from another group plan. The change in coverage must be consistent with the family status change. For example, if an employee gets married, the coverage category can be changed from employee-only coverage to employee and spouse.

## Loss of Coverage

Loss of coverage does **not** qualify as a special enrollment event *unless*:

- You and/or your dependent(s) lost other coverage due to a loss of eligibility
- You and/or your dependent(s) elected to drop the other group health coverage because the employer stopped **all** employer contributions toward the premium (including any employer-paid COBRA premium)
- You and/or your dependent(s) exhausted your COBRA continuation coverage

The following reasons for dropping coverage **do not qualify** as special enrollment events:

- An increase in the premium cost
- A *reduction* in the employer's contribution to the premium
- Any other voluntary termination of coverage, including failure to pay your premium
- Any additional surcharge or benefit reduction for spouse coverage
- Any reduction of benefits such as an increase in deductible or change in the coordination of benefits

If you submit an *Enrollment Application and Change Form* due to "loss of other coverage," your original application will be checked to verify that coverage was declined (in section 9) due to other coverage. **If section 9 was not completed or if no application exists, proof of coverage (such as a certificate of creditable coverage) in lieu of a declination of coverage on the enrollment application must be provided to your Benefits Administrator.** If documentation is not made available, your request to add coverage will be denied.

Note: For TRS-ActiveCare, the loss of coverage from the following also qualifies as a special enrollment event:

- Medicare
- Medicaid
- CHIP
- HIPP
- Individual coverage when outside the control of the individual. For example: The insurance company claims bankruptcy, the insurance company withdraws from doing business in the state, or the insurance company cancels the block of business

## Court-Ordered Dependent Children

If the participating district/entity receives a court order or medical support notice that directs an employee to provide health coverage for a dependent child, the court-ordered dependent child will be automatically enrolled **from the date the participating district/ entity receives notification of the court order or national medical support notice**. Only children listed on the court order may be added to coverage. A court order on anyone other than the employee does not require the plan to provide dependent coverage.

A court order or national medical support notice is not a special enrollment event for an employee. Without a court order or national medical support notice, normal eligibility and special enrollment event rules apply to newly acquired dependent children of an employee if they are enrolled within 31 days of the change of status, for example, stepchildren moved into the employee's household or the couple married.

If you are not covered by TRS-ActiveCare at the time the participating district/entity receives the court order or notice, your court-ordered dependent child(ren) will be automatically enrolled for coverage as noted above, but you cannot enroll for employee coverage until the next enrollment period. If only one child is being added to coverage, the child will be set up with a single ID number and the employee-only premium rate will be charged. If the employee is adding more than one child, the youngest child will be set up with an ID number. The other child(ren) will be listed as dependents, and the employee and child(ren) premium rate will be charged.

If the participating district/entity receives notice of the court order or national medical support notice to add coverage for your dependent child(ren), the child(ren) may be added to your current TRS-ActiveCare plan if you are covered. If you are not covered, you may select a plan for the dependent child(ren).

## Other Court-Ordered Dependents

A court order for you to provide coverage for an ex-spouse does not require the plan to provide dependent coverage. An ex-spouse is not eligible for TRS-ActiveCare coverage unless the ex-spouse is already covered as a COBRA continuation participant.

Request for Exceptions

*Enrollment Application and Change Forms* submitted to your Benefits Administrator after the applicable enrollment period will be denied. You may submit a request to TRS for an exception by writing to: TRS-ActiveCare, 1000 Red River Street, Austin, TX 78701. Such requests will be reviewed on a case-by-case basis.

# Plan Provisions

## Effective Date of Coverage

The effective date is the date TRS-ActiveCare coverage begins for a participant.
See the chart below to help determine the effective date of coverage.

| If … | Your effective date is… | Your eligible dependent's effective date is… | The preexisting condition exclusion applies… |
|---|---|---|---|
| Your district/entity first begins participation in TRS-ActiveCare on September 1, 2010 and you enroll for coverage during spring or summer enrollment… | September 1, 2010 | September 1, 2010 | No *(unless you are already covered by TRS-ActiveCare and have not completed your preexisting condition waiting period or were previously covered by another participating district/entity)* |
| Your district/entity begins participation in TRS-ActiveCare after September 1, 2010 and you enroll for coverage… | The date the district/entity first begins participation in TRS-ActiveCare | The same date as your effective date of coverage<br>*In no event will the dependent's coverage become effective prior to your effective date* | No *(unless you are already covered by TRS-ActiveCare and have not completed your preexisting condition waiting period or were previously covered by another participating district/entity)* |
| You enroll for coverage during the 2010-2011 enrollment period and had originally declined coverage under TRS-ActiveCare… | September 1, 2010 | September 1, 2010 | Yes *(unless enrolling in an HMO option)* |
| A new hire in a TRS-covered position who is a TRS member on his or her actively-at-work date enrolls for coverage within 31 days after the actively-at-work date… | Your choice of:<br>(1) your actively-at-work date, or<br>(2) the first of the month following your actively-at-work date<br>*Premium is billed for the full month in which coverage begins*<br>*New hires must choose the effective date of coverage within 31 days after the actively-at-work date* | The same date as your effective date of coverage<br>*In no event will the dependent's coverage become effective prior to your effective date* | No *(unless you are already covered by TRS-ActiveCare and have not completed your preexisting condition waiting period or were previously covered by another participating district/entity)* |

| If … | Your effective date is… | Your eligible dependent's effective date is… | The preexisting condition exclusion applies… |
|---|---|---|---|
| A new hire in a *non*-TRS-covered position who is regularly scheduled to work 10 or more hours per week on his or her actively-at-work date enrolls for coverage within 31 days after the actively-at-work date… | Your choice of:<br>(1) your actively-at-work date, or<br>(2) the first of the month following your actively-at-work date<br>*Premium is billed for the full month in which coverage begins*<br>*You must choose the effective date of coverage within 31 days after the actively-at-work date* | The same date as your effective date of coverage<br>*In no event will the dependent's coverage become effective prior to your effective date* | No *(unless you are already covered by TRS-ActiveCare and have not completed your preexisting condition waiting period or were previously covered by another participating district/entity)* |
| You are in a non-TRS covered position, working less than 10 regularly scheduled hours per week and become employed in a TRS-covered position and enroll for coverage within 31 days after the date you become an eligible employee…<br>***Note:*** *If you meet eligibility requirements to work 10 or more regularly scheduled hours per week and decline coverage, you may not elect coverage later during that plan year if changing status to a TRS member. (Changing TRS membership status is not an enrollment event.)* | Your choice of:<br>(1) Your eligibility date, or<br>(2) the first of the month following your eligibility date<br>*Premium is billed for the full month in which coverage begins*<br>*You must choose the effective date of coverage within 31 days after the eligibility date* | The same date as your effective date of coverage<br>*In no event will the dependent's coverage become effective prior to your effective date* | No |
| You are in a non-TRS covered position, working less than 10 regularly scheduled hours per week and begin to work 10 or more regularly scheduled hours per week and enroll for coverage within 31 days after the date you become an eligible employee… | Your choice of:<br>(1) Your eligibility date, or<br>(2) the first of the month following your eligibility date<br>*Premium is billed for the full month in which coverage begins*<br>*You must choose the effective date of coverage within 31 days after the eligibility date* | The same date as your effective date of coverage<br>*In no event will the dependent's coverage become effective prior to your effective date* | No |
| You are enrolled in an approved HMO and lose eligibility because you no longer live, work or reside in that HMO service area, you may enroll in another approved HMO (if applicable) or ActiveCare 1-HD, 1, 2 or 3 within 31 days after losing eligibility. | The first of the month following the event date | The same date as your effective date of coverage<br>*In no event will the dependent's coverage become effective prior to your effective date* | No |

| If … | Your effective date is… | Your eligible dependent's effective date is… | The preexisting condition exclusion applies… |
|---|---|---|---|
| You return from military service and enroll (or re-enroll) in TRS-ActiveCare within 31 days after your actively-at-work date…<br>*If you return to active employment within the same plan year and choose to re-enroll in TRS-ActiveCare, you must select the same plan option in which you were previously enrolled.* | Your choice of:<br>(1) your actively-at-work date, or<br>(2) the first of the month following your actively-at-work date<br>*Premium is billed for the full month in which coverage begins*<br>*You must choose the effective date of coverage within 31 days after the actively-at-work date* | The same date as the employee's effective date of coverage<br>*In no event will the dependent's coverage become effective prior to your effective date* | No *(as long as you return to active employment with the participating district/entity directly upon return from military service)* |
| You return from leave-without-pay status and enroll (or re-enroll) for coverage within 31 days after your actively-at-work date…<br>*If you return to active employment within the same plan year and choose to re-enroll in TRS-ActiveCare, you must select the same plan option in which you were previously enrolled.* | Your choice of:<br>(1) your actively-at-work date, or<br>(2) the first of the month following your actively-at-work date<br>*Premium is billed for the full month in which coverage begins*<br>*You must choose the effective date of coverage within 31 days after the actively-at-work date* | The same date as your effective date of coverage<br>*In no event will the dependent's coverage become effective prior to your effective date* | No *(unless there is a gap in coverage of 63 or more consecutive days)* |
| As a covered employee you have a newborn child, you may enroll:<br>(1) your newborn only, or<br>(2) your spouse only, or<br>(3) your spouse and your newborn<br>*Other eligible dependents can also be added at this time*<br>*You have 60 days after the newborn's date of birth to enroll the newborn for coverage. If you have employee and child(ren) or employee and family coverage at the time of the newborn's birth and at the time of enrollment, you have up to one year after the newborn's date of birth to add the newborn to coverage*<br>*Your spouse and other eligible dependents can only be added within 31 days after the newborn's date of birth*<br>*You cannot add a dependent that is already covered by TRS-ActiveCare* | | The newborn's date of birth<br>*If only enrolling the newborn, premium is waived for the first calendar month if the date of birth is other than the first of the month*<br>*If enrolling any other eligible dependent, premium is billed for the full month in which coverage begins*<br>***TRS-ActiveCare automatically provides coverage for a newborn child of a covered employee for the first 31 days after the date of birth, but this coverage ends unless the newborn is added to the employee's coverage.*** | No *(for the newborn)*<br>Yes *(for the spouse and other eligible dependents, unless enrolling in an HMO option)* |

