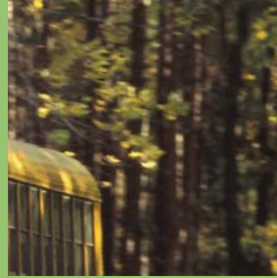


2007-2008 health plans



enrollment guide



TRS-ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

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For Medicare-eligible individuals and individuals expecting to be Medicare-eligible this plan year:

- TRS-ActiveCare 1, 2 and 3 have been determined to be creditable coverage for Medicare Part D purposes under current Medicare guidelines.
- Each HMO has determined that the coverage they are offering is creditable coverage for Medicare Part D purposes under current Medicare guidelines.
- Disclosure Notices are posted on the Creditable Coverage Web page at <http://www.cms.hhs.gov/creditablecoverage>.
- Questions about Medicare Part D should be directed to Medicare at 1-800-MEDICARE (1-800-633-4227).

For more information, see the notice on Medicare Beneficiaries and Medicare Part D on page 44.

Questions? Call Customer Service



ActiveCare 1
ActiveCare 2 1.866.355.5999
ActiveCare 3 8–8 CT (Mon-Fri)



1.800.884.4901
8–6 CT (Mon-Fri)



1.877.410.2432
7–7 CT (Mon-Fri)



1.800.617.3433
8–5 CT (Mon-Fri)



1.800.321.7947
8–5 CT (Mon-Fri)



1.800.829.6440
8–6 CT (Mon-Fri)

TDD Number (for the hearing impaired) 1.800.735.2989

This guide provides an overview of TRS-ActiveCare plan benefits. Your TRS-ActiveCare Benefits Booklet or our HMO’s Evidence of Coverage provides a detailed description of your plan. The Benefits Booklet will be available online before September 1, 2007 and is the official TRS statement on benefits. HMO Evidence of Coverage documents will be available online and printed copies may be available from your HMO. TRS-ActiveCare benefits will be paid according to the Benefits Booklet or HMO’s Evidence of Coverage and other legal documents governing the plan.

This Enrollment Guide applies to the 2007-2008 TRS-ActiveCare plan year and supersedes any prior version of the Enrollment Guide. However, prior versions of the Enrollment Guides remain in effect for the plan year to which they apply. In addition to TRS laws and regulations, the Enrollment Guide is TRS-ActiveCare’s official statement about enrollment matters contained in the Guide and supersedes any other statement or representation made concerning TRS-ActiveCare, regardless of the source of that statement or representation. TRS-ActiveCare reserves the right to amend the Enrollment Guide at any time.

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. Prescription drug benefits for ActiveCare 1, 2 and 3 are administered by Medco Health Solutions, Inc. HMO plans provided by: SHA, L.L.C. dba FirstCare Health Plans, Legacy Health Solutions, Inc., Mercy Health Plans of Missouri, Inc., Scott and White Health Plan and Valley Baptist Insurance Company dba Valley Baptist Health Plans.



Since 1937, the Teacher Retirement System of Texas (TRS) has served public education employees by delivering their retirement and related benefits and by managing the trust fund established to finance their benefits.

On September 1, 2002, TRS introduced TRS-ActiveCare, a new statewide health coverage program for public education employees established by the 77th Texas Legislature. Today, participation in that program has grown to over 300,000 employees and dependents. Of the 1,240 districts/entities eligible to participate in TRS-ActiveCare, almost 85 percent, or 1,051, now do so.

Along with three PPO plan options administered by Blue Cross and Blue Shield of Texas and Medco, there are five health maintenance organization (HMO) options offered under TRS-ActiveCare: FirstCare Health Plans, Legacy Health Solutions, Mercy Health Plans, Scott & White Health Plan, and Valley Baptist Health Plans. These HMO options will provide additional plan choices to the employees of participating entities in areas served by these HMOs. These employees will be able to select TRS-ActiveCare coverage under one of the PPO plans or through the authorized HMO serving their part of the state.

Accessible, affordable and quality health care has become increasingly important to all of us, and we at TRS are committed to providing that for you using all available resources. We hope that you'll take a few minutes to read through this booklet to learn more about your many TRS-ActiveCare benefits.

What's new for 2007-2008?

- Rates and/or benefits for every TRS-ActiveCare option have changed; please review the guide carefully
- If you plan to keep the same TRS-ActiveCare coverage, you do not need to submit an application form. *However, a form must be submitted to decline coverage, even if you declined TRS-ActiveCare coverage in 2006-2007*
- The plan enrollment periods for the 2007-2008 plan year are:
 - Spring Enrollment: April 16 - May 18, 2007
 - Summer Enrollment: August 1 - August 31, 2007
- No preexisting exclusions apply for plan or coverage changes you make *unless you previously declined coverage*. (Preexisting condition exclusions do not apply to HMO coverage.)

If you are initially enrolling or changing TRS-ActiveCare coverage, you must submit an *Enrollment Application and Change Form* to your Benefits Administrator by May 18, 2007 to receive your TRS-ActiveCare ID card by September 1, 2007.

How to use this guide

This guide summarizes TRS-ActiveCare for the coming plan year, effective September 1, 2007. It provides details on all the health benefit plans offered through TRS-ActiveCare. The information will help you understand the different plans and give you the confidence to decide which option is best for you and your family. Throughout the guide, you'll find special sidebars with information to help you better understand your health care options. See Terms to Know on page 34 and the Frequently Asked Questions on page 36 for additional information. If you still have questions, log onto the TRS-ActiveCare Web site or call the health plan's toll-free Customer Service number for assistance.

You'll have from April 16 - May 18 and August 1 - August 31 to enroll in or change your TRS-ActiveCare benefits for 2007-2008. *No plan changes will be accepted after August 31, 2007. For example, if you enroll in ActiveCare 2, you cannot change to ActiveCare 3 after August 31, 2007.*



Benefit Changes for 2007-2008 ~ Effective September 1, 2007

Plan Option	Benefit(s)	Change From	Change To
ActiveCare 1	Deductible per plan year	\$1,050 per individual	\$1,100 per individual
ActiveCare 2	Inpatient hospital copay (in addition to deductible and coinsurance)	None	\$100 per day (\$500 maximum copay per admission, \$1,500 maximum copay per plan year)
	Outpatient surgery copay (in addition to deductible and coinsurance)	None	\$100 per visit
	Emergency room copay (in addition to deductible and coinsurance)	None	\$100 per visit (copay waived if admitted)
ActiveCare 3	No changes		
FirstCare Health Plans	Emergency room copay	\$75	\$100
	Ambulance copay	\$75	\$100
	Minor emergency copay	\$35	\$40
	Generic/preferred brand/non-preferred brand prescription retail copays	\$10/\$20/\$40	\$15/\$30/\$50
	Generic/preferred brand/non-preferred brand prescription mail order copays	\$30/\$60/\$120	\$45/\$90/\$150
	Maximum prescription benefit per plan year	\$3,000	\$10,000
Legacy Health Solutions	No changes		
Mercy Health Plans	No changes		
Scott & White Health Plan	Outpatient specialty drugs copay		
	Level 1	\$0	\$50
	Level 2 (preferred)	\$25	\$100
	Level 3 (premium preferred)	\$50	\$250
	Level 4 (non-preferred)	\$100	50% (does not count toward out-of-pocket maximum)
	Prescription drug copays		
Preferred brand retail	\$20	\$25	
Preferred brand mail	\$40	\$50	
Non-formulary retail	50%	Greater of \$50 or 50%	
Valley Baptist Health Plans	No changes		



Who can enroll in TRS-ActiveCare?

To be eligible for TRS-ActiveCare, you must be employed by a participating district/entity. Then, answer the following questions:

1. Are you an active, contributing TRS member?
2. Are you employed by the participating district/entity for 10 or more regularly scheduled hours each week?

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

- Receiving health care coverage as an employee or retiree under the Texas State College and 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 Employee Uniform Group Insurance Benefits Act.

Example: A school employee who has HealthSelect coverage as an employee with ERS.

- A TRS retiree receiving, or who waived coverage under, TRS-Care, including a retiree who has returned to work.*

* 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.

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.



You may also cover your eligible dependents at the same time you enroll for coverage.

Eligible dependents include:

- Your 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, provided that the child is either mentally retarded or physically incapacitated to such an extent to be dependent on the employee on a regular basis as determined by TRS, and meets other requirements as determined by TRS (**Siblings over age 25 or parents are not the children of an employee and do not meet the definition of an eligible dependent.**)

Note: It is against the law to elect coverage for an ineligible person. Violations may result in prosecution and/or expulsion from the plan for up to five years.

Unmarried (Including Divorced) Children under the Age of 25

An employee may currently 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.





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 of the participating district/entity, not volunteers, and are either active contributing TRS members or are employed by a participating district/entity 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.

Note: Only employees who are active contributing TRS members are eligible for funding under Chapter 1581, Texas Insurance Code.

What if an employee and spouse both work for a participating district/entity?

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.

What if a child works for a participating district/entity?

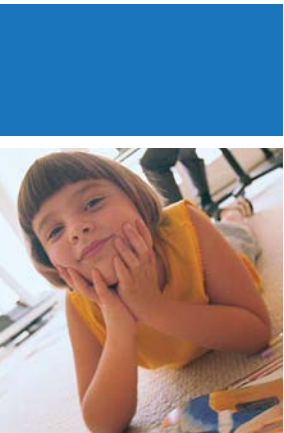
An unmarried child (under age 25) who is employed by a participating district/entity and is a contributing TRS member cannot be covered as a dependent on his or her parent's TRS-ActiveCare coverage. This child must be covered as an **employee** of the participating district/entity. If the child is not a contributing TRS member, the child may be covered as a dependent.

What is CHIP and is it available to my family?

Currently, families may qualify for low-cost children's health insurance through the TexCare Partnership and Children's Health Insurance Program (CHIP).

To apply, call TexCare Partnership at 1-800-647-6558 or log onto www.texcarepartnership.com.

Note: A child cannot receive coverage under both an employer-sponsored health care plan such as TRS-ActiveCare and CHIP.



1. Input your information in the application file
2. Print the application; sign, date, and submit it to your Benefits Administrator

How to Enroll

Enroll Now! The plan enrollment periods for the 2007-2008 plan year are:

- April 16 - May 18 (Spring Enrollment)
- August 1 - August 31 (Summer Enrollment)

During the plan enrollment periods, you may select a plan option, make plan changes, and add or delete dependents from your health coverage without a special enrollment event. No preexisting condition waiting period applies for plan or coverage changes you make this year *unless you previously declined coverage*. If you previously declined coverage and wish to enroll, a 12-month preexisting condition waiting period will apply to anyone enrolling in ActiveCare 1, 2 or 3. (HMO coverage does not contain preexisting condition exclusions.) A preexisting condition waiting period may be reduced by proof of prior creditable coverage. To receive credit for a preexisting condition waiting period, you must provide information about prior creditable coverage for you and/or any dependents. If you have a certificate of creditable coverage, attach a copy to your *Enrollment Application and Change Form*.

Note: You should choose your plan carefully. You may not change plans during a plan year, and there may be restrictions to making plan changes in future plan years. Also if you or one of your covered dependents is subject to a preexisting condition waiting period and you transfer to another TRS-ActiveCare participating district/entity and enroll for coverage, any remaining preexisting condition waiting period will continue to apply.



Enrolling in TRS-ActiveCare is a simple three-step process:

- 1 Choose the health plan option that's right for you
- 2 Complete the *Enrollment Application and Change Form (if required)*, available in English and Spanish, found in the center of this guide and on the TRS-ActiveCare Web site
- 3 Submit the completed, signed and dated form to your Benefits Administrator within the required enrollment period(s).

Note: Some districts/entities may offer electronic enrollment through an interactive voice response (IVR) or Web-based system. If so, you may not need to submit an *Enrollment Application and Change Form*. See your Benefits Administrator for details. Please keep a copy of any confirmation of coverage you receive from the electronic enrollment system for your records.

Important Steps to Remember:

- Please complete all of the required information on the *Enrollment Application and Change Form*.
- Even if you are not accepting available coverage through TRS-ActiveCare, please complete sections 1, 2 and 9 of the *Enrollment Application and Change Form* and note that you are declining health coverage for yourself and/or your dependents.
- If you have questions concerning the information requested on the *Enrollment Application and Change Form*, please ask your Benefits Administrator for assistance or call Customer Service.
- Be sure to complete, sign and date the form before submitting it to your Benefits Administrator.



Who needs to submit an *Enrollment Application and Change Form*?

For employees already enrolled in TRS-ActiveCare:

If you are not making any changes to your current health benefit plan or adding/dropping dependents, you do not need to re-enroll. This year, you only need to complete and return an enrollment form if you want to:

- Change your TRS-ActiveCare plan option, or
- Add or drop the dependents you cover, or
- Choose to cancel and/or decline coverage under TRS-ActiveCare

Forms should be returned to your Benefits Administrator. If you do not return your enrollment form, you will automatically be enrolled in the same plan you elected for 2006-2007 at the same level of coverage. Please pay close attention to any benefit changes from last year as you make your plan choices. Your premium will be adjusted to reflect any rate change on September 1, 2007.

For employees enrolling in TRS-ActiveCare for the first time:

You will need to sign and submit an *Enrollment Application and Change Form* to your Benefits Administrator:

- By the end of your plan enrollment period
- Within 31 calendar days after your actively-at-work date
- Within 31 calendar days after a special enrollment event (Special rules apply to adding newborns; see page 9 for more information)

What if I choose not to enroll in TRS-ActiveCare?

TRS believes it is very important that everybody should have health coverage. Please keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a special enrollment event, such as a marriage, divorce, birth or adoption of a child, or a loss of other coverage. 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. So it is very important

that you complete and submit a form even if you are declining coverage.

To decline coverage: Complete sections 1, 2 and 9 of the *Enrollment Application and Change Form* to voluntarily decline coverage for yourself and any of your dependents and to provide the reason for declining. Submit the form to your Benefits Administrator. If you are currently covered by TRS-ActiveCare but want to decline coverage for 2007-2008, you must sign and submit an *Enrollment Application and Change Form* during the plan enrollment period to terminate coverage at the end of the 2006-2007 plan year by checking the boxes for Cancel Enrollee and Decline Coverage for the new plan year.

If I'm already enrolled and not making any changes, do I have to complete an *Enrollment Application and Change Form*?

No, unless you declined coverage in 2006-2007. If you are not making any changes to your current health benefit plan or adding or dropping dependents, you do not need to enroll. You will automatically be enrolled in the same plan you elected for 2006-2007 at the same level of coverage, and your premium will be adjusted to reflect any rate change on September 1, 2007. You should review any benefit changes, as well as rate changes, for your current plan. **If you declined coverage in 2006-2007 and wish to decline coverage again in 2007-2008, you must resubmit an *Enrollment Application and Change Form* to your Benefits Administrator indicating you are declining coverage.**

What options are available to a husband and wife who both work for a participating entity?

- Each can choose employee-only coverage and select the same or different plans
- One can select employee and spouse coverage, and the spouse must decline coverage
- One can choose employee-only coverage, and the spouse can choose the same or different plan for employee and child(ren) coverage
- One can select employee and family coverage, and the spouse must decline coverage
- Each can decline coverage



Making Changes/Special Enrollment Events

The plan options and coverage levels you select during the 2007-2008 plan enrollment periods will remain in effect from September 1, 2007 through August 31, 2008. Generally you cannot make changes during the year unless you have a special enrollment event (family status change) such as:

- You marry or divorce (a common law marriage is not considered a special enrollment event unless there is a certificate of common law marriage filed with an authorized 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
- A child marries or reaches age 25
- A court orders you to provide health coverage for your child (does not apply to court-ordered coverage for a spouse), or
- You involuntarily lose other health insurance coverage (and you originally declined TRS-ActiveCare coverage in writing because of coverage under another health benefit plan)
- Your eligible dependent involuntarily loses other health insurance coverage (and you originally declined TRS-ActiveCare dependent coverage in writing for the individual(s) losing other coverage because of coverage under another health benefit plan). **Note:** You can only add the dependent if you are already covered by ActiveCare 1, 2 or 3. If you live, work or reside in an HMO service area, you and your dependent can enroll in HMO coverage.

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. **Call Customer Service before you make any changes to other coverage you may have.**

The change in coverage must be consistent with the family status change for special enrollment events as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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 calendar days after the special enrollment event. (Special rules apply to newborns; refer to box below for more information.) **It is YOUR responsibility to meet any such deadlines.** 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 waiting period may apply at that time.

Note: 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.

A change request submitted through your Section 125 vendor (if applicable) will not automatically result in changes to your TRS-ActiveCare coverage. All changes to TRS-ActiveCare coverage must be submitted to your Benefits Administrator, using the TRS-Active Care Enrollment Application and Change Form.

How are newborns covered by TRS-ActiveCare?

TRS-ActiveCare automatically provides coverage for a newborn child of a covered employee for the first 31 days after the date of birth. To add coverage for the newborn, the employee must sign, date and submit an *Enrollment Application and Change Form* to the Benefits Administrator **within 60 days after the date of birth.** However, an employee has up to one year after the newborn's date of birth to add the newborn to coverage if the employee has employee and family or employee and child(ren) coverage with TRS-ActiveCare at the time of the newborn's birth and at enrollment. The effective date of coverage is the date of birth. **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:** It is not necessary to wait for the newborn's Social Security number. You should submit an *Enrollment Application and Change Form* without the newborn's Social Security number to add coverage and re-submit another form once the number has been issued.

Plan Options

TRS-ActiveCare offers many different health plan options

The following pages feature an overview of benefits for all TRS-ActiveCare health plan options. Not all health plan options are available in all areas of the state. The charts to the right display the options available by county (or by ZIP Code in some areas). See your Benefits Administrator or log onto the TRS-ActiveCare Web site to find out which options are available in your area.

ActiveCare 1, 2 and 3 options, administered by Blue Cross and Blue Shield of Texas and Medco, are available to districts/entities in all Texas counties. **To be eligible for an HMO, you must live, work or reside within the HMO service area.**

County	ActiveCare 1, 2 & 3	FirstCare Health Plans	Legacy Health Solutions	Mercy Health Plans	Scott & White Health Plan	Valley Baptist Health Plans
Andrews	•	•				
Armstrong	•	•				
Austin	•				•*	
Bailey	•	•				
Bastrop	•				•	
Bell	•	•			•	
Blanco	•				•	
Borden	•	•				
Bosque	•	•			•	
Brazos	•				•	
Briscoe	•	•				
Burleson	•				•	
Burnet	•				•	
Caldwell	•				•	
Callahan	•	•				
Cameron	•					•
Carson	•	•				
Castro	•	•				
Childress	•	•				
Cochran	•	•				
Coke	•	•	•			
Coleman	•	•	•			
Collingsworth	•	•				
Comanche	•	•				
Concho	•		•			
Coryell	•	•			•	
Cottle	•	•				
Crane	•	•				
Crockett	•		•			
Crosby	•	•				
Dallam	•	•				
Dawson	•	•				
Deaf Smith	•	•				
Dickens	•	•				
Donley	•	•				
Duval	•			•		
Eastland	•	•				
Ector	•	•				
Edwards	•		•			
Erath	•				•*	
Falls	•	•			•	
Fisher	•	•				
Floyd	•	•				
Gaines	•	•				
Garza	•	•				
Glasscock	•	•				
Gray	•	•				





County	ActiveCare 1, 2 & 3	FirstCare Health Plans	Legacy Health Solutions	Mercy Health Plans	Scott & White Health Plan	Valley Baptist Health Plans
Grimes	•				•	
Hale	•	•				
Hall	•	•				
Hamilton	•	•			•	
Hansford	•	•				
Hartley	•	•				
Haskell	•	•				
Hays	•				•	
Hemphill	•	•				
Hidalgo	•					•
Hill	•	•			•	
Hockley	•	•				
Hutchinson	•	•				
Irion	•		•			
Jim Hogg	•			•		
Jones	•	•				
Kent	•	•				
Kimble	•		•			
King	•	•				
Kinney	•		•			
Knox	•	•				
Lamb	•	•				
Lampasas	•	•			•	
Lee	•				•	
Leon	•				•*	
Limestone	•	•				
Lipscomb	•	•				
Llano	•				•	
Loving	•	•				
Lubbock	•	•				
Lynn	•	•				
Madison	•				•	
Martin	•	•				
Mason	•		•			
McCulloch	•		•			
McLennan	•	•			•	
Menard	•		•			
Midland	•	•				
Milam	•				•	
Mills	•				•	
Mitchell	•	•				
Moore	•	•				
Motley	•	•				
Nolan	•	•				
Ochiltree	•	•				
Oldham	•	•				
Parmer	•	•				

County	ActiveCare 1, 2 & 3	FirstCare Health Plans	Legacy Health Solutions	Mercy Health Plans	Scott & White Health Plan	Valley Baptist Health Plans
Pecos	•	•				
Potter	•	•				
Randall	•	•				
Reagan	•	•	•			
Reeves	•	•				
Roberts	•	•				
Robertson	•				•	
Runnels	•	•	•			
San Saba	•				•	
Schleicher	•		•			
Scurry	•	•				
Shackelford	•	•				
Sherman	•	•				
Somervell	•				•	
Starr	•					•*
Stephens	•	•				
Sterling	•		•			
Stonewall	•	•				
Sutton	•		•			
Swisher	•	•				
Taylor	•	•				
Terry	•	•				
Tom Green	•		•			
Travis	•				•	
Upton	•	•				
Val Verde	•		•			
Walker	•				•	
Waller	•				•*	
Ward	•	•				
Washington	•				•	
Webb	•			•		
Wheeler	•	•				
Willacy	•					•
Williamson	•				•	
Winkler	•	•				
Yoakum	•	•				
Zapata	•			•		
All Other Texas Counties	•					

*** Partial counties covered as follows:**
Austin – All of 77452, 77833, 78931 and 78944. Portions of ZIP Codes 77418, 78940 and 78950
Erath – All of 76457. Portions of 76401, 76433 and 76446
Leon – All of 77855 and 77871. Portions of 75833, 75850 and 77865
Starr – All of 78356, 78547, 78548
Waller – All of 77445. Portions of 77423 and 77484



Preferred Provider Organization (PPO)

Generally speaking, a PPO plan offers more choice than an HMO plan. When you enroll in a PPO plan, you do not have to select a primary care physician (PCP), nor do you have to obtain a referral to see a specialist. You have the freedom of visiting any physician or hospital you choose. A PPO plan offers two levels of benefits—network and non-network. When you seek care from a network physician or hospital, the PPO plan pays a larger portion of your health care costs than it pays for services by a non-network provider. However, when you receive care outside the network, you still have coverage, but you may pay more of the cost.

If enrolled in a PPO plan, there may be a plan year deductible to meet before the plan begins paying benefits, and you may pay a copayment or coinsurance when you utilize health care services. Preexisting condition exclusions may also apply. (Prior creditable coverage may offset any preexisting condition waiting period.) Although the out-of-pocket costs are potentially higher than HMO plans, a PPO plan offers enrollees more choice and more flexibility than an HMO plan.

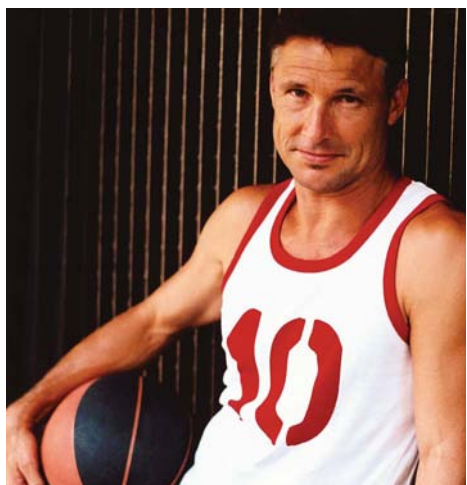
Health Maintenance Organization (HMO)

HMO plans offer prepaid health care for you and your covered dependents. In most instances you will pay only a copayment for your medical services, including prescriptions. A copayment is a set dollar amount that you pay a provider when utilizing services. To be eligible for an HMO plan, you must live, work

or reside within the HMO service area. HMO plans offer a network of providers within a defined service area. Except for emergencies, which are covered worldwide, you and your dependents must use network providers to receive HMO plan benefits. Preexisting condition exclusions do not apply to HMO plans.

When you enroll in an HMO plan, you will be asked to select a primary care physician. This physician will coordinate all of your health care, and provide referrals to specialty care if needed. Females may also select a network OB/GYN and may schedule an appointment with that physician without a referral from a PCP. When you are comparing the merits of a PPO plan or an HMO plan, be sure to compare the providers in all plans. If your physician is within an HMO network, you may find that an HMO plan is a cost-effective way to receive comprehensive medical benefits.

TRS-ActiveCare has given you the opportunity to take control of your health care. Please review the Benefits Summaries and Plan Comparisons on pages 16-29 to decide which plan option meets the needs of your family and your lifestyle.



If you have the opportunity to select between a PPO option and an HMO option, there are several factors you should consider when making a decision including cost, choice, access to providers and your own lifestyle



Take the time to review the Benefits Summaries and Plan Comparisons. Think about which plan works best for you and your family. Before you make your choice, consider:

- Do you have access to health coverage other than what is provided by TRS-ActiveCare? If so, how do the costs and provisions of that coverage compare?
- If you have a choice of provider networks, which one is nearest to you? Is your current physician in one of the networks? If your doctor is in a PPO and an HMO network, and if you are eligible for the PPO and the HMO, you might want to evaluate your anticipated out-of-pocket costs for all of the options available to you.
- Are you willing to change physicians if your current physician is not in the network?
- What specific benefits do you or your family use most frequently? Preventive? Maintenance prescriptions? Behavioral health? Make sure you look at the corresponding line in the comparison chart to see which plan would work best.
- Whom do you need to cover? Where do they live?
- Do you or members of your family travel? Make sure you understand how treatment is received outside of your local area.

Also when choosing a health plan, be sure to consider the total cost of your options, including:

- **Coinsurance:** The percentage of medical expenses that you and the plan share. For example, if the network coinsurance amount is “80/20,” that means that the plan pays 80% and you pay 20%.
- **Copayments:** The set amount you pay for certain medical services and prescription drugs at the time of service.
- **Deductibles:** The set amount of out-of-pocket expense, if applicable, that must be paid for health care services by the covered person before the plan begins to share costs. For example, ActiveCare 1 has a \$1,100 deductible, which must be met before the plan pays any benefits.
- **Employee contributions:** The expense paid by the employee for coverage through the TRS-ActiveCare program.