| If … | Your effective date is… | Your eligible dependent's effective date is… | The preexisting condition exclusion applies… |
|---|---|---|---|
| As an eligible, but not covered employee, you have a newborn child, you may enroll:<br>(1) yourself only, or<br>(2) you and your spouse, or<br>(3) you and your newborn, or<br>(4) you, your spouse and your newborn<br>*Other eligible dependents can also be added at this time*<br>*You have 60 days after the newborn's date of birth to enroll the newborn for coverage*<br>*You, your spouse and other eligible dependents can only be added within 31 days after the newborn's date of birth*<br>*You cannot add a dependent that is already covered by TRS-ActiveCare* | The newborn's date of birth<br>*Premium is billed for the full month in which coverage begins* | The newborn's date of birth<br>*Premium is billed for the full month in which coverage begins*<br>***TRS-ActiveCare automatically provides coverage for a newborn child of a covered employee for the first 31 days after the date of birth, but this coverage ends unless the newborn is added to the employee's coverage.*** | No *(for the newborn)*<br>Yes *(for the employee, spouse, and other eligible dependents, unless enrolling in an HMO option)* |
| As a covered employee, you adopt a child and choose to enroll within 31 days after the date of adoption or date on which the child to be adopted is placed with you, you may enroll:<br>(1) your adopted child only, or<br>(2) your spouse only, or<br>(3) your spouse and your adopted child<br>*Other eligible dependents can also be added at this time*<br>*You cannot add a dependent that is already covered by TRS-ActiveCare* | | The date of adoption or the date on which the child to be adopted is placed with you<br>*If only enrolling the adopted child, premium is waived for the first calendar month if the date of birth is other than the first of the month*<br>*If enrolling any other eligible dependent, premium is billed for the full month in which coverage begins* | No *(for the adopted child)*<br>Yes *(for the spouse and other eligible dependents, unless enrolling in an HMO option)* |

| If … | Your effective date is… | Your eligible dependent's effective date is… | The preexisting condition exclusion applies… |
|---|---|---|---|
| As an eligible, but not covered employee, you adopt a child and choose to enroll within 31 days after the date of adoption or date on which the child to be adopted is placed with you, you may enroll:<br>(1) yourself only, or<br>(2) you and your spouse, or<br>(3) you and your adopted child, or<br>(4) you, your spouse and your adopted child<br>*Other eligible dependents can also be added at this time*<br>*You cannot add a dependent that is already covered by TRS-ActiveCare as an employee* | The date of adoption or date on which the child to be adopted is placed with you<br>*Premium is billed for the full month in which coverage begins* | The date of adoption or the date on which the child to be adopted is placed with you<br>*Premium is billed for the full month in which coverage begins* | No *(for the adopted child)*<br>Yes *(for the employee, spouse, and other eligible dependents, unless enrolling in an HMO option)* |
| As a covered employee, you become a legal guardian of an eligible dependent child and choose to enroll the dependent within 31 days after the date the legal guardianship is granted…<br>*An award of legal guardianship is not a special enrollment event if you or your dependents are not covered* | | The date the guardianship is granted<br>*Premium is waived for the first calendar month if the date of notification is other than the first of the month* | Yes *(unless enrolling in an HMO option)* |
| As a covered employee, your court-ordered eligible dependent child is automatically enrolled in TRS-ActiveCare when the participating district/entity receives notice of the court order or national medical support notice …<br>*A court order on the spouse (or ex-spouse) of a covered employee does not require the plan to provide dependent coverage.* | | The date the participating district/entity receives notification of the court order or national medical support notice<br>*Premium is waived for the first calendar month if the date of notification is other than the first of the month* | Yes *(unless enrolling in an HMO option)* |

# Plan Provisions

| If … | Your effective date is… | Your eligible dependent's effective date is… | The preexisting condition exclusion applies… |
|---|---|---|---|
| As an eligible, but not covered employee, your court-ordered eligible dependent child is automatically enrolled in TRS-ActiveCare when the participating district/entity receives notice of the court order or national medical support notice…<br>*A court order or national medical support notice is not a special enrollment event for an employee or other dependents* | | The date the participating district/entity receives notification of the court order or national medical support notice<br>*Premium is billed for the full month in which coverage begins* | Yes *(unless enrolling in an HMO option)* |
| As a covered employee, you add an eligible newborn grandchild or another newborn child who is in a regular parent-child relationship with you within 31 days after the date of birth… | | The newborn's date of birth<br>*Premium is waived for the first calendar month if the date of birth is other than the first of the month* | No |
| As a covered employee, you add an eligible grandchild or another child who is in a regular parent-child relationship with you within 31 days after the child qualifies as a dependent… | | First of the month following the date the child qualifies as a dependent | Yes *(unless enrolling in an HMO option)* |
| As a covered employee, you get married and choose to enroll within 31 days after the date of marriage, you may enroll:<br>(1) your spouse only<br>(2) your spouse's eligible children, or<br>(3) your spouse and your spouse's eligible children<br>*Other eligible dependents can also be added at this time*<br>*You cannot add a dependent that is already covered by TRS-ActiveCare* | | The first of the month following the date of marriage | Yes *(unless enrolling in an HMO option)* |

| If … | Your effective date is… | Your eligible dependent's effective date is… | The preexisting condition exclusion applies… |
|---|---|---|---|
| As an eligible, but not covered employee, you get married choose to enroll within 31 days after the date of marriage, you may enroll:<br>(1) yourself only, or<br>(2) you and your spouse, or<br>(3) you and your spouse's eligible children, or<br>(4) you, your spouse and your spouse's eligible children<br>*Other eligible dependents can also be added at this time*<br>*You cannot add a dependent that is already covered by TRS-ActiveCare* | The first of the month following the date of marriage | The first of the month following the date of marriage | Yes *(unless enrolling in an HMO option)* |
| As a covered employee, your dependent child under the age of 25 obtains a divorce (or annulment) and you choose to enroll the child within 31 days after the date of the divorce (or the annulment)… | | The first of the month following the date of the divorce (or the annulment) | Yes *(unless enrolling in an HMO option)* |
| You receive an Insurance Enrollment Notification letter from the Texas Health and Human Services agency, regarding eligibility for HIPP | The first of the month following the date of the notification letter | The first of the month following the date of the notification letter | Yes (unless enrolling in an HMO option) |
| You make changes to coverage due to other special enrollment events within 31 days after the qualifying event… | The first of the month following the event date | The first of the month following the event date | Yes *(unless enrolling in an HMO option)* |

Promptly notify your Benefits Administrator to:

- Terminate TRS-ActiveCare coverage when a child marries or reaches age 25, or
- Terminate TRS-ActiveCare coverage for a spouse upon a divorce.

When coverage is terminated, benefits for expenses incurred after termination will not be available. If you receive benefits to which you are not entitled, refunds will be requested.

Also remember to notify your Benefits Administrator if you or your covered dependents have an address change.

## When Coverage Ends

Your TRS-ActiveCare employee coverage will end:

- The last day of the month in which your employment ends, unless otherwise provided by TRS rules or law
- The last day of the month you are expelled from the TRS-ActiveCare program
- The last day of the month in which you are no longer eligible for TRS-ActiveCare coverage
- When you stop making the required premium contribution payments
- The last day of the month in which you enter into active, full-time military, naval, or air service except as provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) or other applicable law
- The last day of the month in which eligibility for COBRA continuation coverage expires
- If a participating district/entity fails to make all premium payments for a period of at least 90 days, or
- When the TRS-ActiveCare program is terminated.

A dependent's coverage will end:

- When the employee's coverage ends
- The last day of the month in which he or she is no longer an eligible dependent (for example, your spouse's coverage will end if you get divorced or your dependent child gets married)
- If a dependent becomes eligible as an employee who is an active contributing TRS member
- The last day of the month in which he or she enters into active, full-time military, naval, or air service except as provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) or other applicable law
- The last day of the month in which eligibility for COBRA continuation coverage expires, or
- When you stop paying required contributions for dependent coverage.

### Notice of Creditable Coverage

Upon termination of your coverage under TRS-ActiveCare, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your dependent's coverage under TRS-ActiveCare.

### Can coverage be dropped throughout the plan year?

Unless restricted due to participation in an Internal Revenue Code Section 125 cafeteria plan, an employee can drop all coverage or drop dependent coverage. If coverage is dropped during the plan year, the individual will not be eligible to re-enroll in TRS-ActiveCare until the next plan enrollment period even if there is a special enrollment event, including a loss of other coverage. Preexisting condition exclusions may apply. Note: You cannot elect to drop coverage retroactively; a future cancellation date is required.

### When is a dependent child no longer eligible for coverage?

Coverage for a dependent child terminates at the end of the month in which the child turns 25 or marries or enters into active, full-time military service, whichever occurs first, unless eligible as disabled dependent. If an unmarried child becomes an employee and is a contributing TRS member, the child's coverage will also terminate. An unmarried child under age 25 who is employed by a district/entity and is a contributing TRS member cannot be covered as a dependent on his or her parent's TRS-ActiveCare coverage. Coverage terminates at the end of the month prior to the month in which the child becomes a contributing TRS member. Refer to page 66 of this booklet for information on how to apply for COBRA continuation coverage for the dependent.