Plan options and preferred brand-name prescription drugs

All TRS-ActiveCare plan options include prescription drug benefits. As you select a plan option, you should know that the prescription drug benefits differ. To find out if and how your medication is covered by TRS-ActiveCare, check the Web site or call the specific health plan’s toll-free Customer Service number listed on page 1 of this guide.

Important Notice

TRS does not offer, nor does it endorse, any form of supplemental coverage for any of the health coverage plans available under TRS-ActiveCare. To obtain information about any coverage that is purported to be a companion or supplement to any TRS-ActiveCare plan, employees should contact the organization making such offerings and/or the Texas Department of Insurance (TDI) at <http://www.tdi.state.tx.us> or the TDI Consumer Helpline at (800)252-3439.



What's New for 2007-2008 for the ActiveCare 1, 2 and 3 Plans?

- Premium increase (approximately 7%)

ActiveCare 1:

- Plan year deductible per individual increases from \$1,050 to \$1,100 due to IRS regulations for high deductible health plans (**Note:** ActiveCare 1 meets the IRS definition of a high deductible health plan for individual coverage only. The \$3,000 per family deductible for ActiveCare 1 does **not** meet the IRS requirements for a high deductible health plan for families.)

ActiveCare 2:

- For an inpatient hospital admission, you pay 20% network/40% non-network after deductible plus \$100 copay per day (\$500 maximum copay per admission, \$1,500 maximum copay per plan year)
- For outpatient surgery, you pay 20% network/40% non-network after deductible plus \$100 copay per visit
- For emergency room care, you pay 20% after deductible plus \$100 copay per visit (copay waived if admitted)

ActiveCare 3:

- No changes

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)
- Opt-out of receiving paper copies of your Explanation of Benefits (view online)
- Locate a physician in your network who meets your needs
- Sign up to receive email notifications of new claim activity
- Request a new or replacement ID card or print a temporary ID card
- Take a Health Risk Assessment

How to Find Blue Access for Members

- 1 Go to www.trs.state.tx.us/trs-activecare
- 2 Select the link for "ActiveCare Plans 1, 2 or 3"
- 3 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.

Online Resources for Health and Wellness

Through Blue Access for Members, you and your family have access to online resources where you will find practical and useful information. For example, you can research specific health conditions and get advice on how to start a program for exercise, smoking cessation or weight loss. And now, you can also take a Health Risk Assessment (HRA), a confidential tool that helps you learn more about your individual health risks. The HRA is easy to understand and takes approximately 10 to 15 minutes to complete. Once you have completed the assessment, you will receive an individualized report that will provide you with guidance and suggestions on the next steps to improving your health.

To take a Health Risk Assessment: Log onto Blue Access for Members and click on the My Health tab. Select the icon or text for Health & Wellness, then select the link, Take a Health Risk Assessment.

Please be assured your information is kept confidential and will not be released to your employer.

The screenshot shows the TRS-ActiveCare website. At the top, it says "Blue Cross Blue Shield of Texas | Shining Through" and "TRS-ActiveCare | TEACHER RETIREMENT SYSTEM OF TEXAS". Navigation tabs include Home, Coverage, Doctors & Hospitals, and For Benefits Administrators. A welcome message states: "Welcome to TRS-ActiveCare, the statewide health care coverage program for public education employees." Below this, there are sections for "Contact Us" with phone numbers for Customer Service, Preauthorization, INROADS Behavioral Health, and Blue Card PPO Access. A "Mailing Address for Claims" is also provided. The "How Can We Help You?" section lists several options: filling out an enrollment form, reviewing guides, searching for a doctor or hospital, downloading forms, and learning about health care fraud. On the right, the "Blue Access for Members" login section is visible, with fields for User Name and Password, a "Log In" button, and links for "I forgot my User Name", "I forgot my Password", and "Sign Up Today!". An "Attention" box at the bottom right highlights the "Special Beginnings" program, a prenatal care program for expectant mothers, with a toll-free number: 1-800-462-3275.

Having a baby?

Special Beginnings is a voluntary program for covered participants who are expecting a baby. This program helps expectant mothers and their babies get off to a healthy start by providing prenatal and postnatal health education, pregnancy risk assessment, educational materials and follow-up monitoring from pregnancy to six weeks after delivery. Special Beginnings coordinates with the mother's physician to provide case management services to help reduce the chance of low birth-weight infants and/or premature delivery. The program is available at no additional cost. **Call toll free 1-800-462-3275 to enroll or ask questions.**

Even if you visit a non-network doctor, you may still save money using a ParPlan physician

Blue Cross and Blue Shield of Texas contracts with many non-network doctors and hospitals. These providers accept the Blue Cross and Blue Shield of Texas allowable amounts for covered services and cannot bill you more. In most cases they will file claims, too. Look for participating doctors and hospitals on the TRS-ActiveCare Web site under Provider Locator; select Blue Cross and Blue Shield of Texas, then select ParPlan.

How the ActiveCare 1, 2 and 3 PPO Plans Work



BlueCross BlueShield of Texas



Service Area
Statewide

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

If you need to...	Network: You pay lower out-of-pocket costs if you choose network care	Non-Network: (Including ParPlan) You pay higher out-of-pocket costs if you choose non-network care <i>Payment for non-network services is limited to the allowable amount as determined by Blue Cross and Blue Shield of Texas. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan Providers which exceed the allowable amount.</i>
Visit a doctor or specialist A "specialist" is any physician other than a family practitioner, internist, OB/GYN or pediatrician	<ul style="list-style-type: none"> Visit any network doctor or specialist Pay the office visit copay (<i>not applicable for ActiveCare 1</i>) Pay any coinsurance and deductible Your doctor cannot charge more than the allowable amounts for covered services 	<ul style="list-style-type: none"> Visit any licensed doctor or specialist Pay for the office visit File a claim and get reimbursed for the visit minus any coinsurance and deductible 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 determined by Blue Cross and Blue Shield of Texas
Receive preventive care	<ul style="list-style-type: none"> Visit any network doctor or specialist Pay the preventive care copay (<i>not applicable for ActiveCare 1</i>) Pay any coinsurance and deductible Your doctor cannot charge more than the allowable amounts for covered services 	<ul style="list-style-type: none"> Visit any licensed doctor or specialist Pay for the preventive care visit File a claim and get reimbursed for the visit minus any coinsurance and deductible 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 determined by Blue Cross and Blue Shield of Texas
Receive emergency care	<ul style="list-style-type: none"> Call 911 or go to any hospital or doctor immediately; you will receive network benefits for emergency care Pay any copay (waived if admitted) Pay any coinsurance and deductible Call the preauthorization number on your ID card within 48 hours 	<ul style="list-style-type: none"> Call 911 or go to any hospital or doctor immediately; you will receive network benefits for emergency care Pay any copay (waived if admitted) Pay any coinsurance and deductible Call the preauthorization number on your ID card within 48 hours
Be admitted to the hospital	<ul style="list-style-type: none"> Your network doctor will preauthorize your admission Go to the network hospital Pay any coinsurance and deductible 	<ul style="list-style-type: none"> You, a family member, your doctor or the hospital must preauthorize your admission Go to any licensed hospital Pay any coinsurance and deductible each time you are admitted
Receive behavioral health or chemical dependency services	<ul style="list-style-type: none"> Call the behavioral health number on your ID card first to authorize all care See a network doctor or health care professional, or go to any network hospital or facility Pay any coinsurance and deductible 	<ul style="list-style-type: none"> Call the behavioral health number on your ID card first to authorize all care See any licensed doctor or health care professional, or go to any licensed hospital or facility Pay any coinsurance and deductible
File a claim Get prescription drugs	Claims will be filed for you ActiveCare 1 <ul style="list-style-type: none"> Take prescription to a network retail pharmacy or mail order service Pay the total <i>discounted</i> cost of the drug File a claim with Blue Cross and Blue Shield of Texas and get reimbursed for the drug <i>minus</i> any coinsurance and deductible ActiveCare 2 and ActiveCare 3 <ul style="list-style-type: none"> Take prescription to a network retail pharmacy or mail order service Pay the prescription drug copay 	You may need to file the claim yourself ActiveCare 1 <ul style="list-style-type: none"> Take prescription to any licensed pharmacy Pay the <i>total</i> cost of the drug File a claim with Blue Cross and Blue Shield of Texas and get reimbursed for the drug <i>minus</i> any coinsurance and deductible ActiveCare 2 and ActiveCare 3 <ul style="list-style-type: none"> Take prescription to any licensed pharmacy File a claim with Medco and get reimbursed the amount that would have been charged by a network pharmacy <i>less</i> the required copay

Your Benefits Booklet will have more information.

Type of Service	ActiveCare 1	
	Network	Non-Network
General Provisions	No primary care physician required	
Deductible (per plan year)		
Individual–You pay	\$1,100	
Family–You pay	\$3,000	
Out-of-pocket maximum (per plan year)		
Individual–You pay	\$2,000 plus deductible	
Family–You pay	\$6,000 plus deductible	
Maximum Lifetime Benefit	Unlimited	Unlimited
Doctor and Lab Services		
Doctor office visits–You pay	20% after deductible	40% after deductible
Allergy injections–You pay	20% after deductible	40% after deductible
Office surgery–You pay	20% after deductible	40% after deductible
Outpatient surgery–You pay	20% after deductible	40% after deductible
Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges)–You pay	20% after deductible	40% after deductible
Inpatient doctor visits–You pay	20% after deductible	40% after deductible
Contraceptive devices–You pay	20% after deductible	40% after deductible
Preventive Care		
Doctor office visits	<p>Plan pays 100% up to the first \$500 per individual, per plan year; remaining charges will be subject to deductible and coinsurance</p> <p>Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams, routine mammograms, and eye exams. Other services include well-baby exams, immunizations, hearing exams, and PSA, colorectal cancer, osteoporosis screenings</p>	<p>40% after deductible</p> <p>Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams, routine mammograms, and eye exams</p>
Hospital/Facility Services		
Inpatient hospital and other inpatient charges–You pay	20% after deductible (preauthorization required)	40% after deductible (preauthorization required)
Outpatient surgery–You pay	20% after deductible	40% after deductible
Outpatient hospital/facility–You pay	20% after deductible	40% after deductible
Emergency room care–You pay	20% after deductible	



Service Area
Statewide

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

ActiveCare 2		ActiveCare 3	
Network	Non-Network	Network	Non-Network
No primary care physician required		No primary care physician required	
\$500		None	\$500
\$1,500		None	\$1,500
\$2,000 plus deductible and copays		\$1,000 plus copays	\$3,000 plus deductible and copays
\$6,000 plus deductible and copays		N/A	N/A
Unlimited	Unlimited	Unlimited	\$1,000,000
\$25 copay for primary \$35 copay for specialist	40% after deductible	\$20 copay for primary \$30 copay for specialist	40% after deductible
20% after deductible (when no office visit is billed)	40% after deductible	20% (when no office visit is billed)	40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
\$25 copay for primary \$35 copay for specialist (for initial visit only; 20% after deductible for delivery)	40% after deductible	\$20 copay for primary \$30 copay for specialist (for initial visit only; 20% for delivery)	40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
\$25 copay for primary \$35 copay for specialist (includes all preventive care services billed with an office visit by a network doctor)	40% after deductible	\$20 copay for primary \$30 copay for specialist (includes all preventive care services billed with an office visit by a network doctor)	40% after deductible
Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams, routine mammograms, and eye exams. Other services include well-baby exams, immunizations, hearing exams, and PSA, colorectal cancer, osteoporosis screenings	Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams, routine mammograms, and eye exams	Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams, routine mammograms, and eye exams. Other services include well-baby exams, immunizations, hearing exams, and PSA, colorectal cancer, osteoporosis screenings	Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams, routine mammograms, and eye exams
20% after deductible plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)	40% after deductible plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)	20% plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)	40% plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)
20% after deductible plus \$100 copay per visit	40% after deductible plus \$100 copay per visit	20% plus \$100 copay per visit	40% plus \$100 copay per visit
20% after deductible	40% after deductible	20%	40% after deductible
20% after deductible, plus \$100 copay (copay waived if admitted)		20% after \$100 copay (copay waived if admitted)	

This is a general summary of your TRS-ActiveCare plan options. Please refer to your Benefits Booklet for details specific to your plan. Please see the Limitations and Exclusions section at the back of your enrollment guide.