If you have an unmarried disabled dependent child that reaches age 25, your child may be eligible for dependent coverage if the child is either mentally retarded or physically incapacitated to such an extent as to be dependent on you on a regular basis and the child meets other requirements as determined by TRS. You (and your dependent's attending physician) must complete a *Dependent Child's Statement of Disability* form to provide satisfactory proof of the disability and dependency. The form must be submitted within 31 days after the date the child turns 25. To avoid any gap in coverage, the form must be submitted and approved prior to the end of the month in which the child turns 25. (Siblings over age 25 or parents are not the children of an employee and do not meet the definition of an eligible dependent.)

# Plan Provisions

## Continuation of TRS-ActiveCare Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) passed by the 99th Congress provides that when employees and covered dependents lose their eligibility for group health plan coverage because of any of the events listed below, they may elect to continue group health plan participation. The continued coverage can remain in effect for a maximum period of either 18, 29, or 36 months, depending on the reason the coverage terminated.

**What happens if an employee or covered dependent enters into military service?**

If you enter into active, full-time military service, you may continue TRS-ActiveCare coverage while on leave without pay. Employees on military leave without pay will be treated in the same manner as other employees on leave without pay in accordance with the participating district/entity's requirements for leave-without-pay status, for a period not to exceed six months.

An individual who elected coverage on or before December 9, 2004, may elect under the Uniformed Services Employment and Reemployment Rights Act (USERRA) to continue health coverage with his or her employer's plan for a maximum coverage period of 18 months. An individual who elected coverage on or after December 10, 2004, may elect under USERRA to continue health coverage with his or her employer's plan for a maximum coverage period of 24 months. Under most circumstances, the coverage period under COBRA and USERRA runs concurrently during the first 24 months. Coverage may be elected from USERRA or COBRA, but not both.

Once you return to active employment and meet eligibility requirements, you can re-enroll for TRS-ActiveCare coverage within 31 days. If you return to active employment within the same plan year and choose to re-enroll in TRS-ActiveCare, you must select the same plan option in which you were previously enrolled. Preexisting conditions will not apply.

| Events Qualifying for 18-Month Continuation | Events Qualifying for 29-Month Continuation | Events Qualifying for 36-Month Continuation |
| --- | --- | --- |
| • Loss of eligibility due to reduction of employee work hours<br>• Voluntary employee termination including retirement (early or disability)<br>• Employee layoff for economic reasons<br>• Employee discharge, except for discharge for gross misconduct, or<br>• Failure of a participating district/entity to pay all premiums for at least 90 days | • Loss of coverage by employee or dependent if determined by the Social Security Administration to be disabled at any time during the first 60 days after employment terminated or hours were reduced<br>*To receive the additional 11 months of COBRA continuation coverage, you must notify your plan administrator (Health Care Service Corporation/Blue Cross and Blue Shield of Texas) of the Social Security Administration's (SSA) determination before the end of the 18-month period of COBRA continuation coverage.* | • Death of an employee<br>• Divorce or legal separation of an employee, so long as the spouse was previously enrolled as a covered participant<br>• Employee becomes eligible for Medicare, leaving dependents without group medical coverage (as in the case of an employee who reaches age 65, retires, and begins Medicare coverage), or<br>• Children who lose coverage due to plan provisions (for example, reaching the maximum age) |

# Plan Provisions

### Eligibility

Employees and dependents covered by TRS-ActiveCare the day before the qualifying event are eligible to continue coverage. Dependents not previously enrolled *cannot* elect to begin coverage.

Note: Employees may not make plan changes during a plan year–even if changing from active to COBRA status, except as provided under TRS laws and rules.

### How to Apply for COBRA

When your group coverage ends, you or your covered dependents have 60 days to elect continuation coverage through COBRA. You, your spouse, or dependent child must first notify your district/entity's Benefits Administrator. You then will be provided with information on your COBRA rights, including forms and general information on the continuation option. **Any correspondence or materials sent by the plan administrator to you, at the most current address of record provided to the plan administrator, is presumed to have been received by you.** Coverage will be made retroactive to the date of the qualifying event, and all back premiums must be paid before coverage is effective, unless otherwise provided under COBRA laws and regulations. You will have 45 days from the date of your first bill to make your initial premium payment, but coverage will not be verified for providers until payment is received.

### When COBRA Coverage Ends

COBRA/continuation coverage ends if:

- The COBRA benefits continuation period expires
- Premiums are not paid within 30 days of the due date unless an exception is approved by TRS
- A COBRA participant becomes covered under another group health plan either as an employee, spouse, or dependent, unless a preexisting condition exclusion prevents the participant from being covered for a specific condition under another group medical plan
- A COBRA participant becomes entitled to (enrolled in) Medicare benefits, or
- TRS-ActiveCare no longer provides group medical coverage for public education employees.

**What is the cost for COBRA coverage?**

Any eligible individual electing to continue coverage must pay the full premium rates for active employees plus an additional 2% administrative fee. If entitled to the 11-month disability extension, an individual will be charged 150% of the full premium rates for the additional 11 months of COBRA coverage. Benefits for COBRA participants will be the same as those for active employees. Rates will be based on the rates for active employees. If there is a change in TRS-ActiveCare's benefits or rates, COBRA participants will receive the new benefits and be charged the new rates.

**Who administers COBRA coverage?**

Billing and eligibility processing for COBRA coverage will be administered by Health Care Service Corporation. Blue Cross and Blue Shield of Texas is a Division of Health Care Service Corporation. Please call **1-888-541-7107** if you have any questions regarding COBRA/continuation coverage.

## How to File a Medical Claim

You or your provider must submit and Blue Cross and Blue Shield of Texas must receive all claims for benefits under TRS-ActiveCare within 12 months of the date on which you received the services or supplies. Claims not submitted and received by Blue Cross and Blue Shield of Texas within this 12-month period will not be considered for payment of benefits.

### Who files claims?

When you receive treatment or care from a network provider (or non-network provider who is a ParPlan provider), you will not be required to file claims. The provider will submit the claims directly to Blue Cross and Blue Shield of Texas for you.

You may be required to file your own claims when you receive treatment or care from a non-network provider who is not a ParPlan provider. At the time services are provided, inquire whether the provider will file claims for you.

Benefit payments will be made directly to network or contracting providers when they bill Blue Cross and Blue Shield of Texas. Written agreements between Blue Cross and Blue Shield of Texas and other providers may require payment directly to them. However, if the benefit payments are for claims from providers with no written agreement with Blue Cross and Blue Shield of Texas, Blue Cross and Blue Shield of Texas may choose to pay either you or your provider. If you receive payment from Blue Cross and Blue Shield of Texas, it will be your responsibility to settle your account with your provider.

If allowed by law, any benefits available to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

# Plan Provisions

| To file a medical claim, follow these steps: | |
|---|---|
| 1 Get a claim form | Claim forms are available from your Benefits Administrator, or you can download a claim form from the website by logging on to www.trs.state.tx.us/trs-activecare. Use a separate claim form for each individual; do not combine expenses for family members on one claim form. |
| 2 Complete the claim form | Complete all information requested on the claim form. Any missing information, especially the items listed below, will cause a delay in processing your claim.<br>• Patient's name<br>• Subscriber number, including the alpha prefix *(ISD)*<br>• Correct address<br>• Diagnosis *(preferably indicated by your provider on an itemized bill)*<br>• Date of injury, illness, or pregnancy<br>• Whether the patient has other group health insurance coverage |
| 3 Attach an itemized bill | Attach an itemized bill to the completed claim form. An itemized bill includes the following information that is critical to prompt processing of your claim:<br>• Name and address of the provider providing the services or supplies<br>• Date of service<br>• Type of service<br>• Charges for each service<br>• Patient's name<br>• Diagnosis<br>Keep a copy of the claim form and itemized bills for your records. |
| 4 Mail the claim form and itemized bills | Send the claim form and itemized bills to: Blue Cross and Blue Shield of Texas, P.O. Box 660044, Dallas, TX 75266-0044. (The address also appears on the form.) Do not send the claim form to TRS. This will only delay processing. *You must file and Blue Cross and Blue Shield of Texas must receive claims for expenses within 12 months of the date of service.* |
| 5 You will receive an Explanation of Benefits (EOB) after the claim is processed | The EOB will confirm if the expense is covered by TRS-ActiveCare and is eligible for payment. If so, you or the provider will receive a check. If your claim is denied, the EOB will state the reasons why. |

To assist providers in filing your claims, you should always carry your TRS-ActiveCare ID card with you.

### Receipt of Claims

A claim will not be considered received for processing until Blue Cross and Blue Shield of Texas actually receives the claim at the proper address and with all of the required information. If the claim is not complete, Blue Cross and Blue Shield of Texas will return it. On claims that need further information for proper processing, Blue Cross and Blue Shield of Texas may contact either you or the provider for the additional information. The claim will be processed when Blue Cross and Blue Shield of Texas receives all the requested information.

### Interpretation of TRS-ActiveCare Provisions

TRS has full and complete authority to make decisions regarding TRS-ActiveCare plan provisions and to determine questions of eligibility and benefits.

Blue Cross and Blue Shield of Texas has been given authority by TRS to determine whether:

- Services, care, treatment or supplies are medically necessary
- Surgery is cosmetic or reconstructive
- Charges are allowable
- Surgery, medical treatment, services or drugs are experimental/investigational

## Review of Claim Determinations

*Claims Processing*: When a claim is submitted correctly and received by Blue Cross and Blue Shield of Texas, it will be processed to determine if, and in what amount, benefits should be paid. Blue Cross and Blue Shield of Texas has authority to interpret and determine benefits in accordance with TRS-ActiveCare provisions. Some claims take longer to process because they require information not provided with the claim, such as medical records or operative reports.

*If a Claim Is Denied or Not Paid in Full*: On occasion, all or part of your claim may be denied. There are a number of reasons why the claim may be denied or not paid in full. First read the Explanation of Benefits and then review this booklet to see whether you understand the reason for the determination. Decisions regarding medical necessity are guided by current medical policies that may be viewed at www.trs.state.tx.us/trs-activecare. If you have additional information that you believe could change the payment decision, call Customer Service at 1-866-355-5999 or write to Blue Cross and Blue Shield of Texas at P.O. Box 660044, Dallas, TX 75266-0044 to request a review of the decision.

## Request for Reconsideration of Claim Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for inpatient preauthorization, extended care and home infusion therapy preauthorization, or any other determination made by the plan regarding your TRS-ActiveCare benefits.

If you believe all or part of your benefits were incorrectly denied and want to obtain a review of the benefit determination, you must:

1. Call Customer Service (1-866-355-5999) or submit by U.S. Mail a written Request for Reconsideration to Blue Cross and Blue Shield of Texas. The request must contain your name, the participant's name, your group and subscriber numbers, and the claim you want reviewed.
2. The written request must contain the questions and comments you have concerning the determination, and you must submit all additional information (especially medical information) that has a bearing on why you believe the determination was incorrect.

Blue Cross and Blue Shield of Texas will review your claim on the basis of the comments, questions, and information received in the Request for Reconsideration, together with any other available information.

You will be notified in writing of Blue Cross and Blue Shield of Texas' decision and the reasons for it within 60 days of Blue Cross and Blue Shield of Texas' receipt of the Request for Reconsideration.

*Decisions that are based on medical necessity*: If you are not in agreement with a Blue Cross and Blue Shield of Texas decision based on medical necessity, you may request a second review by making a Request for Reconsideration by Blue Cross and Blue Shield of Texas. In order to make an appeal to the Teacher Retirement System of Texas (TRS) with regard to a decision based on medical necessity, you must file a Request for Reconsideration with Blue Cross and Blue Shield of Texas.

*Decisions that are not based on medical necessity:* You do not need to file a second Request for Reconsideration with Blue Cross and Blue Shield of Texas in order to make an appeal to TRS with regard to a decision that is not based on medical necessity.

In the event that you have filed all your Requests for Reconsideration with Blue Cross and Blue Shield of Texas, as noted above, and all such Requests for Reconsideration are denied by Blue Cross and Blue Shield of Texas, you may further appeal to the Teacher Retirement System of Texas (your plan sponsor) at the address below:

TRS-ActiveCare Grievance Administrator
Teacher Retirement System of Texas
1000 Red River Street
Austin, TX 78701

grievance.administrator@trs.state.tx.us

(512) 542-6784 FAX

Your written appeal must be submitted by U.S. Mail, fax, or e-mail and be received by TRS within 60 days from: (1) with regard to decisions that are based on medical necessity, the date of the Blue Cross and Blue Shield of Texas letter notifying you of their decision on your required second Request for Reconsideration; and (2) with regard to decisions that are not based on medical necessity, the date of the Blue Cross and Blue Shield of

Texas letter notifying you of their decision on your first and only required Request for Reconsideration.

The appeal to TRS must be submitted in writing and accompanied by copies of all relevant documents, including copies of correspondence to and from Blue Cross and Blue Shield of Texas. You must include a copy of any and all the letters from Blue Cross and Blue Shield of Texas denying your Request(s) for Reconsideration. **Please include a daytime telephone number.**

Upon receipt of a written appeal, TRS will advise you of any procedures available to you under TRS Rules and Laws.

### Subrogation, Reimbursement and Third Party Recovery Provision

**When this Provision Applies:** If you, your spouse, one of your dependents, or anyone who receives benefits under this health plan is injured and entitled to receive money from any source, including but not limited to any party's liability or auto insurance and uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by TRS-ActiveCare are secondary, not primary, and will be paid only if you fully cooperate with the terms and conditions of TRS-ActiveCare.

As a condition of receiving benefits under TRS-ActiveCare, the employee or covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the plan 100% of benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. If the employee or covered person retains an attorney, then the employee or covered person agrees to only retain one who will not assert the Common Fund or Made Whole Doctrines. Reimbursement shall be immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

The employee or covered person agrees to sign any documents requested by TRS-ActiveCare, including but not limited to reimbursement and/or subrogation agreements the plan or its agent(s) may request. Also, the employee or covered person agrees to furnish any information as requested by the plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the plan from exercising its rights to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the plan. Any excess after 100% reimbursement of the plan may be divided up between the employee or covered person and their attorney if applicable. The employee or covered person agrees to take no action that in any way prejudices the rights of the plan.

If it becomes necessary for the plan to enforce this provision by initiating any action against the employee or covered person, then the employee or covered person agrees to pay the plan's attorney's fees and costs associated with the action regardless of the action outcome.

TRS has the sole authority to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.

If the employee or covered person takes no action to recover any money from any source, the employee or covered person agrees to allow the plan to initiate its own direct action for reimbursement.

## Coordination of Benefits

TRS-ActiveCare includes a Coordination of Benefits (COB) provision that determines how benefits will be paid when you or your dependent is covered by more than one group health plan. When you have other group medical coverage (through your spouse's employer, for example), your TRS-ActiveCare benefits may be combined with others to pay covered charges. The COB provision eliminates duplicate payments for the same medical expenses. Coordination of Benefits does not apply to any individual policy you may have.

Under the COB provision, the plan that pays first is called the primary plan. The secondary plan typically makes up the difference between the primary plan's benefit and the covered charge. When one plan does not have a COB provision, that plan is always considered primary and always pays first. COB payments do not always total 100% of charges.

### How to determine which plan is primary

These rules are applied in the order in which they appear until one resolves the issue.

- The plan without a COB provision is considered primary. If both plans have COB, then the plan covering the patient as an employee rather than a dependent is primary.
- If a child is covered under both parents' plans, the plan of the parent whose birth date is earlier in the calendar year is primary. If both parents have the same birthday, the plan which has covered one parent longer is primary. If the other plan does not have this provision regarding birthdays, then the rules in that plan determine the order of benefits.
- Dependent children of divorced or separated parents receive benefits payments in this order from the plan of the:
  - Parent with custody
  - Stepparent with custody
  - Parent without custody

The parent with financial responsibility for the child's health care expenses under a court decree is primary. The other parent's plan would be secondary.

In the case of joint custody with no specific requirements to provide health care expenses, the birthday rule as described above would apply.

- The plan that covers a person as an active employee is primary over the plan that covers that person as a laid-off or retired employee. If both plans do not agree on the order of benefits, this rule does not apply.
- If a person is covered as an employee under one plan and as a dependent under another plan, the plan that covers the person as an employee is primary over the plan that covers the person as a dependent. If both plans do not agree on the order of benefits, this rule does not apply.
- The plan that covers a person as an active employee (or that employee's dependent) is primary over the plan that covers the employee (or that employee's dependent) under COBRA/continuation coverage. If both plans do not agree on the order of benefits, this rule does not apply.

If none of these rules apply, the plan that has covered the patient longer will be primary. *Special rules apply when you are covered by TRS-ActiveCare and Medicare.* Generally, TRS-ActiveCare is the primary plan if you are an active employee or a dependent of an active employee, and Medicare is secondary. Special rules may apply to participants with End Stage Renal Disease (ESRD).

For all TRS-ActiveCare participants without ESRD:

- TRS-ActiveCare participants covered by Medicare Parts A and/or B ***prior*** to a COBRA qualifying event date: Medicare will be primary and COBRA continuation coverage through TRS-ActiveCare will be secondary.
- TRS-ActiveCare COBRA continuation coverage ***terminates*** for participants when they become covered by Medicare Parts A and/or B ***subsequent*** to their COBRA qualifying event date.

### How are benefits coordinated for a newborn within the first 31 days after birth?

A newborn child is automatically covered for the first 31 days after the date of birth. The plan of the parent whose birth date is earlier in the calendar year is primary. See page 35 for information on enrolling newborns.

### How are COB benefits paid?

TRS-ActiveCare will pay the difference between the allowable amount and the benefit paid by the primary plan, not to exceed the amount TRS-ActiveCare would have paid in the absence of any other coverage. You or your provider must submit and Blue Cross and Blue Shield of Texas must receive all claims for benefits under TRS-ActiveCare within 12 months of the date on which you received the services or supplies. Claims not submitted and received by Blue Cross and Blue Shield of Texas within this 12-month period will not be considered for payment of benefits.

All claims for prescription drugs should be submitted to Medco within 12 months of the date you received the services or supplies.

### How is the primary plan determined for COB purposes between a husband and wife?

When both plans have a Coordination of Benefits (COB) provision, the following chart shows how the primary plan is determined for the spouse. The chart assumes that the husband and wife are both active employees and not covered by COBRA.

| If the TRS-ActiveCare covered employee is: | ...and the other plan is sponsored by: | ...and expenses are for: | ...then TRS-ActiveCare is: |
|---|---|---|---|
| The husband | Wife's employer | Husband | Primary |
| The husband | Wife's employer | Wife | Secondary |
| The wife | Husband's employer | Husband | Secondary |
| The wife | Husband's employer | Wife | Primary |

# Online Resources

## Website Features

You can access helpful information and administrative forms from the Blue Cross and Blue Shield of Texas and Medco websites through the TRS-ActiveCare website, www.trs.state.tx.us/trs-activecare. Blue Cross and Blue Shield of Texas and Medco are solely responsible for the accuracy and security of information maintained on or through their websites.