Type of Service	ActiveCare 1	
	Network	Non-Network
General Provisions	No primary care physician required	
Behavioral Health (Mental Health and Chemical Dependency)		
Mental Health	Preauthorization required	Preauthorization required
Inpatient facility–You pay	20% after deductible	40% after deductible
Maximum per plan year	30 days	
Inpatient physician charges–You pay	20% after deductible	40% after deductible
Maximum per plan year	30 visits	
Outpatient/Office visit	20% after deductible	40% after deductible (maximum \$60 allowable per visit)
Maximum per plan year	30 visits	
Chemical dependency	Maximum of two separate series per lifetime	
Inpatient facility–You pay	20% after deductible	40% after deductible
Inpatient physician charges–You pay	20% after deductible	40% after deductible
Outpatient–You pay	20% after deductible	40% after deductible
Office visit–You pay	20% after deductible	40% after deductible
Serious Mental Illness		
Inpatient facility–You pay	Preauthorization required	Preauthorization required
	20% after deductible	40% after deductible
Maximum per plan year	45 days	
Inpatient physician charges–You pay	20% after deductible	40% after deductible
Maximum per plan year	45 visits	
Outpatient/Office visit–You pay	20% after deductible	40% after deductible
Maximum per plan year	60 visits	
Prescription Drugs	Subject to \$1,100 plan year deductible	
Drug deductible (per person, per plan year)		
Retail Short-Term	Up to 30-day supply	Up to 30-day supply
Generic–You pay	100% of the discounted cost at the time of purchase; 80% will be reimbursed by Blue Cross and Blue Shield of Texas after deductible	100% at the time of purchase; 80% will be reimbursed by Blue Cross and Blue Shield of Texas after deductible
Preferred Brand–You pay		
Non-preferred Brand–You pay		
Retail Maintenance (after second fill)	Up to 30-day supply	Up to 30-day supply
Generic–You pay	100% of the discounted cost at the time of purchase; 80% will be reimbursed by Blue Cross and Blue Shield of Texas after deductible	100% at the time of purchase; 80% will be reimbursed by Blue Cross and Blue Shield of Texas after deductible
Preferred Brand–You pay		
Non-preferred Brand–You pay		
Medco by Mail	Up to 90-day supply	N/A
Generic–You pay	100% of the discounted cost at the time of purchase; 80% will be reimbursed by Blue Cross and Blue Shield of Texas after deductible	N/A
Preferred Brand–You pay		
Non-preferred Brand–You pay		
Maximum Plan Year Prescription Benefit	Unlimited	Unlimited



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

ActiveCare 2	
Network	Non-Network
No primary care physician required	

Network	Non-Network
Preauthorization required 20% after deductible plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)	Preauthorization required 40% after deductible plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year ; preauthorization required)
30 days	
20% after deductible	40% after deductible
30 visits	
20% after deductible	40% after deductible (maximum \$60 allowable per visit)
30 visits	
Maximum of two separate series per lifetime	
20% after deductible plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)	40% after deductible plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year ; preauthorization required)
20% after deductible	40% after deductible
20% after deductible	40% after deductible
\$25 copay for primary \$35 copay for specialist	40% after deductible

ActiveCare 3	
Network	Non-Network
No primary care physician required	

Network	Non-Network
Preauthorization required 20% plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)	Preauthorization required 40% plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)
30 days	
20%	40% after deductible
30 visits	
20%	40% after deductible (maximum \$60 allowable per visit)
30 visits	
Maximum of two separate series per lifetime	
20% plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)	40% plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)
20%	40% after deductible
20%	40% after deductible
\$20 copay for primary \$30 copay for specialist	40% after deductible

Network	Non-Network
Preauthorization required 20% after deductible plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)	Preauthorization required 40% after deductible plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year ; preauthorization required)
45 days	
20% after deductible	40% after deductible
45 visits	
\$25 copay for primary \$35 copay for specialist (for other services, 20% after deductible)	40% after deductible
60 visits	

Network	Non-Network
Preauthorization required 20% plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)	Preauthorization required 40% plus \$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year; preauthorization required)
No day limitations	
20%	40% after deductible
No visit limitations	
\$20 copay for primary \$30 copay for specialist (20% for other services)	40% after deductible
No visit limitations	

\$50	
Up to 30-day supply \$10 copay \$25 copay* \$45 copay*	Up to 30-day supply You will be reimbursed the amount that would have been charged by a network pharmacy less the required copay
Up to 30-day supply \$15 copay \$35 copay* \$60 copay*	Up to 30-day supply You will be reimbursed the amount that would have been charged by a network pharmacy less the required copay
Up to 90-day supply \$20 copay \$62.50 copay* \$112.50 copay*	N/A N/A
Unlimited	Unlimited

\$50	
Up to 30-day supply \$10 copay \$25 copay* \$40 copay*	Up to 30-day supply You will be reimbursed the amount that would have been charged by a network pharmacy less the required copay
Up to 30-day supply \$15 copay \$35 copay* \$55 copay*	Up to 30-day supply You will be reimbursed the amount that would have been charged by a network pharmacy less the required copay
Up to 90-day supply \$20 copay \$62.50 copay* \$100 copay*	N/A N/A
Unlimited	Unlimited

*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 is a general summary of your TRS-ActiveCare plan options. Please refer to your Benefits Booklet for details specific to your plan. Please see the Limitations and Exclusions section at the back of your enrollment guide.



Service Area

85 Texas Counties
(Panhandle, West Texas
and Central Texas)

To be eligible for coverage from this HMO, you must live, work or reside in one of the following counties:

- Andrews
- Armstrong
- Bailey
- Bell
- Borden
- Bosque
- Briscoe
- Callahan
- Carson
- Castro
- Childress
- Cochran
- Coke
- Coleman
- Collingsworth
- Comanche
- Coryell
- Cottle
- Crane
- Crosby
- Dallam
- Dawson
- Deaf Smith
- Dickens
- Donley
- Eastland
- Ector
- Falls
- Fisher
- Floyd
- Gaines
- Garza
- Glasscock
- Gray
- Hale
- Hall
- Hamilton
- Hansford
- Hartley
- Haskell
- Hemphill
- Hill
- Hockley
- Hutchinson
- Jones
- Kent
- King
- Knox
- Lamb
- Lampasas
- Limestone
- Lipscomb
- Loving
- Lubbock
- Lynn
- Martin
- McLennan
- Midland
- Mitchell
- Moore
- Motley
- Nolan
- Ochiltree
- Oldham
- Parmer
- Pecos
- Potter
- Randall
- Reagan
- Reeves
- Roberts
- Runnels
- Scurry
- Shackelford
- Sherman
- Stephens
- Stonewall
- Swisher
- Taylor
- Terry
- Upton
- Ward
- Wheeler
- Winkler
- Yoakum

FirstCare Health Plans’ personal care system incorporates private physicians and other health care providers who work together to coordinate your health care needs and provide you with quality health care at an affordable cost.

You have your choice of a participating primary care physician, direct access to specialist physician services and coverage for preventive and routine medical care.

There is a \$20 copayment for primary care office visits; \$40 copayment for specialist office visits; \$20 copayment for gynecological services performed by the PCP or OB/GYN. FirstCare Health Plans provides comprehensive hospital and emergency coverage.

The prescription drug benefit provides broad prescription drug coverage and allows you to share in the savings when you and your doctor decide on certain medications. All drugs covered under this benefit plan are assigned to one of four copayment tiers. The retail copayments are \$15 for generic drugs, \$30 for preferred brand-name drugs, \$50 for non-preferred drugs, and 20 percent for self-injectables and other high technology drugs for up to a 30-day supply. Injectable medications are those recognized by the FDA as appropriate for self-administration regardless of the participant’s ability to self-administer (excludes diabetic medication and allergy serum). A 90-day mail order prescription or refill will require one mail order copayment. The mail order copayments are \$45 for generic drugs, \$90 for preferred brand-name drugs, \$150 for non-preferred drugs and 20 percent for self-injectables and other high technology drugs. There is a maximum plan year benefit per person of \$10,000 for prescription drugs.

General Provisions	Primary care physician required to direct care and for benefits to be paid
Deductible (per plan year)	
Individual—You pay	None
Family—You pay	None
Out-of-pocket maximum (per plan year)	
Individual—You pay	2x total plan year cost of coverage* (does not include pharmacy)
Family—You pay	
Maximum Lifetime Benefit	Unlimited
Doctor and Lab Services	
Doctor office visits—You pay	\$20 for primary care physician; \$40 for specialist
Allergy injections—You pay	50% for serum; 50% for administration
Office surgery—You pay	\$50 copay
Outpatient surgery—You pay	\$150 copay
Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges)—You pay	\$0 physician copay for pre- and post-natal care and delivery
Inpatient doctor visits—You pay	\$0 copay
Contraceptive devices—You pay	20%
Preventive Care	
Doctor office visits—You pay	\$20 for primary care physician; \$40 for specialist (includes all preventive care services billed with an office visit by a network doctor)
	Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams and routine mammograms (\$0 copay). Other services include well-baby exams, immunizations, hearing exams, and PSA, colorectal cancer, and \$50 copay for osteoporosis screenings



Customer Service

1-(800) 884-4901

8 a.m. to 6 p.m.

(Central Time)

Monday through Friday

What's new for 2007-2008?

- \$100 emergency room copay
- \$100 ambulance copay
- \$40 minor emergency copay
- \$15 generic drug copay, \$30 preferred brand-name drug copay, \$50 non-preferred brand-name drug copay (retail)
- \$45 generic drug copay, \$90 preferred brand-name drug copay, \$150 non-preferred brand-name drug copay (mail order)
- \$10,000 maximum prescription benefit per plan year
- Premium increase of approximately 7%

* Maximum depends on coverage category:
 Employee Only – \$8,616
 Employee & Spouse – \$21,360
 Employee & Child(ren) – \$13,704
 Employee & Family – \$21,432

** 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.

General Provisions	Primary care physician required to direct care and for benefits to be paid
Hospital/Facility Service	
Inpatient hospital and other inpatient charges–You pay	\$150 per day (maximum \$750 per admission)
Outpatient hospital/facilities–You pay	\$40 copay
Emergency room care–You pay	\$100 copay (waived if admitted)
Urgent care services/facility–You pay	\$40 copay
Behavioral Health (Mental Health and Chemical Dependency)	
Mental health	
Inpatient facility–You pay	\$150 per day (maximum \$750 copay per admission)
Maximum per plan year	15 days
Inpatient physician charges–You pay	\$0 copay
Maximum per plan year	15 visits
Outpatient/Office visit–You pay	\$40 copay
Maximum per plan year	20 visits
Chemical dependency	
Inpatient facility–You pay	Maximum of three series per lifetime \$150 per day (maximum \$750 per admission)
Inpatient physician charges–You pay	\$0 copay
Outpatient–You pay	\$40 copay
Office visit–You pay	\$40 copay
Serious Mental Illness	
Inpatient facility–You pay	\$150 per day (maximum \$750 copay per admission)
Maximum per plan year	45 days
Inpatient physician charges–You pay	\$0 copay
Maximum per plan year	45 visits
Outpatient/Office visit–You pay	\$40 copay
Maximum per plan year	60 visits
Prescription Drugs	
Retail	
	Up to 30-day supply
Generic–You pay	\$15 copay
Preferred Brand–You pay	\$30 copay**
Non-preferred Brand–You pay	\$50 copay**
Self-injectable and high technology medications	20%
Mail Order	
	Up to 90-day supply
Generic–You pay	\$45 copay
Preferred Brand–You pay	\$90 copay**
Non-preferred Brand–You pay	\$150 copay**
Self-injectable and high technology medications	20%
Maximum Plan Year Prescription Benefit	\$10,000 per person

Online resources from FirstCare Health Plans

Link from the TRS-ActiveCare Web site for easy access to:

- View and update address
- Print temporary ID cards
- Check claims status
- View plan documents
- Request ID cards
- Change PCPs
- Check authorization status
- E-mail customer service

This is a general summary of your TRS-ActiveCare plan options. Please refer to your Evidence of Coverage for details specific to your plan. Please see the Limitations and Exclusions section at the back of your enrollment guide.



Service Area

18 Texas Counties
(West Texas)

To be eligible for coverage from this HMO, you must live, work or reside in one of the following counties:

- Coke
- Coleman
- Concho
- Crockett
- Edwards
- Iron
- Kimble
- Kinney
- Mason
- McCulloch
- Menard
- Reagan
- Runnels
- Schleicher
- Sterling
- Sutton
- Tom Green
- Val Verde

Legacy Health Solutions provides for the medical needs of its members through a seamless managed care system personalized with local doctors, nurses, medical personnel and facilities. West Texas Shannon Medical Center, serving West Texans for the past 75 years, anchors this system of care for our members. Legacy Health Solutions has expanded its HMO physician panel to offer members broader choice. A small copayment at time of service covers everything. Young families find the predictable cost of an HMO very attractive. Copay Covers It takes the guesswork out of medical expenses.

Legacy Health Solutions requires you to choose a primary care physician (PCP) who will provide and coordinate your medical care within the Legacy network. You can choose an internist, family practice physician or pediatrician as your PCP. You pay a \$20 copayment for a PCP office visit. Women can self refer anytime to an OB/GYN and receive OB/GYN services for a \$20 copayment. You may also receive care at one of our network urgent care clinics for a \$20 copayment.

If you need to see a specialist, you must obtain a referral from your PCP. The specialist copayment is \$35. There are a few exceptions to a PCP specialist-referral rule. Members may self refer to a network ophthalmologist/optometrist, to an orthopedic surgeon or dermatologist without first seeing their PCP. The specialist copayment of \$35 still applies.

Prescription coverage is provided through Scott and White Prescription Services (SWPS). The retail copayments for a 30-day supply are \$8 for a generic drug, \$20 for a brand-name drug and for non-formulary drugs, \$200 or 50%, whichever is less. You have the option to obtain a 90-day supply of identified maintenance medicine for two copayments through SWPS mail order program. The mail order form and formulary list is available online at www.trs.state.tx.us/trs-activecare. The Legacy Health Solutions prescription benefit has a plan year maximum of \$10,000 per person.