The chart below highlights online capabilities and features for TRS-ActiveCare participants. To access online information, go to www.trs.state.tx.us/trs-activecare, then select ActiveCare Plans 1-HD, 1, 2 and 3. Many of the most frequently requested features appear directly on the TRS-ActiveCare home page. The website appearance and content are subject to change at any time.

| Teacher Retirement System of Texas (TRS) | ActiveCare 1-HD, ActiveCare 1, ActiveCare 2 and ActiveCare 3<br>Blue Cross and Blue Shield of Texas and Medco | |
|---|---|---|
| Health Benefits | Health Benefits | Pharmacy Benefits |
| Provider Locator<br>Frequently Asked Questions<br>Enrollment Guide<br>Enrollment Application and Change Form | Provider Finder<br>Enrollment Guide<br>Forms<br>Benefits Booklet<br>Medical Policies<br>Healthy Living Information<br>Blue Access for Members (view claims)<br>Contact Information | Pharmacy Benefits<br>Retail Pharmacy Locator<br>Drug Name Search<br>Copays<br>What are Possible Alternatives<br>Preferred Drug List<br>View Formulary Alternatives<br>Maintenance Drug List<br>Mail Order Forms<br>Online Refills<br>Savings Advisor |

## Blue Access for Members (requires registration)

With Blue Access for Members you can:

- Check the status of a claim
- Confirm who is covered under your plan
- View and print detailed claim history and information (Explanation of Benefits/EOBs) **EOBs are available online. You must log into Blue Access for Members to elect to receive paper copies by mail or call Customer Service for assistance.**
- Locate a physician in your network that meets your needs
- Sign up to receive e-mail notifications of new claim activity
- Request a new or replacement ID card or print a temporary ID card
- Access Personal Health Manager and earn Blue Points℠
- Take a Health Risk Assessment

Use Blue Access for Members for Live Chat to e-mail and gain immediate access to Customer Service with questions about your ActiveCare 1-HD, 1, 2 or 3 benefits and claims.

### How to Find Blue Access for Members

1. Go to www.trs.state.tx.us/trs-activecare
2. Select the link for "Blue Access for Members"

To register for Blue Access for Members, you'll need your group and member identification number, found on your TRS-ActiveCare ID card. Upon authentication, you'll be asked to create a user name and password that you'll use for all future visits to Blue Access for Members.

Use Blue Access for Members from 6 a.m. to 3 a.m. (Central Time), seven days a week.

# Online Resources

## Online Resources for Health and Wellness

### Personal Health Manager

With Personal Health Manager, the support and resources you need to manage your health online will be just a click away. By logging onto Blue Access® for Members though www.bcbstx.com/trs and clicking on Personal Health Manager you can:

- Complete a **health risk assessment** to evaluate your health status.
- Request fitness and weight loss advice with **Ask A Dietitian.**
- Receive help on managing stress, workplace conflicts or other issues with **Ask A Life Coach.**
- Ask registered nurses health-related questions online with the **Ask A Nurse** feature.
- Request exercise and fitness tips with **Ask A Trainer.**
- Receive targeted wellness information via e-mail to help manage specific medical conditions, including alerts for screening tests, and set up reminders for medical appointments and medication refills.
- Access wellness tracking tools, videos and interactive tutorials.
- Get information on exercise, nutrition and lifestyle issues in the **For Your Health** section.
- Earn **Blue Points**℠ every time you use the health and wellness features in the **For Your Health** section. Receive up to 1,000 points a week when you set up and track the progress of an exercise or meal program, read and rate health and wellness related articles, or e-mail your health-related questions to licensed professionals.

### Health Risk Assessment

Learn about your health status and risks by completing a confidential Health Risk Assessment (HRA) available through Blue Access® for Members. By completing the HRA, you can receive recommendations for improving your health and share the information with your physicians. The HRA focuses on four key areas—stress, sleep, fitness, and nutrition.

- You can take the HRA multiple times.
- Information is available about emotional well-being, in addition to physical well-being.
- Based on your responses, you can receive additional information about programs and services.

The HRA includes an easy-to-use online questionnaire. Upon completion, you can receive an in-depth personal report that helps you understand your current health status and risks, along with specific suggestions on how to make positive and lasting changes. Results can help determine if you need intervention before a more serious condition may develop. Take the HRA today! **Be assured that your information is kept confidential and will not be released to your employer or to TRS.**

* All information is intended for your general use only and is not a substitute for medical advice or treatment for specific medical conditions. You should seek prompt medical care for specific health issues and consult your physician before taking any action on your health conditions. Use of this online service is subject to Terms and Conditions.

# Glossary of Terms

These definitions apply to all TRS-ActiveCare benefits unless specifically limited.

**Accidental Injury:** Accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a physician or professional other provider within 30 days after the occurrence.

**Actively-at-Work Date:** The actively-at-work date is the date the employee of a participating district/entity starts to work.

**Allowable Amount:** **Medical–**The allowable amount is the maximum amount determined by Blue Cross and Blue Shield of Texas to be eligible for consideration of payment by TRS-ActiveCare for a particular service, supply, or procedure. **Prescription Drug--**The allowable amount means the lesser of: (1) *usual and customary*; (2) maximum allowable cost plus a contractually determined dispensing fee; or (3) the average wholesale price less a contractually determined discount amount plus dispensing fee.

*Usual and customary means the price a cash patient would have paid the day the prescription was dispensed, inclusive of all applicable discounts.*

**Ambulance Service:** Involves the use of a specially designed and equipped automotive or other vehicle, licensed by the state, and regulated by local, state and federal laws, to transport the ill or injured to the nearest hospital equipped and staffed to treat the condition. Ambulances can be classified as either basic life support or advanced life support depending upon how the vehicle is equipped. This in turn regulates the level of care that can be provided in the actual transport.

**Benefits Administrator:** The person employed by a participating district/entity who can help employees enroll in various benefits plans and make changes to their coverage.

**Balance Billing:** A non-contracted provider's practice of billing the patient directly for the provider's charges that remain unpaid after the plan pays the allowable amount for covered services.

**Blue Distinction Centers for Bariatric Surgery:** Blue Distinction® is a designation awarded by Blue Cross and Blue Shield to medical facilities that have demonstrated expertise in delivery quality health care, resulting in better overall outcomes for bariatric patients. Blue Distinction Centers for Bariatric Surgery provide a full range of bariatric surgery care services, including inpatient care, post-operative care, outpatient follow-up care and patient education. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, and is subject to periodic reevaluation as criteria continue to evolve. Effective September 1, 2009, all medically necessary bariatric surgical procedures, such as lap band and gastric bypass for weight loss, will be covered only if performed at one of the Blue Distinction Centers for Bariatric Surgery. Refer to the Doctors and Hospital section of the website, www.bcbstx.com/trs to search for current Blue Distinction Centers for Bariatric Surgery or contact Customer Service.

**Chemical Dependency Treatment Center:** An institution which provides a program for the treatment of chemical dependency following a written treatment plan approved and monitored by a physician affiliated with a hospital under a contractual agreement with an established system for patient referral. Any such facility must be licensed, certified, or approved as a chemical dependency treatment center by the appropriate state agency and be accredited by the Joint Commission on Accreditation of Health Care Organizations.

**Clinical Ecology:** The inpatient or outpatient diagnosis or treatment of allergic symptoms by:

- Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
- Urine auto injection (injecting one's own urine into the tissue of the body);
- Skin irritation by Rinkel method;
- Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
- Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

**TRS-ActiveCare does not provide coverage for clinical ecology; the definition is included for clarification purposes only.**

**Coinsurance:** A participant's share of covered services and supplies, not counting the deductible or copayments. It is usually a percentage of the allowable amount. For example, if the coinsurance amount is "80/20" that means that TRS-ActiveCare pays 80% and you pay 20% of the allowable amount for the eligible charges.

# Glossary of Terms

**Copayment (Copay):** The set amount you pay for certain medical services and prescription drugs at the time of service. Copays do not apply to deductibles or out-of-pocket maximums.

**Creditable Coverage:** Prior health coverage under various plans including, but not limited to, group health plans, individual health policies, Medicare, and Medicaid. Any prior coverage preceding a gap of 63 or more consecutive days without coverage will not be considered to be creditable coverage.

**Crisis Stabilization Unit:** An institution which is appropriately licensed and accredited as a crisis stabilization unit or facility for the provision of mental health care and serious mental illness services to persons who are demonstrating an acute, demonstrable psychiatric crisis of moderate to severe proportions.

**Custodial Care:** Services and supplies, including room and board and other institutional services, provided primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. Custodial care is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a person walk, bathe, dress, eat, prepare special diets, and take medication.

**Deductible:** The amount of out-of-pocket expense that must be paid by the covered person before health care services and supplies (including prescription medications) become payable by the health plan.

**Dental Care Services:** The professionally recognized dental services, supplies, or appliances which are provided to a participant by a physician or provider, when acting within the scope of his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree), and shall also include a provider who is a Doctor of Medicine or a Doctor of Osteopathy. Dental care services include, but are not limited to cleaning, filling of teeth, crowns (or capping), root canals, restoration, replacement or repositioning of teeth, or alteration of the alveolar or periodontium process of the maxilla and the mandible. **TRS-ActiveCare does not provide coverage for dental services; the definition is included for clarification purposes only.**

**Emergency:** An emergency is the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate care could result in:

- Placing the person'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.

TRS-ActiveCare covers medical emergencies wherever they occur. In case of emergency, call 911 or go to the nearest emergency room.

**Alert: Free-Standing Emergency Care Centers**
There has been an increase in the number of facilities not located in a hospital that represent themselves as "Emergency Care" treatment centers. Because these facilities are not licensed by the state as emergency facilities, Blue Cross and Blue Shield of Texas has developed criteria that a facility must meet to be considered a non-hospital based emergency room facility. You should be aware that if you seek emergency treatment at an emergency care center in a facility that is **not** located in a hospital, and **not** in your network of contracted providers, **you may incur additional** expense.

1. The following is a summary of the BCBSTX criteria for a facility to be a free standing emergency care facility. The facility complies with Emergency Medical Treatment and Active Labor Act (EMTALA) applicable requirements (whether or not it is subject to EMTALA).
2. The facility must have and maintain appropriate standing arrangements for the transfer of the member to an acute care hospital with an emergency department if medically necessary.
3. Physicians performing services at the facility must have additional training in emergency medicine and/or be board certified in emergency medicine.
4. The facility must be open 24 hours a day, 7 days a week, with at least one emergency care qualified physician and one licensed nurse on duty at all times.

5. The facility must have and maintain equipment and supplies suitable for provision of emergency care services.
6. The facility must be accredited by one of the following programs: (1)Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or (2) Accreditation Association for Ambulatory Health Care (AAAHC)

**Environmental Sensitivity**: The inpatient or outpatient treatment of allergic symptoms by controlled environment; or sanitizing the surroundings, removal of toxic materials; or use of special non-organic, non-repetitive diet techniques. **TRS-ActiveCare does not provide coverage for environmental sensitivity; the definition is included for clarification purposes only.**

**Experimental/Investigational and/or Unproven:** A drug, device or medical treatment or procedure is experimental or investigational if:

- The drug or device has not received U.S. Food and Drug Administration approval both for marketing and as safe and efficacious at the time the drug or device is furnished; or
- The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

*Reliable evidence*, as used in this definition, shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Although a physician or other health care provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, such services or supplies still may be considered to be experimental/ investigational within this definition.

**Hospital:** A short-term acute care facility which:
- Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Health Care Organizations or is certified as a hospital provider under Medicare
- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians for compensation from its patients
- Has organized departments of medicine and major surgery and maintains clinical records on all patients
- Provides 24-hour nursing services by or under the supervision of a registered nurse
- Has a hospital utilization review plan, and
- Is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, sanitarium, place for rest, place for the aged, place for the treatment of chemical dependency, hospice, or place for the provision of rehabilitative care.

**Hospital Admission:** The period between entry into a hospital as a bed patient and the time of discharge. If a patient is admitted to and discharged from a hospital within a 24-hour period but is confined as a bed patient in a bed accommodation during the period of time confined in the hospital, the admission shall be considered a hospital admission. *Bed patient* means confinement in a bed accommodation located in a portion of a hospital which is designed, staffed and operated to provide acute, short-term hospital care on a 24-hour basis; the term does not include confinement in a portion of the hospital designed, staffed and operated to provide long-term institutional care on a residential basis.

# Glossary of Terms

**Marriage and Family Therapy:** Includes professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems. **TRS-ActiveCare does not provide coverage for marriage and family therapy.**

**Out-of-Pocket Maximum:** Your share of eligible expenses incurred during a plan year excluding the deductible and copays (medical and prescription drug). After you reach the out-of-pocket maximum, TRS-ActiveCare pays 100% of the allowable amount for covered charges for the rest of the plan year. Deductibles and copays do not apply to the out-of-pocket maximum. **Preauthorization penalties and billed charges exceeding the Blue Cross and Blue Shield of Texas allowable amount also do not apply to the out-of-pocket maximum.**

**Participant:** A person who is enrolled in TRS-ActiveCare.

**Plan Year:** The plan year for TRS-ActiveCare begins September 1 and ends August 31.

**Psychiatric Day Treatment Facility:** An institution appropriately licensed and accredited by the Joint Commission on Accreditation of Health Care Organizations as a psychiatric day treatment facility for the provision of mental health care and serious mental illness services to participants for time periods not to exceed eight hours in any 24-hour period.

Treatment must be in lieu of hospitalization and certified in writing by the attending physician.

**Residential Treatment Center for Children and Adolescents:** An institution appropriately licensed and accredited by the Joint Commission on Accreditation of Health Care Organizations or the American Association of Psychiatric Services for Children and/or is approved by Blue Cross and Blue Shield of Texas as a residential treatment center for certain mental health care services for emotionally disturbed children and adolescents under the age of 18. Services provided to an individual age18 or older by a Residential Treatment Center for Children and Adolescents will not be covered by TRS-ActiveCare.

**Special Enrollment Event:** An event as defined by the TRS-ActiveCare plan design that may provide a special enrollment period for individuals and dependents when there is a loss of other coverage or a gain of additional dependents. See Making Changes/Special Enrollment Events for more information.

**Surgery/Office Surgery:** The terms include any procedure billed under a surgery code as defined in the Current Procedural Terminology (CPT) published by the American Medical Association or otherwise determined to be a surgical procedure by Blue Cross and Blue Shield of Texas. **Note:** A surgical procedure does not always meet the layperson's image of surgery, but includes almost all invasive procedures.

**Telemedicine:** The use of interactive audio, video or other electronic media (excluding telephone or fax machines) to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education.

# Notices

## Initial Notice about Special Enrollment Rights and Preexisting Condition Exclusion Rules in Your Group Health Plan

A federal law called HIPAA requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. Second, this notice advises you of the plan's preexisting condition exclusion rules that may temporarily exclude coverage for certain preexisting conditions that you or a member of your family may have.

### I. Special Enrollment Provisions

**Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program)**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment, and Blue Cross and Blue Shield of Texas (BCBSTX) must receive your request, no later than 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). You or your spouse or dependents may also have special enrollment rights in another group health plan at the time a claim is denied as a result of a lifetime limit on all benefits, if you request enrollment within 31 days after the claim has been denied.

**Loss of Coverage for Medicaid or a State Children's Health Insurance Program**

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under the Texas Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment and BCBSTX must receive your request within 60 days after your or your dependents' coverage ends under Medicaid or CHIP.

**New Dependent by Marriage, Birth, Adoption, or Placement for Adoption**

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment, and BCBSTX must receive your request, within 31 days after the marriage, birth*, adoption, or placement for adoption.

**Eligibility for Health Insurance Premium Payment (HIPP) Reimbursement Program for Enrollees of Medicaid or a State Children's Health Insurance Program**

If you or your dependents (including your spouse) become eligible for a premium assistance subsidy under the state of Texas HIPP Reimbursement Program from Medicaid or through CHIP with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment, and BCBSTX must receive your request, within 60 days after your or your dependents' determination of eligibility for such assistance under the HIPP Reimbursement Program.

**To request special enrollment or obtain more information, please contact a BCBSTX Customer Advocate by calling the Customer Service number on the back of your member ID card.**

### II. Preexisting Condition Exclusion Rules

Most health plans impose pre-existing condition exclusions. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. The preexisting condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 31 days after birth*, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, you have a right to request a certificate from your prior plan or issuers. We will help you obtain one from your prior plan or issuer, if necessary. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

Please direct all questions about the preexisting condition exclusion and creditable coverage rules affecting your plan to a BCBSTX Customer Advocate by calling the Customer Service number on the back of your member ID card.

*Special rules apply to newborns; see box on page 35 for more information.*

## HIPAA Notice of Election of Exemption

Under Title 1 of a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below:

1. Limitations on a preexisting condition exclusion period.
2. Special enrollment periods.
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status.
4. Standards relating to benefits for mothers and newborns.
5. Parity in the application of certain limits to mental health benefits.
6. Required coverage for reconstructive surgery following mastectomies.
7. Coverage of dependent students on medically necessary leave of absence.

However, HIPAA also permits certain self-funded, governmental group health plans to elect to exempt a plan from these requirements for any portion of the plan that is "self-funded," rather than provided through a health insurance policy. For the 2010-2011 plan year beginning September 1, 2010 and ending August 31, 2011, the Teacher Retirement System of Texas (TRS) has elected to exempt TRS-ActiveCare 1-HD, TRS-ActiveCare 1, TRS-ActiveCare 2, and TRS-ActiveCare 3 plans from HIPAA provisions 2 and 3 listed above. The election may be renewed for subsequent plan years.

Special enrollment events will be defined by TRS-ActiveCare plan documents rather than HIPAA for the 2010-2011 plan year. This will allow TRS-ActiveCare to continue to apply the same rules and practices as in the past.

TRS-ActiveCare does not currently require health status information in order to enroll in TRS-ActiveCare, with the exception of enrolling an incapacitated child over the age of 25.

This election by TRS to opt TRS-ActiveCare Plans 1-HD, 1, 2, and 3 out of certain HIPAA provisions does not apply to the three insured health maintenance organizations (HMO) participating in TRS-ActiveCare for the 2010-2011 plan year. These HMOs will continue to comply with all the provisions of HIPAA, including those listed in this notice.

HIPAA also requires TRS-ActiveCare 1-HD, TRS-ActiveCare 1, TRS-ActiveCare 2, and TRS-ActiveCare 3 to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under TRS-ActiveCare 1-HD, TRS-ActiveCare 1, TRS-ActiveCare 2 or TRS-ActiveCare 3. There is no exemption from this requirement. The certificate provides evidence that you were covered under TRS-ActiveCare 1-HD, TRS-ActiveCare 1, TRS-ActiveCare 2 or TRS-ActiveCare 3, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another health plan, or if you wish to purchase an individual health insurance policy.

If you have any questions, please contact TRS-ActiveCare at 1000 Red River Street, Austin, Texas 78701-2698 or at 1-800-223-8778 ext. 6446.

# Notices

## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

Federal law requires the Teacher Retirement System of Texas (TRS) to protect the privacy of your health information. Your protected health information is information that:

- **Identifies you**; and
- **TRS created or received about:**
  - Your past, present or future health condition;
  - The health care you receive; or
  - The payment for this health care.