General Provisions	Primary care physician required to direct care and for benefits to be paid
Deductible (per plan year)	
Individual–You pay	None
Family–You pay	None
Out-of-pocket maximum (per plan year)	
Individual–You pay	\$2,000
Family–You pay	\$6,000
Doctor and Lab Services	
Doctor office visits–You pay	\$20 for primary care physician; \$35 for specialist
Allergy injections–You pay	\$20 for primary care physician; \$35 for specialist 50% copay for serum and administration
Office surgery–You pay	Included in office visit
Outpatient surgery–You pay	Included in outpatient hospital/facility service
Maternity care–You pay	\$20 copay for initial visit; \$150/day inpatient Admission (\$750 copay maximum)
Inpatient doctor visits–You pay	\$0 copay
Contraceptive devices–You pay	15%
Preventive Care	
Doctor office visits–You pay	\$20 for primary care physician; \$35 for specialist
Routine eye exam (annual)	No additional copay required when performed during an office visit (refractive exams not covered)
Hearing exams	No additional copay required when performed during an office visit
Lab and X-ray	\$0 copay
Immunizations	\$0 copay to age 6 \$20 copay for 6 and adult
Routine mammograms	\$0 copay, bundled with wellness exam

Copays are waived for the first five dependent pediatric visits.

Copay is waived for the first annual adult visit.



Customer Service

1-(877) 410-2432
7 a.m. to 7 p.m.
(Central Time)
Monday through Friday

What's new for 2007-2008?

- No plan changes
- Premium increase of approximately 11%

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.

General Provisions	Primary care physician required to direct care and for benefits to be paid
Hospital/Facility Service	
Inpatient hospital—You pay	\$150/day (\$750 copay maximum)
Other inpatient charges	Included in above copay
Outpatient hospital/facility service—You pay	\$150 copay
Emergency room care within 48 hours—You pay	\$100 copay waived if admitted, contact plan within 24 hours
Urgent care services/facility—You pay	\$20 copay
Extended Care Services	
Skilled nursing facility	\$150/day; limited to 90 days
Home health care	\$20
Hospice	\$0 copay
Other Medical Services	
Physical therapy	
Office visit	\$30 copay
All other services	prior authorization required/\$30 copay
Chiropractic care	
Office visit	\$25 copay; limited to \$1,000/year
All other services	Not covered
Home infusion therapy	20% plus office copay
Hearing aids	\$0 copay (covered up to \$500/year)
Durable medical equipment	20%; up to \$2,000 maximum
Prosthetics	\$250 per device (\$10,000 limit per occurrence)
Ambulance services (ground or air)	Ground - \$50 / Air - 20%
Behavioral Health (Mental Health and Chemical Dependency)	
Mental health	
Inpatient facility—You pay	\$150/day (\$750 copay maximum) 15 day max/yr
Inpatient physician charges—You pay	\$0 copay
Outpatient/office visit—You pay	\$35/visit (limited to 26 visits/year)
Chemical dependency	
Inpatient facility—You pay	\$150/day (\$750 copay maximum) 3 series of treatment per lifetime
Inpatient physician charges—You pay	\$0 copay
Outpatient—You pay	\$35/visit/limited to 3 series of treatment per lifetime
Office visit—You pay	\$35/visit/limited to 3 series of treatment per lifetime
Serious Mental Illness	
Inpatient facility—You pay	\$150/day (\$750 copay maximum) 45 day max/yr
Inpatient physician charges—You pay	\$0 copay
Outpatient/office visit—You pay	\$35/visit (limited to 60 visits/yr)
Prescription Drugs	
Retail	Up to 30-day supply
Generic—You pay	\$8 copay
Preferred Brand—You pay	\$20 copay
Non-preferred Brand—You pay	\$200 or 50% of charges, whichever is less
Mail Order	Up to 90-day supply
Generic—You pay	\$16 copay
Preferred Brand—You pay	\$40 copay
Non-preferred Brand—You pay	Not Available
Self-injectable and high technology medications	25% of charges
Maximum Plan Year Prescription Benefit	\$10,000 per person

This is a general summary of your TRS-ActiveCare plan options. Please refer to your Evidence of Coverage for details specific to your plan. Please see the Limitations and Exclusions section at the back of your enrollment guide.



Service Area

4 Texas Counties
(South Texas)

To be eligible for coverage from this HMO, you must live, work or reside in one of the following counties:

Duvall
Jim Hogg
Webb
Zapata

With Mercy Health Plans, you and each of your dependents select a primary care physician (PCP) from the plan’s provider directory. Females can choose an OB/GYN as their PCP to provide health care services within the scope of their practice. All visits to a specialist require a referral except for visits to OB/GYNs, dermatologists, orthopedic surgeons, optometrists and ophthalmologists (for annual eye exams).

There is a \$10 copayment for primary care office visits. Outpatient emergency room is covered at a \$50 copayment. If you are hospitalized, the copayment is waived. There are no copayments for diagnostic X-rays, mammography and lab tests. Inpatient covered services and supplies, semi-private (or private if medically necessary) room or ICU are covered at 100% after a \$500 deductible. There is no copayment for maternity hospital and physician services (including delivery by C-section) after a \$500 deductible.

Prescription coverage is provided through the AdvancePCS network. The retail copayments for up to a 30-day supply are \$5 for generic drugs, \$20 for brand-name drugs, and \$35 for non-preferred drugs. Mail order prescriptions for up to a 90-day supply of maintenance medications are also available through Walgreens. There is a \$10 copayment for generic drugs, \$40 for brand-name drugs, and \$70 for non-preferred drugs. The maximum plan year benefit for prescription drugs is \$2,000 per person.

General Provisions	Primary care physician required to direct care and for benefits to be paid
Deductible (per plan year)	
Individual–You pay	\$500 per plan year for all inpatient hospital admissions
Family–You pay	None
Out-of-pocket maximum (per plan year)	
Individual–You pay	\$1,000 (does not include pharmacy)
Family–You pay	\$2,000 (does not include pharmacy)
Maximum Lifetime Benefit	Unlimited
Doctor and Lab Services	
Doctor office visits–You pay	\$10 copay
Allergy injections–You pay	50% for serum; \$0 copay for administration
Office surgery–You pay	\$0 copay
Outpatient surgery–You pay	\$0 copay
Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges)–You pay	\$0 physician copay for pre- and post-natal care and delivery
Inpatient doctor visits–You pay	\$0 copay
Contraceptive devices–You pay	\$10 office visit
Preventive Care	
Doctor office visits–You pay	\$10 office visit copay (includes all preventive care services billed with an office visit by a network doctor)
	Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams and routine mammograms (\$0 copay), and eye exams. Other services include well-baby exams, immunizations (\$0 copay to age 6), hearing exams, and PSA, colorectal cancer, and \$0 copay for osteoporosis screenings

Mercy Health Plans

**Customer Service**

1-(956) 723-7667 or

1-(800) 617-3433

8 a.m. to 5 p.m.

(Central Time)

Monday through Friday

What's new for 2007-2008?

- No plan changes
- Premium increase of approximately 18%

General Provisions	Primary care physician required to direct care and for benefits to be paid
Hospital/Facility Service	
Inpatient hospital and other inpatient charges—You pay	\$0 copay, after deductible
Outpatient hospital/facilities—You pay	\$0 copay
Emergency room care—You pay	\$50 copay (waived if admitted for the same condition within 24 hours)
Urgent care services/facility—You pay	\$25 copay
Behavioral Health (Mental Health and Chemical Dependency)	
Mental health	
Inpatient facility—You pay	\$0 copay, after deductible
Maximum per plan year	30 days
Inpatient physician charges—You pay	\$0 copay
Maximum per plan year	30 visits
Outpatient/office visit—You pay	\$25 copay
Maximum per plan year	25 visits
Chemical dependency	Covered as any other illness
Inpatient facility—You pay	\$0 copay, after deductible
Inpatient physician charges—You pay	\$0 copay
Outpatient—You pay	\$25 copay
Office visit—You pay	\$25 copay
Serious Mental Illness	
Inpatient facility—You pay	\$0 copay, after deductible
Maximum per plan year	No day limitations
Inpatient physician charges—You pay	\$0 copay
Maximum per plan year	No visit limitations
Outpatient/office visit—You pay	\$25 copay
Maximum per plan year	No visit limitations
Prescription Drugs	
Retail	Up to 30-day supply
Generic—You pay	\$5 copay
Preferred Brand—You pay	\$20 copay
Non-preferred Brand—You pay	\$35 copay
Mail Order	Up to 90-day supply
Generic—You pay	\$10 copay
Preferred Brand—You pay	\$40 copay
Non-preferred Brand—You pay	\$70 copay
Maximum Plan Year Prescription Benefit	\$2,000 per person

This is a general summary of your TRS-ActiveCare plan options. Please refer to your Evidence of Coverage for details specific to your plan. Please see the Limitations and Exclusions section at the back of your enrollment guide.



Service Area

32 Texas Counties
(Central Texas)

To be eligible for coverage from this HMO, you must live, work or reside in one of the following counties:

- Austin*
- Bastrop
- Bell
- Blanco
- Bosque
- Brazos
- Burleson
- Burnet
- Caldwell
- Coryell
- Erath*
- Falls
- Grimes
- Hamilton
- Hays
- Hill
- Lampasas
- Lee
- Leon*
- Llano
- Madison
- McLennan
- Milam
- Mills
- Robertson
- San Saba
- Somervell
- Travis
- Walker
- Waller*
- Washington
- Williamson

* Partial counties covered as follows:

Austin – All of 77452, 77833, 78931 and 78944. Portions of ZIP Codes 77418, 78940 and 78950

Erath – All of 76457. Portions of 76401, 76433 and 76446

Leon – All of 77855 and 77871. Portions of 75833, 75850 and 77865

Waller – All of 77445. Portions of 77423 and 77484

Scott & White's interdisciplinary team approach to health care helps assure you of proper diagnoses, treatments, rehabilitative and support services throughout our health care system. Comprehensive coverage for medical, surgical, hospital and preventive services, such as routine check-ups, well baby care and immunizations are included.

When you enroll in Scott & White Health Plan, you will select a primary care physician (PCP). Each member of your family may select a different PCP. In addition to their PCP, females may select a participating OB/GYN physician and may receive OB/GYN services from that physician without a referral. There is a \$25 copayment for office visits with your primary care physician or a specialist.

The copayment for an emergency room visit is \$100 and an urgent care visit is \$40. If you are admitted to the hospital from the emergency room within 24 hours, your emergency room copayment is waived. The copayment for an inpatient stay is \$200 per day with a maximum copayment of \$1,000. This copayment includes all physician fees and services utilized during your stay.

Prescription coverage is included with the Scott & White Health Plan benefits. Through Scott & White Health Plan pharmacies or participating retail pharmacies, you may purchase a 34-day supply or 100 units, whichever is less, and will be charged \$5 for a generic drug, \$25 for a brand-name drug, or the lesser of \$50 or 50% for an alternate brand-name drug, and greater of \$50 or 50% for a non-formulary drug. To receive a 90-day supply, your prescription must be on the Scott & White Health Plan Pharmacy's maintenance drug list and must be purchased either through Scott & White Health Plan's mail order pharmacy or a Scott & White Health Plan-owned pharmacy located in Bryan/College Station, Georgetown, Killeen, Temple, Waco or Belton. A maintenance supply of a generic drug costs \$10, and a brand-name drug costs \$50. There is a maximum plan year benefit per person of \$2,000 for prescription drugs.

General Provisions	Primary care physician required to direct care and for benefits to be paid
Deductible (per plan year)	
Individual–You pay	None
Family–You pay	None
Out-of-pocket maximum (per plan year)	
Individual–You pay	\$3,000 per individual per plan year (does not include pharmacy)
Family–You pay	\$6,000 (does not include pharmacy)
Maximum Lifetime Benefit	Unlimited
Doctor and Lab Services	
Doctor office visits–You pay	\$25 copay
Allergy injections–You pay	\$25 per vial
Office surgery–You pay	\$25 copay
Outpatient surgery–You pay	\$100 copay
Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges)–You pay	\$25 per visit (maximum \$300); \$0 physician copay for delivery
Inpatient doctor visits–You pay	\$0 copay
Contraceptive devices–You pay	\$25 copay

Scott & White
Health Plan



Customer Service

1-(800) 321-7947 or
1-(254) 298-3000
8 a.m. to 5 p.m.
(Central Time)
Monday through Friday

What's new for 2007-2008?

- **Outpatient specialty drug copays**
 - Level 1 \$50
 - Level 2 (preferred) \$100
 - Level 3 (premium-preferred) \$250
 - Level 4 (non-preferred) 50% (does not count toward out-of-pocket maximum)
- **Prescription drug copays**
 - Preferred brand retail \$25
 - Preferred brand mail \$50
 - Non-formulary retail—greater of \$50 or 50%
- **Premium increase of approximately 3%**

* If a brand-name drug is dispensed when there is a generic available, the participant will pay 50% of charges.