**The effective date of this notice is April 14, 2003.** Texas law already makes your member information, including your protected health information, confidential. Therefore, TRS is not changing the way that it protects your information.

On April 14, 2003, the new rights and other terms in this notice will automatically apply. **You do not need to do anything to get privacy protection for your health information.**

Federal law requires that TRS provide you with this notice about its privacy practices and its legal duties regarding your protected health information. This notice explains how, when, and why TRS uses and discloses your protected health information. By law, TRS must follow the privacy practices that are described in the most current privacy notice.

TRS reserves the right to change its privacy practices and the terms of this notice at any time. Changes will be effective for all of your protected health information that TRS maintains. If TRS makes an important change that affects what is in this notice, TRS will mail you a new notice within 60 days of the change. This notice is on the TRS website, and TRS will post any new notice on its website at www.trs.state.tx.us.

### How TRS May Use and Disclose Your Protected Health Information

**Certain Uses and Disclosures Do Not Require Your Written Permission**

TRS may use and disclose your protected health information **without** your written permission (an authorization) for the following reasons:

- **For treatment.** TRS does not directly participate in decisions about what kind of health treatment you should receive. TRS also does not maintain your current medical records. However, TRS may disclose your protected health information for treatment purposes. For example, TRS may disclose your protected health information if your doctor asks that TRS disclose the information to another doctor to help in your treatment.

- **For payment.** Here are two examples of how TRS might use or disclose your protected health information for payment. TRS or one of its business associates, who are discussed below, may use or disclose your information to prepare a bill for medical services to you or another person or company responsible for paying the bill. The bill may include information that identifies you, the health services you received, and why you received those services. The second example is that TRS or its business associates could use or disclose your protected health information to collect your premium payments.

- **For health care operations.** TRS may provide your protected health information to its accountants, attorneys, consultants, and others in order to make sure TRS is complying with the laws that affect it. For example, your protected health information may be given to people looking at the quality of the health care you received. Another example of health care operations is TRS using and sharing this information to manage its business and perform its administrative activities.

- **To you or your personal representative.** TRS may provide your protected health information to you, a person representing or authorized by you, or any person that you tell TRS in writing is acting on your behalf. For this purpose, a person acts on your behalf by being involved in your health care or in the payment for your health care.

- **When federal, state or local law, judicial or administrative proceedings, or law enforcement requires a disclosure.** For example, TRS may disclose your protected health information:
  - To a federal or state criminal law enforcement agency that asks for the information for a law enforcement purpose;
  - To the Texas Attorney General to collect child support or to ensure health care coverage for your child;
  - In response to a subpoena if the TRS Executive Director determines that you will have a reasonable opportunity to contest the subpoena;
  - To a governmental entity, an employer, or a person acting on behalf of the employer, to the extent that TRS needs to share the information to perform TRS's business; and
  - If required by other federal, state, or local law.

- **For specific government functions.** TRS may disclose protected health information of military personnel and veterans in certain situations. TRS may also disclose protected health information for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

- **Business associates.** TRS has contracts with companies (business associates) that help TRS in its business of providing health care coverage. For example, several companies assist TRS with the TRS-ActiveCare program: Blue Cross and Blue Shield of Texas, Medco Health Solutions, Inc. and Gabriel, Roeder, Smith and Company. TRS may disclose your protected health information to its business associates so that they can perform the services that TRS has asked them to do. To protect your health information, however, TRS requires that these companies follow the same rules that are set out in this notice.

- **Executor or administrator.** TRS may disclose your protected health information to the executor or administrator of your estate.

- **Health-related benefits.** TRS or one of its business associates may contact you to provide appointment reminders. They may also contact you to give you information about treatment alternatives or other health benefits or services that may be of interest to you.

**All Other Uses And Disclosures Require Your Prior Written Authorization**

For any other use or disclosure of your protected health information, TRS must have your written permission (an authorization). You may cancel (revoke) your written permission at any time. Revoking your written permission will not affect a use or disclosure of your protected health information that TRS already made based on your written permission.

## Your Rights

- **The Right to Request Limits on Uses and Disclosures of Your Protected Health Information**

You can ask that TRS limit how it uses and discloses your protected health information. TRS will consider your request but is not required to agree to it. If TRS agrees to your request, TRS will put the agreement in writing and will follow the agreement unless you need emergency treatment, and the information that you asked be limited is needed for your emergency treatment. You cannot limit the uses and disclosures that TRS is legally required to make.

- **The Right to Choose How TRS Sends Protected Health Information to You**

You can ask that TRS send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, courier service instead of U.S. mail) only if not changing the address or the way TRS communicates with you could put you in physical danger. You must make this request in writing. You must be specific about where and how to contact you. TRS must agree to your request **only** if:

- You clearly tell TRS that sending the information to your usual address or in the usual way could put you in physical danger; **and**
- You tell TRS a specific alternative address or specific alternative means of sending protected health information to you.

- **The Right to See and Get Copies of Your Protected Health Information**

You can look at or get copies of your protected health information that TRS has or that a business associate maintains on TRS's behalf. You must make this request in writing. If your protected health information is not on file at TRS and TRS knows where the information is maintained, TRS will tell you where you can ask to see and get copies of your information.

If you request copies of your protected health information, TRS can charge you a fee for each page copied, for the labor involved in copying the information, and for postage if you request that the copies be mailed to you. Instead of providing the protected health information you request, TRS may provide you with a summary or explanation of the information, but only if you agree in advance to:

- Receive a summary or explanation instead of the detailed protected health information; and
- Pay the cost of preparing the summary or explanation.

The fee for the summary or explanation will be in addition to any copying, labor, and postage fees that TRS may require. If the total fees will exceed $40, TRS will tell you in advance. You can withdraw or change your request at any time.

### • The Right to Get a List of TRS's Uses and Disclosures of Your Protected Health Information

You have the right to get a list of TRS's uses and disclosures of your protected health information. By law, TRS is not required to create a list that includes any uses or disclosures:

- To carry out treatment, payment, or healthcare operations;
- To you or your personal representative;
- Because you gave your permission;
- For national security or intelligence purposes;
- To corrections or law enforcement personnel; or
- Before April 14, 2003.

TRS will respond to your request within 60 days of receiving it. TRS can extend this deadline one time by an additional 30 days. If TRS extends its response time, TRS will tell you in writing the reasons for the delay and the date by which TRS will provide the list. The list will include:

- The date of the disclosure or use;
- The person or entity that received the protected health information;
- A description of the information disclosed; and
- Why TRS disclosed or used the information.

If TRS disclosed your protected health information because you gave TRS written permission to disclose the information, instead of telling you why TRS disclosed the information, TRS will give you a copy of your written permission.

You can get a list of disclosures for free every 12 months. If you request more than one list during a 12-month period, TRS can charge you for preparing the list, including charges for copying, labor, and postage to process and mail each additional list. These fees will be the same as the fees allowed under the Texas Public Information Act. TRS will tell you in advance of the fees it will charge. You can withdraw or change your request at any time.

### • The Right to Correct or Update Your Protected Health Information

If you believe that there is a mistake in your protected health information or that a piece of important health information is missing, you can ask TRS to correct or add the information. You must request the correction or addition in writing. Your letter must tell TRS what you think is wrong and why you think it is wrong. TRS will respond to your request within 60 days of receiving it. TRS can extend this deadline one time by an additional 30 days. If TRS extends its response time, it must tell you in writing the reasons for the delay and the date by which TRS will respond.

Because of the technology used to store information and laws requiring TRS to retain information in its original text, TRS may not be able to change or delete information, even if it is incorrect. If TRS decides that it should correct or add information, it will add the correct or additional information to your records and note that the new information takes the place of the old information. The old information may remain in your record. TRS will tell you that the information has been added or corrected. TRS will also tell its business associates that need to know about the change to your protected health information.

TRS will deny your request if your request is not in writing or does not have a reason why the information is wrong or incomplete. TRS will also deny your request if the protected health information is:

- Correct and complete;
- Not created by TRS; or
- Not part of TRS's records.

TRS will send you the denial in writing. The denial will say why your request was denied and explain your right to send TRS a written statement of why you disagree with TRS's denial. TRS's denial will also tell you how to complain to TRS or the Secretary of the Department of Health and Human Services. If you send TRS a written

statement of why you disagree with the denial, TRS can file a written reply to your statement. TRS will give you a copy of any reply.

If you file a written statement disagreeing with the denial, TRS must include your request for an amendment, your written statement of disagreement, and any reply when TRS discloses the protected health information that you asked to be changed. Or TRS can choose to give out a summary of that information with a disclosure of the protected health information that you asked to be changed. Even if you do not send TRS a written statement explaining why you disagree with the denial, you can ask that your request and TRS's denial be attached to all future disclosures of the protected health information that you wanted changed.

- The Right to Get This Notice

You can get a paper copy of this notice on request.

- The Right to File a Complaint

If you think that TRS has violated your privacy rights concerning your protected health information, you can file a written complaint with the TRS Privacy Officer by mailing your complaint to:

Privacy Officer
Teacher Retirement System of Texas
1000 Red River Street
Austin, Texas 78701.

All complaints must be in writing.

You can also send a written complaint to the Office for Civil Rights, U.S. Department of Health and Human Services: Region VI, Office for Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, Texas 75202, FAX (214) 767-0432, and e-mail at OCRComplaint@hhs.gov. Finally, you can send a written complaint to the Texas Office of the Attorney General by mail at P.O. Box 12548, Austin, Texas, 78711-2548, or by telephone at (800) 806-2092. TRS will not retaliate against you if you file a complaint.