General Provisions	Primary care physician required to direct care and for benefits to be paid
Preventive Care	
Doctor office visits—You pay	\$25 office visit copay (includes all preventive care services billed with an office visit by a network medical professional) Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams, routine mammograms (\$0 copay), and eye exams. Other services include well-baby exams, immunizations (\$0 copay to age 7), hearing exams, and PSA, colorectal cancer, osteoporosis screenings
Hospital/Facility Service	
Inpatient hospital and other inpatient charges—You pay	\$200 per day (maximum \$1,000 per admission)
Outpatient hospital/facilities—You pay	\$25 copay
Emergency room care—You pay	\$100 copay (waived if admitted for the same condition within 24 hours)
Urgent care services/facility—You pay	\$40 copay
Behavioral Health (Mental Health and Chemical Dependency)	
Mental health	
Inpatient facility—You pay	50% of charges
Maximum per plan year	20 days
Inpatient physician charges—You pay	\$0 copay
Maximum per plan year	20 visits
Outpatient/office visit—You pay	50% of charges
Maximum per plan year	20 visits
Chemical dependency	
Covered as any other illness	
Inpatient facility—You pay	\$200 per day (maximum \$1,000 per admission)
Inpatient physician charges—You pay	\$0 copay
Outpatient—You pay	\$25 copay
Office visit—You pay	\$25 copay
Serious Mental Illness	
Inpatient facility—You pay	\$200 per day (maximum \$1,000 copay per admission)
Maximum per plan year	45 days
Inpatient physician charges - You pay	\$0 copay
Maximum per plan year	45 visits
Outpatient/office visit—You pay	\$25 copay
Maximum per plan year	60 visits
Prescription Drugs	
Retail	
Generic—You pay	Up to 34-day supply \$5 copay
Preferred Brand—You pay	\$25 copay*
Non-preferred Brand—You pay	If on formulary, lesser of \$50 or 50% of charges; if not on formulary, greater of \$50 or 50% of charges
Mail Order	
Generic—You pay	Up to 90-day supply \$10 copay
Preferred Brand—You pay	\$50 copay*
Non-preferred Brand—You pay	If on formulary, lesser of \$100 or 50% of charges; not on formulary, not available
Outpatient Specialty Drugs	
Level 1	\$50 copay
Level 2 (preferred)	\$100 copay
Level 3 (premium preferred)	\$250 copay
Level 4 (non-preferred)	50% of charges; does not count toward out-of-pocket maximum
Maximum Plan Year Prescription Benefit	\$2,000 per person (does not apply to outpatient specialty drugs)

This is a general summary of your TRS-ActiveCare plan options. Please refer to your Evidence of Coverage for details specific to your plan. Please see the Limitations and Exclusions section at the back of your enrollment guide.



Service Area

4 Texas Counties (The Valley)

To be eligible for coverage from this HMO, you must live, work or reside in one of the following counties:

- Cameron
- Hidalgo
- Starr*
- Willacy

* Partial counties covered as follows:

Starr – All of 78536, 78547, 78548

Valley Baptist Health Plans personal care system incorporates private physicians and other health care providers who work together to coordinate your health care needs and provide you with quality health care at an affordable cost.

As a locally owned and operated health plan with more than 800 physicians and five hospitals across the Rio Grande Valley, Valley Baptist Health Plans offers an easy-to-use health plan with no deductibles or claim forms.

You have your choice of a participating primary care physician (PCP) for each member of your family. PCPs are chosen from family, general, pediatrics or internal medicine physicians. Females can select an OB/GYN physician and have direct access to a designated OB/GYN for gender-related services. Specialist physician services must be properly referred. Coverage is provided for preventive as well as routine medical care.

There is a \$25 copayment for primary care office visits; \$35 copayment for specialist office visits; \$25 copayment for gynecological services performed by the PCP; \$35 copayment for services performed by an OB/GYN (if OB/GYN is designated, a referral from your PCP is not required). Valley Baptist Health Plans provides comprehensive hospital and emergency coverage. Emergency services are covered anywhere you travel when medically necessary.

Prescription coverage is provided using a three-tier prescription copayment plan. For a 30-day supply, the retail copayments are \$15 for generic drugs, \$25 for brand-name drugs, \$45 for non-preferred drugs. For a 90-day mail-order supply the mail-order copayments are \$30 for generic drugs, \$50 for brand-name drugs, \$90 non-preferred drugs.

General Provisions	Primary care physician required to direct care and for benefits to be paid
Deductible (per plan year)	
Individual–You pay	None
Family–You pay	None
Out-of-pocket maximum (per plan year)	
Individual–You pay	\$3,000 copay maximum per plan year for hospital admissions
Family–You pay	\$6,000 copay maximum per plan year for hospital admissions
Maximum Lifetime Benefit	Unlimited
Doctor and Lab Services	
Doctor office visits–You pay	\$25 copay for primary care physician \$35 for specialist
Allergy injections–You pay	\$25 for primary care physician; \$35 for specialist; No office visit copay when injection only; 50% copay for serum
Office surgery–You pay	Included in office visit copay
Outpatient surgery–You pay	Included in outpatient hospital/facility copay
Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges)–You pay	\$25 for primary care physician; \$35 for specialist for initial visit No copay after initial visit
Inpatient doctor visits–You pay	\$0 copay
Contraceptive devices–You pay	\$25 for primary care physician; \$35 for specialist

Valley Baptist Health Plans



Customer Service

1-(800) 829-6440

8 a.m. to 6 p.m.

(Central Time)

Monday through Friday

What's new for 2007-2008?

- No plan changes
- Premium decrease of approximately 3%

* 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.

General Provisions

Primary care physician required to direct care and for benefits to be paid

Preventive Care

Doctor office visits—You pay

\$25 for primary care physician office visit copay; \$35 for specialist office visit copay (includes all preventive care services billed with an office visit by a network doctor)

Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams, routine mammograms (\$0 copay), and eye exams. Other services include well-baby exams, immunizations (\$0 copay), hearing exams, and PSA, colorectal cancer, osteoporosis screenings

Hospital/Facility Service

Inpatient hospital and other inpatient charges—You pay

\$300 per day (maximum \$1,500 per admission)

Outpatient hospital/facility—You pay

\$250 copay

Emergency room care—You pay

\$150 copay (waived if admitted)

Urgent care services/facility—You pay

\$25 copay

Behavioral Health (Mental Health and Chemical Dependency)

Mental health

Inpatient facility—You pay

\$300 per day (maximum \$1,500 per admission)

Maximum per plan year

15 days

Inpatient physician charges—You pay

\$0 copay

Maximum per plan year

15 visits

Outpatient/office visit—You pay

\$25 copay

Maximum per plan year

20 visits

Chemical dependency

Maximum of three series per lifetime

Inpatient facility—You pay

\$300 per day (maximum \$1,500 per admission)

Inpatient physician charges—You pay

\$0 copay

Outpatient—You pay

\$25 copay

Office visit—You pay

\$25 copay

Serious Mental Illness

Inpatient facility—You pay

\$300 per day (maximum \$1,500 per admission)

Maximum per plan year

45 days

Inpatient physician charges—You pay

\$0 copay

Maximum per plan year

45 visits

Outpatient/office visit—You pay

\$25 copay

Maximum per plan year

60 visits

Prescription Drugs

Retail

Up to 30-day supply

Generic—You pay

\$15 copay

Preferred Brand—You pay

\$25 copay*

Non-preferred Brand—You pay

\$45 copay*

Mail Order

Up to 90-day supply

Generic—You pay

\$30 copay

Preferred Brand—You pay

\$50 copay*

Non-preferred Brand—You pay

\$90 copay*

Maximum Plan Year Prescription Benefit

Unlimited

This is a general summary of your TRS-ActiveCare plan options. Please refer to your Evidence of Coverage for details specific to your plan. Please see the Limitations and Exclusions section at the back of your enrollment guide.

Example 1 It's the Flu.

Steve visited his primary doctor complaining of aching joints, chills, fever and a queasy stomach. The physician charge was \$85. Here's what Steve would pay under each medical option.

	ActiveCare 1	ActiveCare 2	ActiveCare 3	FirstCare Health Plans	Legacy Health Solutions	Mercy Health Plans	Scott & White Health Plan	Valley Baptist Health Plans
	Network	Network	Network	When services are provided by a primary care physician				
Steve Pays	\$85	\$25	\$20	\$20	\$20	\$10	\$25	\$25

ActiveCare 1: This assumes Steve has not met his plan year deductible, so he must pay the full charge.

ActiveCare 2 and 3: Steve would pay the office visit copay to his physician (no deductible applies when receiving services from a network provider).

FirstCare Health Plans: Steve pays the office visit copay to his primary care physician.

Legacy Health Solutions: Steve pays the office visit copay to his primary care physician.

Mercy Health Plans: Steve pays the office visit copay to his primary care physician.

Scott & White Health Plan: Steve pays the office visit copay to his primary care physician.

Valley Baptist Health Plans: Steve pays the office visit copay to his primary care physician.

Example 2 Coronary Bypass.

Keith needed a coronary bypass.

The charges were:	
Surgeon	\$ 8,000
Anesthesiologist	3,600
All hospital charges (five days)	19,300
	\$30,900

	ActiveCare 1	ActiveCare 2	ActiveCare 3	FirstCare Health Plans	Legacy Health Solutions	Mercy Health Plans	Scott & White Health Plan	Valley Baptist Health Plans
	Network	Network	Network	When services are provided by a primary care physician				
Keith Pays	\$3,100	\$2,500	\$1,500	\$750	\$750	\$500	\$1,000	\$1,500

ActiveCare 1: This assumes Keith meets his deductible as services are performed and that the billed charges and allowable amounts are equal. If Keith uses network providers, his expenses are determined by subtracting his deductible from the total charge and multiplying the coinsurance percentage ($\$30,900 - \$1,100 = \$29,800 \times .20 = \$5,960$). Because of the \$2,000 out-of-pocket maximum, Keith's expenses are \$3,100, including his deductible ($\$2,000 + \$1,100$).

ActiveCare 2: This assumes Keith meets his deductible as services are performed and that the billed charges and allowable amounts are equal. If Keith uses network providers, his expenses are determined by subtracting his deductible and hospitalization copay (\$100 per day) from the total charge and multiplying the coinsurance percentage ($\$30,900 - \$500 \text{ deductible} - \$500 \text{ copay} = \$29,900 \times .20 = \$5,980$). Because of the \$2,000 out-of-pocket maximum, Keith's expenses are \$3,000, including his \$500 deductible and \$500 copay for hospitalization.

ActiveCare 3: If Keith uses network providers, there is no plan deductible, but he must pay \$100 per day for hospitalization up to 5 days or \$500. Keith's expenses are determined by multiplying the

remaining charge by the coinsurance percentage ($\$30,400 \times .20 = \$6,080$). Keith is responsible for paying \$1,500 (\$1,000 out-of-pocket maximum plus \$500 hospital copay).

FirstCare Health Plans: When using an HMO network provider to coordinate care, Keith will be responsible for paying \$150 per day for hospitalization up to 5 days or \$750.

Legacy Health Solutions: When using an HMO network provider to coordinate care, Keith will be responsible for paying \$150 per day for hospitalization up to 5 days or \$750.

Mercy Health Plans: When using an HMO network provider to coordinate care, Keith will be responsible for paying a \$500 deductible.

Scott & White Health Plan: When using an HMO network provider to coordinate care, Keith will be responsible for paying \$200 per day for hospitalization up to 5 days or \$1,000.

Valley Baptist Health Plans: When using an HMO network provider to coordinate care, Keith will be responsible for paying \$300 per day for hospitalization up to 5 days or \$1,500.

Example 3 It's a Boy!

Linda delivered a healthy baby boy after an uncomplicated pregnancy. (Example does not include charges for the baby)

The charges were:

Nine primary care office visits (\$80 each) and delivery	\$3,000
All hospital charges (two days)	5,000
	\$8,000

	ActiveCare 1	ActiveCare 2	ActiveCare 3	FirstCare Health Plans	Legacy Health Solutions	Mercy Health Plans	Scott & White Health Plan	Valley Baptist Health Plans
	Network	Network	Network	When services are provided by a network provider				
Linda Pays	\$2,480	\$2,180	\$1,220	\$300	\$320	\$500	\$625	\$635

ActiveCare 1: This assumes Linda meets her deductible as services are performed and that the billed charges and allowable amounts are equal. If Linda uses network providers, her expenses are determined by subtracting her deductible from the total charge and multiplying the coinsurance percentage ($\$8,000 - \$1,100 = \$6,900 \times .20 = \$1,380$), then adding the deductible to the coinsurance amount ($\$1,100 + \$1,380 = \$2,480$).

ActiveCare 2: This assumes Linda meets her deductible as services are performed and that the billed charges and allowable amounts are equal. If Linda uses network providers, her expenses are determined by subtracting her office visit copay, hospitalization copay and deductible from the total charge and multiplying the coinsurance percentage ($\$8,000 - \$25 - \$200 - \$500 = \$7,275 \times .20 = \$1,455$). Linda is responsible for paying \$2,180 ($\$25 + \$200 + \$500 + \$1,455$).

ActiveCare 3: If Linda uses network providers, her expenses are determined by subtracting her office visit and hospitalization copays from the total charge and multiplying the coinsurance percentage ($\$8,000 - \$20 - \$200 = \$7,780 \times .20 = \$1,556$). Linda is responsible for paying \$1,220 ($\$1,000$ out-of-pocket maximum, plus \$200 hospitalization copay and \$20 office visit copay).

FirstCare Health Plans: When using an HMO network provider to coordinate care, there is no office visit copay for maternity care, but Linda must pay \$150 per day (2 days = \$300) for the inpatient hospital admission.

Legacy Health Solutions: When using an HMO network provider to coordinate care, Linda would pay \$320 (\$20 copay for the initial visit to the OB/GYN and \$300 — 2 x \$150 per day — for the hospital stay).

Mercy Health Plans: When using an HMO network provider to coordinate care, there are no office visit copays, but there is a \$500 deductible for hospital charges for maternity care.