### More Information

If you want more information about this notice, how to exercise your rights, or how to file a complaint, please contact the TRS Telephone Counseling Center at 1-800-223-8778. TDD users should call 1-800-841-4497. Additional information is also available on the TRS website at www.trs.state.tx.us.

## Notice of Continuation Coverage Rights Under COBRA

### Introduction

You are receiving this notice because you have recently become covered under TRS-ActiveCare, your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the TRS-ActiveCare Benefit Booklet or contact the Plan Administrator by calling Customer Service at 1-866-355-5999.

### What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

**If you are an employee**, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your hours of employment are reduced;
- Your eligibility or employment ends for any reason other than your gross misconduct; or
- Your participating district/entity fails to pay all premiums for at least 90 days.

**If you are the spouse of an employee**, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's eligibility or employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- You become divorced or legally separated from your spouse; or
- Your spouse's participating district/entity fails to pay all premiums for at least 90 days.

**Your dependent children** will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated;
- The child stops being eligible for coverage under the Plan as a "dependent child"; or
- The parent-employee's participating district/entity fails to pay all premiums for at least 90 days.

### When Is COBRA Coverage Available?

- The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

### You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days of the later of (1) the date on which the qualifying event occurs; or (2) the date coverage would have been lost as a result of the qualifying event. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

### How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment, reduction of the employee's hours of employment, or failure of the participating district/entity to pay all premiums for at least 90 days, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment, reduction of the employee's hours of employment, or failure of the participating district/entity to pay all premiums for at least 90 days, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

# Notices

## Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within the timeframe stated in this section, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualified. Each qualified beneficiary will be charged 150% of the applicable cost for the additional 11 months of COBRA coverage.

**If the SSA determines a qualified beneficiary is disabled, the SSA will send that individual a "Social Security Administration Retirement, Survivors and Disability Insurance Notice of Award" letter. You must send a copy of this letter before the end of the first 18 months of COBRA coverage to Health Care Service Corporation, the Plan's COBRA administrator, at the following address:**

Health Care Service Corporation
P.O. Box 1180
Marion, IL 62959-7680

**Also, if the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.**

## Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

## When is COBRA Coverage Not Available?

COBRA continuation coverage may not be available to you, your spouse, and/or your children if:

- You or your Benefits Administrator did not notify Blue Cross and Blue Shield of Texas within 60 days of the qualifying event; or
- Your TRS-ActiveCare coverage was cancelled due to your failure to make required premium contributions; or
- You voluntarily dropped TRS-ActiveCare coverage for you and/or your spouse/child(ren); or
- You were terminated from employment due to gross misconduct; or
- Any other reason under COBRA laws and regulations.

## If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

## Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Any correspondence or materials sent by the Plan Administrator to you, at the most current address-of-record provided to the Plan Administrator, is presumed to have been received by you.**

# Notices

## Plan Contact Information

Health Care Service Corporation is the party responsible for administering your COBRA continuation coverage. Their address is:

Health Care Service Corporation
P.O. Box 1180
Marion, IL 62959-7680

You may also contact the Plan Administrator by calling Customer Service at 1-866-355-5999.

## Women's Health and Cancer Notice

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles and coinsurance amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

# Notices

## Notice Regarding Network Facilities and Non-Network Providers

Although health care services may be or have been provided to you at a health care facility that is a member of the provider network used by your health benefit plan, other professional services may be or have been provided at or through the facility by physicians and other health care practitioners who are not members of that network. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by your health benefit plan.

## Other Blue Cross and Blue Shield Plans' Separate Financial Arrangements with Providers

### BlueCard

Blue Cross and Blue Shield hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas ("Host Blue") may have contracts similar to the contracts described above with certain providers ("Host Blue Providers") in their service area.

When you receive health care services through BlueCard outside of Texas and from a provider which does not have a contract with Blue Cross and Blue Shield, the amount you pay for covered services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield.

Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

# Notices

## Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

As indicated below, Texas provides premium assistance for State Medicaid, but not for CHIP.

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**If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of April 16, 2010. You should contact your State for further information on eligibility.**

| **ALABAMA** – Medicaid | **CALIFORNIA** – Medicaid |
|---|---|
| Website: http://www.medicaid.alabama.gov<br>Phone: 1-800-362-1504 | Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx<br>Phone: 1-866-298-8443 |
| **ALASKA** – Medicaid | **COLORADO** – Medicaid and CHIP |
| Website: http://health.hss.state.ak.us/dpa/programs/medicaid/<br>Phone (Outside of Anchorage): 1-888-318-8890<br>Phone (Anchorage): 907-269-6529 | Medicaid Website: http://www.colorado.gov/<br>Medicaid Phone: 1-800-866-3513<br>CHIP Website: http:// www.CHPplus.org<br>CHIP Phone: 303-866-3243 |
| **ARIZONA** – CHIP | **FLORIDA** – Medicaid |
| Website: http://www.azahcccs.gov/applicants/default.aspx<br>Phone: 1-877-764-5437 | Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml<br>Phone: 1-866-762-2237 |
| **ARKANSAS** – CHIP | **GEORGIA** – Medicaid |
| Website: http://www.arkidsfirst.com/<br>Phone: 1-888-474-8275 | Website: http://dch.georgia.gov/<br>Click on Programs, then Medicaid<br>Phone: 1-800-869-1150 |

## Notices

**IDAHO – Medicaid and CHIP**

Medicaid Website: www.accesstohealthinsurance.idaho.gov

Medicaid Phone: 208-334-5747

CHIP Website: www.medicaid.idaho.gov

CHIP Phone: 1-800-926-2588

**INDIANA – Medicaid**

Website: http://www.in.gov/fssa/2408.htm

Phone: 1-877-438-4479

**IOWA – Medicaid**

Website: www.dhs.state.ia.us/hipp/

Phone: 1-888-346-9562

**KANSAS – Medicaid**

Website: https://www.khpa.ks.gov

Phone: 800-766-9012

**KENTUCKY – Medicaid**

Website: http://chfs.ky.gov/dms/default.htm

Phone: 1-800-635-2570

**LOUISIANA – Medicaid**

Website: www.dhh.louisiana.gov/offices/?ID=92

Phone: 1-888-342-6207

**MAINE – Medicaid**

Website: http://www.maine.gov/dhhs/oms/

Phone: 1-800-321-5557

**MASSACHUSETTS – Medicaid and CHIP**

Medicaid & CHIP Website: http://www.mass.gov/MassHealth

Medicaid & CHIP Phone: 1-800-462-1120

**MINNESOTA – Medicaid**

Website: http://www.dhs.state.mn.us/

Click on Health Care, then Medical Assistance

Phone: 800-657-3739

**MISSOURI – Medicaid**

Website: http://www.dss.mo.gov/mhd/index.htm

Phone: 573-751-6944

**MONTANA – Medicaid**

Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml

Telephone: 1-800-694-3084

**NEBRASKA – Medicaid**

Website: http://www.dhhs.ne.gov/med/medindex.htm

Phone: 1-877-255-3092

**NEVADA – Medicaid and CHIP**

Medicaid Website: http://dwss.nv.gov/

Medicaid Phone: 1-800-992-0900

CHIP Website: http://www.nevadacheckup.nv.org/

CHIP Phone: 1-877-543-7669

**NEW HAMPSHIRE – Medicaid**

Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm

Phone: 1-800-852-3345 x 5254

**NEW JERSEY – Medicaid and CHIP**

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

Medicaid Phone: 1-800-356-1561

CHIP Website: http://www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710

**NEW MEXICO – Medicaid and CHIP**

Medicaid Website: http://www.hsd.state.nm.us/mad/index.html

Medicaid Phone: 1-888-997-2583

CHIP Website: http://www.hsd.state.nm.us/mad/index.html

Click on Insure New Mexico

CHIP Phone: 1-888-997-2583

**NEW YORK – Medicaid**

Website: http://www.nyhealth.gov/health_care/medicaid/

Phone: 1-800-541-2831

**NORTH CAROLINA – Medicaid**

Website: http://www.nc.gov

Phone: 919-855-4100

**NORTH DAKOTA – Medicaid**

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-800-755-2604

| OKLAHOMA – Medicaid | VERMONT– Medicaid |
|---|---|
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://ovha.vermont.gov/<br>Telephone: 1-800-250-8427 |
| **OREGON – Medicaid and CHIP** | **VIRGINIA – Medicaid and CHIP** |
| Medicaid Website: http://www.oregon.gov/DHS/healthplan/index.shtml<br>Medicaid Phone: 1-800-359-9517<br>CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml<br>CHIP Phone: 1-800-359-9517 | Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm<br>Medicaid Phone: 1-800-432-5924<br>CHIP Website: http://www.famis.org/<br>CHIP Phone: 1-866-873-2647 |
| **PENNSYLVANIA – Medicaid** | **WASHINGTON – Medicaid** |
| Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm<br>Phone: 1-800-644-7730 | Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm<br>Phone: 1-877-543-7669 |
| **RHODE ISLAND – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: www.dhs.ri.gov<br>Phone: 401-462-5300 | Website: http://www.wvrecovery.com/hipp.htm<br>Phone: 304-342-1604 |
| **SOUTH CAROLINA – Medicaid** | **WISCONSIN – Medicaid** |
| Website: http://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm<br>Phone: 1-800-362-3002 |
| **TEXAS – Medicaid** | **WYOMING – Medicaid** |
| Website: https://www.gethipptexas.com/<br>Phone: 1-800-440-0493 | Website: http://www.health.wyo.gov/healthcarefin/index.html<br>Telephone: 307-777-7531 |
| **UTAH – Medicaid** | |
| Website: http://health.utah.gov/medicaid/<br>Phone: 1-866-435-7414 | |

To see if any more States have added a premium assistance program since April 16, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565