Scott & White Health Plan: When using an HMO network provider to coordinate care, Linda pays \$625 ($\$25 \times 9 = \225 for the office visits and $\$400 — 2 \times \200 per day — for the hospital stay).

Valley Baptist Health Plans: When using an HMO network provider to coordinate care, Linda would pay \$635 ($\35 initial office visit copay with OB/GYN and $\$600 — 2 \times \300 per day — for the hospital stay).

What You Can Do to Help Keep Your Costs Down

- Use network providers
- Work with your doctor to understand treatment options and costs to make sure you are getting the most for your health care dollars
- Visit your doctor instead of the emergency room for non-emergency care
- Talk with your doctor about choosing generic drugs when possible, which can help reduce prescription costs
- Work with your doctor to learn ways to stay healthy through exercising, eating a balanced diet, modifying your lifestyle and other preventive measures

Your cost for TRS-ActiveCare coverage is determined by the funding available from the state and district as well as your choice of health plan, including deductibles, copayments, coinsurance, and your monthly contributions

Chapter 1581, Texas Insurance Code, authorizes funding to help active employees who are TRS members—those making retirement contributions to the Teacher Retirement System of Texas—pay for TRS-ActiveCare coverage. Currently, each district/entity is required to contribute at least \$150 per month per active TRS member for coverage. (Your participating district/entity may contribute more.) The state currently contributes \$75 per month per active TRS member. That's a minimum of \$225 per month to help you pay for health coverage. Your Benefits Administrator will provide you with information on any additional funding that may be available.

Pooling Funds/Split Premium

Married employees who are both active contributing TRS members may “pool” their local district and state funding to use toward the cost of TRS-ActiveCare coverage. If a husband and wife both work for a participating entity, funds may be pooled when:

- One selects employee and spouse coverage, and the spouse declines coverage; or
- One selects employee and family coverage, and the spouse declines coverage.

If a husband and wife work for different participating entities and wish to pool funds, each employee and their Benefits Administrators must complete an *Application to Split Premium* (available on the TRS-ActiveCare Web site). This form should be submitted to Blue Cross and Blue Shield of Texas with the *Enrollment Application and Change Form*. For the husband and wife who choose this option, the cost of coverage will be split between and billed to the two employers. (A split premium form is not necessary if both employees work for the same participating district/entity.)

Note: Both participating districts/entities need to have the same effective date of coverage for married employees to split premium **except** for the following: If an employee already has employee and family coverage and the spouse is hired by another participating entity, the spouse can decline coverage and complete an *Application to Split Premium* to be effective on the first of the month following the spouse's actively-at-work date. Requests for split premium must be signed and submitted to the Benefits Administrator within the plan enrollment period.





2007-2008 Plan Year
Effective September 1, 2007 Through August 31, 2008

	ActiveCare 1	ActiveCare 2	ActiveCare 3
Coverage Category	Total Cost*	Total Cost*	Total Cost*
Employee Only	\$266.00	\$354.00	\$ 477.00
Employee and Spouse	\$606.00	\$806.00	\$1,085.00
Employee and Child(ren)	\$424.00	\$564.00	\$ 760.00
Employee and Family	\$667.00	\$886.00	\$1,193.00

	FirstCare Health Plans	Legacy Health Solutions	Mercy Health Plans
Coverage Category	Total Cost*	Total Cost*	Total Cost*
Employee Only	\$359.00	\$370.07	\$553.30
Employee and Spouse	\$890.00	\$834.80	\$1,101.58
Employee and Child(ren)	\$571.00	\$585.46	\$1,041.29
Employee and Family	\$893.00	\$918.40	\$1,792.45

	Scott & White Health Plan	Valley Baptist Health Plans
Coverage Category	Total Cost*	Total Cost*
Employee Only	\$351.48	\$357.30
Employee and Spouse	\$827.76	\$800.30
Employee and Child(ren)	\$555.28	\$563.02
Employee and Family	\$862.10	\$879.02

*District and state funds are provided each month to active contributing TRS members to use toward the cost of TRS-ActiveCare coverage. State funding is subject to appropriation by the Texas Legislature. Please contact your Benefits Administrator to determine your cost of coverage.



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

Allowable Amount: The maximum amount that will be allowed for a medical service or supply under ActiveCare 1, 2 and 3 plans (not applicable to HMO plans). The allowable amount is determined by Blue Cross and Blue Shield of Texas based on either charges made for the same service by providers in the same geographic area with similar training, experience, and facilities, or negotiated rates with providers who have contracted with Blue Cross and Blue Shield of Texas. Non-network and non-ParPlan providers may bill you for amounts exceeding the allowable amount.

Benefits Administrator: The person employed by your district/entity that is designated to help employees enroll in various benefits plans and make changes to their coverage.

Behavioral Health Care: Any treatment or advice supplied to an individual relating to any mental health or substance abuse problem to which that individual may be subject.

Chapter 1579, Texas Insurance Code: This chapter sets out the laws that govern the TRS-ActiveCare Program. The program was established in 2001 and was designed to address the health care needs of Texas public education employees by creating a statewide health care program administered by TRS.

Chapter 1581, Texas Insurance Code: This chapter addresses funding issues for health care for active contributing TRS members.

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 for the ActiveCare 1, 2 and 3 plans. Copays do apply to the out-of-pocket maximums for the HMO plans, with the exception of pharmacy copays.

Coinsurance: The percentage of medical expenses that you and the plan share. For example, if the network coinsurance amount is "80/20" that means that the plan pays 80% and you pay 20% of the allowable amount for the eligible charges. Coinsurance applies to ActiveCare 1, 2 and 3 plans and, in most cases, does not apply to the HMO plans.

Deductible: The amount of out-of-pocket expense that must be paid for health care services by the covered person before becoming payable by the health care plan. ActiveCare 1, 2 and 3 plans include deductibles, but the HMO plans do not.

District Contribution: A defined dollar amount determined and paid by your district on a monthly basis to offset the covered person's plan costs.

Employee Contribution: The dollar amount the covered employee pays for coverage through the TRS-ActiveCare program after any applicable state and district contributions have been subtracted. This amount is based upon the selected plan and the coverage level (employee only, employee and spouse, employee and child(ren), and employee and family).

Generic Drug: Drug products manufactured and distributed after the patent of the innovator brand-name drug has expired. The generic drug must have the same active ingredient, strength and dosage form as its brand-name counterpart. Generic drugs may have a lower copayment than brand-name drugs.

Lifetime Maximum: This maximum indicates the most an individual can receive in benefits while covered by TRS-ActiveCare. This applies only to non-network benefits under ActiveCare 3.

Network Pharmacy: A pharmacy that has entered into an agreement with the health plan to provide prescription drug benefits to TRS-ActiveCare participants.

Network Provider: Doctors, hospitals and other providers who have contracted with the network.

Non-Preferred Brand-Name Drug: A higher-cost drug that the plan would prefer that the patient switch from in favor of a lower-cost, therapeutically equal, substitute.

Non-Network Pharmacy: A pharmacy that has not entered into an agreement with the health plan to provide prescription drug benefits to TRS-ActiveCare participants.

Non-Network Provider: Doctors, hospitals and other providers who have not contracted with the network.

Out-of-Pocket Maximum: If you reach your plan's out-of-pocket maximum, the plan then pays 100% of any eligible expenses for the remainder of the plan year. Office visit copays continue after the out-of-pocket maximum is reached. Copays do not apply to the out-of-pocket maximums for the ActiveCare 1, 2 and 3 plans. Copays do apply to the out-of-pocket maximums for the HMO plans, with the exception of pharmacy copays.



ParPlan Physicians and Contracting Facilities: Participating (ParPlan) physicians and contracting facilities offer services plus cost advantages when you go out-of-network by agreeing to accept an allowable amount for covered services. They may also file your claims. When going to a ParPlan physician, you will receive the non-network level of benefits. ParPlan applies to the ActiveCare 1, 2 and 3 PPO plans and not to the HMO plans.

Preauthorization: Advance approval that is required from Blue Cross and Blue Shield of Texas or INROADS Behavioral Health Services for certain treatment or services, such as a hospital admission, covered by the ActiveCare 1, 2 and 3 plans, but not by the HMO plans.

Preexisting Condition: Any physical or mental condition for which an individual sought or received care, medical advice, treatment or diagnosis during the six months prior to individual's enrollment date. Pregnancy is not a preexisting condition.

Preferred Brand-Name Drug: A therapeutic alternative that is the preferred drug for your plan. These medications are recommended by the Pharmacy and Therapeutics Committee as acceptable based on three criteria: efficacy, safety and cost.

Prescription Drug Formulary: A list of drugs that your plan prefers physicians to prescribe based on cost-effective and quality standards. This list is distributed to prescribers, pharmacies and/or subscribers and offers guidelines for cost-effective prescribing.

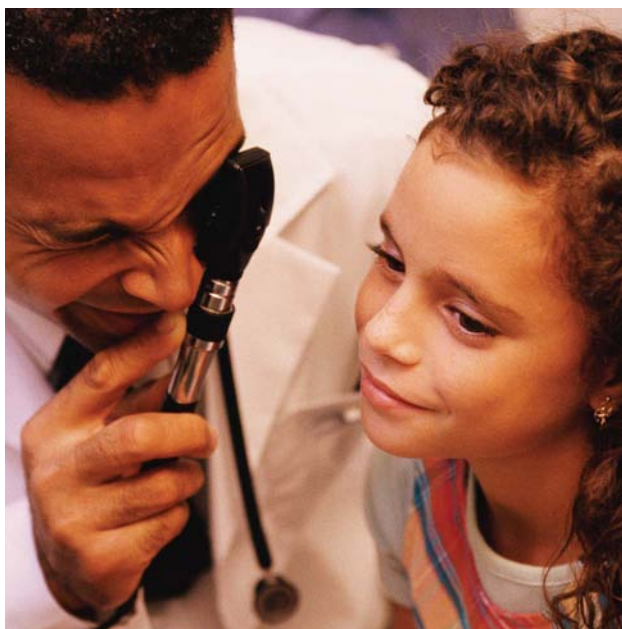
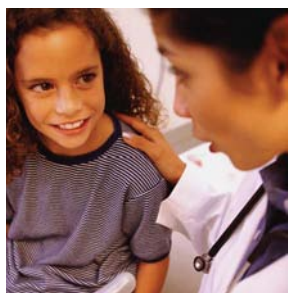
Primary Care Physician (PCP): A general practitioner, family practitioner, internist or pediatrician who is responsible for providing or coordinating all the care you receive through an HMO network.

Referral: When a provider determines that a patient has a condition that requires the attention of a specialist, the physician makes a referral or a medical recommendation for that patient to see a specialist. A referral is not required for those enrolled in ActiveCare 1, 2 or 3 plans. However, under the TRS-ActiveCare HMO plans, a referral by your provider is usually required before seeing another provider or specialist. Refer to your HMO's Evidence of Coverage for more information.

Service Area: The geographical area that the health plan is authorized by law to serve.

Special Enrollment Event: An event as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that may provide a 31-day special enrollment period for individuals and dependents when there is an involuntary loss of other coverage or a gain of additional dependents. *See the online Benefits Booklet or the HMO's Evidence of Coverage for details regarding your rights in the event you experience a special enrollment event.*

State Contribution: A defined dollar amount determined and paid by the state of Texas to eligible employees on a monthly basis to offset the covered person's TRS-ActiveCare plan costs.



Enrollment

Q. When does coverage begin and end?

A. The plan options and dependent coverage levels you select during the spring and summer enrollment periods will remain in effect from September 1, 2007 through August 31, 2008. However, for employees of districts/entities who elect to come into TRS-ActiveCare after September 1, 2007, the selected coverage will not go into effect until the district/entity enters TRS-ActiveCare. For example, if your district/entity decides to keep its present health benefit plan coverage until December 31, 2007, your plan options under TRS-ActiveCare will not go into effect until January 1, 2008 and will remain in effect until August 31, 2008.

New Hires: New hires have 31 days after the first day of employment to select health coverage through TRS-ActiveCare. New hires may choose their actively-at-work date (the date they start to work), or the first of the month following their actively-at-work date as their effective date of coverage.

Q. How will TRS-ActiveCare enrollment be handled?

A. Each participating district/entity will be responsible for enrolling its employees. Your Benefits Administrator can provide you with information on the location and dates of enrollment meetings.

Q. Can I enroll my spouse in one plan and myself in another?

A. No. All covered dependents must be on the same plan option as the employee.

Q. Can an employee of a participating district decline coverage during an enrollment period and then enroll later?

A. An employee may choose coverage during the initial enrollment period or may decline coverage. An employee must complete sections 1, 2 and 9 of an Enrollment Application and Change Form if choosing to decline coverage. It is anticipated, but not guaranteed, that there will be periodic enrollment opportunities and an individual may be able to enroll due to a special enrollment event. Individuals that previously declined coverage may be subject to preexisting condition exclusions. (Preexisting condition exclusions do not apply to HMO coverage.)

Q. Can coverage be dropped throughout the plan year?

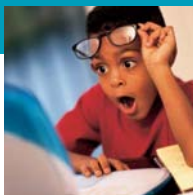
A. Unless restricted due to participation in an Internal Revenue Code Section 125 cafeteria plan, an employee can drop all coverage or drop dependent coverage. If coverage is dropped during the plan year, the individual will not be eligible to re-enroll in TRS-ActiveCare until the next plan enrollment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

Medical

Q. If my district/entity is new to TRS-ActiveCare and if I have already satisfied my deductible this year with my present health coverage carrier, will I have to satisfy another deductible under my TRS-ActiveCare health plan option?

A. Deductible and out-of-pocket expense accumulations from your prior health plan will not carry over to your TRS-ActiveCare plan option. This also applies to any expenses accumulated toward lifetime maximum.





Q. Are there any preexisting condition exclusions?

A. It depends. If you enroll in TRS-ActiveCare when you are first eligible for coverage, you may choose any option for the 2007-2008 plan year without preexisting condition exclusions. If you do not enroll during your initial period of eligibility, or if you are transferring employment and TRS-ActiveCare coverage from one participating district/entity to another, preexisting condition exclusions may apply. If you previously declined coverage, a 12-month preexisting condition waiting period will apply to ActiveCare 1, 2, and 3, but not for HMO coverage. There are never preexisting condition exclusions for HMO coverage. Prior creditable coverage may be used to offset a preexisting condition waiting period as provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Q. What if I'm already in treatment when I enroll and my provider isn't in the network?

A. If your district/entity is participating in TRS-ActiveCare for the first time in the 2007-2008 plan year, transitional care benefits may be available when you enroll in a health plan option. If you are pregnant or receiving treatment for a serious illness, you may still be able to see your non-network provider for a period of time and receive network benefits for covered services. Log onto the TRS-ActiveCare Web site for information on transitional care for your specific health plan.

Q. What if I do not choose a primary care physician (PCP) when I enroll for HMO coverage?

A. A PCP will be assigned for you. You will be required to use this PCP until the health plan receives a PCP change request from you.

Q. How will my child be covered if he or she is going to college in another city?

A. The answer depends on whether you and your child are enrolled in a PPO or HMO plan. PPO: If enrolled in ActiveCare 1, 2 or 3, your child will be covered for both emergency and non-emergency care no matter where he or she lives. Your child will receive the highest level of benefits when using network providers. If your child uses non-network providers for care, he or she will receive a lower level of benefits for covered charges. HMO: Your child will be covered worldwide for emergency care. For routine care, if your child is going to a college that is located within an HMO network service area, your child can choose a PCP in the community in which he or she is located. If your child resides outside of the HMO network service area, he or she can choose a PCP in the parent's service area to coordinate the child's health care needs within the network.

Q. Do I have health coverage when traveling out of state?

A. The answer depends on whether you are enrolled in a PPO or HMO plan. PPO: If enrolled in ActiveCare 1, 2 or 3, you will receive network

benefits when you use Blue Cross and Blue Shield (BCBS) PPO network providers. Although you may choose to use any provider, you will receive benefits at the non-network level if you use a non-network provider. To locate network providers outside of Texas, contact Customer Service. HMO: You have worldwide coverage for emergency care. All non-emergency care must be provided by or referred by your primary care physician.

Pharmacy

Q. Do I need a new prescription from my doctor when using the mail order pharmacy service offered by my health plan or will my existing refills be honored?

A. You will be required to get a new prescription from your doctor before filling or refilling your prescription through the mail order service. Additional information on using your mail order (and retail) pharmacy benefits will be provided to you by your health plan prior to your effective date of coverage.

Q. How do I find out if my medication is on the preferred drug list?

A. You can locate the preferred drug list for the health plan you select on the Web site or by calling Customer Service.

Q. Can I have the brand-name medication my doctor prescribed even if a generic is available?

A. Yes, you can get the brand-name medication if your doctor specifies "brand only" or "dispense as written" on the prescription. However, you may pay the generic copayment plus, depending on the plan option you select, a portion of (or all of) the cost difference between the generic and the brand-name drug. See the Benefits Summaries and Plan Comparisons on pages 14 to 29 of this guide for more information.

Q. How do I know if the medication I am taking is a maintenance medication?

A. PPO plan participants can call Customer Service to determine whether their medication is a maintenance medication. Additional drug coverage and pricing information can be obtained through the Web site, www.trs.state.tx.us/trs-activecare, or by registering online at www.medco.com once enrolled in TRS-ActiveCare. HMO plan participants should call their plan's Customer Service number.

Q. Will I be charged a lower copay for mail service if my prescription order is for less than a 90-day supply?

A. No, the same copay applies at mail service regardless of day supply. For example, a person who sends in a prescription for a 60-day supply will pay the same copayment as a person who sends in a prescription for a 90-day supply, provided that the cost of the medication is not less than the copay.

Important: This list does not contain all of the limitations and exclusions. The TRS-ActiveCare Benefits Booklet will be available online by September 1, 2007. If you choose an HMO, their Evidence of Coverage will have a complete list and description of plan coverage, limitations and exclusions. For additional information, call your plan's Customer Service number.

ActiveCare 1, 2 and 3

- As determined by Blue Cross and Blue Shield of Texas, services or supplies that are not medically necessary or any experimental/investigational 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 insurance 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, photorefractive keratotomy, and LASIK.
- Cosmetic (including reduction mammoplasty), reconstructive, or plastic surgery except as listed in the Benefits Booklet.
- General dental services, including dental appliances (except for appliances as allowed for accidental injury under covered oral surgery).
- Any items of medical/surgical expense incurred for dental surgery except as described in the Benefits Booklet.
- Services or supplies for routine foot care, including shoe orthotics, insoles, or shoe inserts of any type (except when prescribed for a diagnosis of, or related to, diabetes).
- 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 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.
- Dietary and nutritional services or 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, or medically necessary dietary supplements required for the treatment of Phenylketonuria (PKU).
- 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 insurance 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, or there is a diagnosed fetal anomaly, or unless 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. The following are examples of, but is not a complete listing of, categories that are excluded: non-federal legend drugs; ostomy supplies; allergy serums; blood or blood plasma products; implantable contraceptives; experimental drugs; drugs whose sole purpose are 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.
- Acupuncture, intersegmental traction, surface EMGs, manipulation under anesthesia, and muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph, and Dynatron.
- Any occupational therapy services that 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.
- 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.
- Telemedicine services provided by telephone or fax machine.
- Services or supplies provided by an immediate family member (spouse, child or self).

Important: This list does not contain all of the limitations and exclusions. The TRS-ActiveCare Benefits Booklet will be available online by September 1, 2007. If you choose an HMO, their Evidence of Coverage will have a complete list and description of plan coverage, limitations and exclusions. For additional information, call your plan's Customer Service number.

FirstCare Health Plans

- Cosmetic or other reconstructive procedures.
- All dental care.
- Inpatient or outpatient custodial care.
- Mental health services for the specific conditions. Marriage counseling is not a covered health service. Court-ordered evaluation, diagnosis and treatment for mental conditions are excluded unless the Evidence of Coverage would otherwise cover such services.
- Reversal of voluntary sterilization and infertility treatment unless specified in the Evidence of Coverage.
- Any and all transplants of organs, cells, and other tissues, except for those listed in the Evidence of Coverage.
- Experimental or investigational drugs, devices, treatments or procedures.
- Health care services for any work-related injury or illness, if any other source of coverage or reimbursement is (or was) available.
- Take-home and over-the-counter drugs, except as used in the treatment of diabetes.
- Disposable or consumable outpatient supplies (except supplies used in the treatment of diabetes and allergy syringes).
- Elective, non-therapeutic termination of pregnancy (abortions) including any abortion-inducing medications.
- All surgical procedures for snoring and sleep apnea.
- Charges for the normal delivery of a baby outside our plan's service area if the delivery is within 30 days of the due date.
- Educational testing and therapy, including the treatment of learning disabilities, motor or language skills, behavioral disorders or services that are educational in nature or are for vocational testing or training.
- Treatments and evaluations required by a third party.
- Eyeglasses, (including eyeglasses and contact lenses prescribed following vision surgery) contact lenses, except for treatment of keratoconus, and any other items or services for the correction of your eyesight unless specifically provided in the Evidence of Coverage.
- Services intended primarily to treat obesity.
- Sex-change surgery and related treatment, including hormone therapy and medical or psychological counseling.
- Acupuncture, naturopathy, hypnotherapy and Christian Science Practitioner services.
- Comfort or convenience items in a hospital or other inpatient facility.
- Transportation, except for ambulance or air ambulance used for transport in a medical emergency or pre-approved services for medical transport purposes only.
- If a service is not covered under the plan, we will not cover any services that are related to it.
- Nutritional counseling and diet planning, unless pre-approved.
- Growth hormone drugs for persons 18 years of age or older. However, growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred, is covered when services are pre-authorized.
- Genetic counseling and testing, except medically necessary peri-natal genetic counseling and testing.
- Biofeedback services, except for the treatment of acute brain injury and for rehabilitation of acute brain injury.
- Implanted neurological stimulators.
- Mastectomy for relief of pain, to prevent breast cancer (except when you have been previously diagnosed with breast cancer), or due to any disease or illness other than for the treatment of breast cancer.
- Massage therapy, unless associated with a physical therapy modality provided by a licensed physical therapist.
- Sports cords and TENS units.
- Cochlear implants, and repair or replacement of hearing aids due to normal wear, loss, or damage, hearing aid batteries.
- Orthotic devices, except for the treatment of diabetes and those described in Evidence of Coverage.
- Equine or Hippo therapy.
- Reduction mammoplasty.
- Electron Beam Tomography (EBT).
- Medications prescribed for non-FDA approved indications, referred to as off-label drug use.
- Certain medications are subject to dispensing limitations.
- Certain medications are subject to prior authorization.
- Brand-name prescription drugs will not be covered as preferred drugs when a generic equivalent prescription drug is available.
- Prescriptions written in connection with any treatment or service that is not a covered benefit are excluded.
- Appetite suppressants, anti-smoking aids, medications used for cosmetic improvement, uncomplicated nail fungus and hair loss are excluded.
- Any prescription drug for which the actual cost is less than the required copayment is not covered.
- Experimental drugs are excluded.
- Prescriptions or refills that replace lost, stolen, spoiled, expired, spilled or are otherwise misplaced or mishandled are excluded.
- Prescriptions written for the treatment of infertility are excluded.

Important: This list does not contain all of the limitations and exclusions. The TRS-ActiveCare Benefits Booklet will be available online by September 1, 2007. If you choose an HMO, their Evidence of Coverage will have a complete list and description of plan coverage, limitations and exclusions. For additional information, call your plan's Customer Service number.

Legacy Health Solutions

- Major disaster or epidemic.
- Circumstances beyond the control of Legacy Health Solutions or participating providers.
- Continuity of treatment in the event of the termination of a primary care physician.
- Non-participating provider and out-of-area services and benefits.
- Services and supplies furnished in connection with correction, by manual or mechanical means, of subluxation of the spine.
- Artificial internal organs and animal organs.
- Acupuncture.
- Transport services for non-emergency conditions unless pre-authorized.
- Biofeedback therapy, excluded for the treatment of ordinary tension and muscle contraction headaches or psychosomatic conditions.
- Blood and blood derivatives, including administration, when prescribed by a participating provider and determined to be medically necessary by Legacy Health Solutions.
- Charges for broken appointments.
- Charges for completion of any forms.
- Services or supplies furnished by the employer or you, your spouse, or a child, brother, sister, or parent of you or your spouse.
- Chelation therapy, excluded except when used in the treatment of heavy metal poisoning.
- Services including, but not limited to, AA/NA, support or education groups, and/or other services that primarily focus on relapse prevention to the member who completed treatment and/or their family members.
- Clothing, shoes and diapers, unless specifically covered by the Legacy Health Solutions Certificate of Coverage.
- Corrective appliances and artificial aids, including, but not limited to, communication devices, wigs, and eyeglasses or contact lenses of any type.
- Cosmetic surgery or other reconstructive services.
- Services or supplies furnished in connection with custodial care.
- Diagnostic tests to establish paternity of a child and tests to determine sex of an unborn child.
- Dental care, oral surgery or treatment of teeth or periodontium.
- Services and supplies, other than those covered under "covered services", that are determined by Legacy Health Solutions to be educational.
- Consultations of an environmental engineer, air conditioners, humidifiers, dehumidifiers, purifiers, elevators and chair lifts.
- Experimental or investigational drugs, devices, treatments or procedures.
- Services and supplies for or furnished in connection with eye surgery such as radial keratotomy and lasik, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- Flu vaccine. Includes intranasal flu vaccine.
- Routine foot care, treatment of flat feet and treatment of subluxations of the feet are excluded. Orthopedic shoes are not covered, except as part of an integral part of a leg brace. Diabetic equipment copayments count toward your out-of-pocket maximum.
- Genetic counseling and testing, except when prescribed by a participating provider and authorized by Legacy Health Solutions.
- Home and automobile modifications or improvements. Excluded even when necessary to accommodate installation of covered services or to facilitate entrance or exit.
- Hospital private room, unless determined to be medically necessary by Legacy Health Solutions.
- Immunizations provided solely for the purpose of travel, employment or school.
- Drug therapy for infertility.
- Services or supplies furnished in connection with any procedures which involve harvesting, storage and/or manipulation of eggs and sperm for in-vitro fertilization.
- Charges associated with copying or transferring medical records.
- Services and supplies furnished in connection with military service-connected disabilities for which the Member is legally entitled to services and for which facilities are reasonable available to the Member.
- Services intended primarily to treat obesity.
- Over-the-counter medications and supplies.
- Personal comfort items which are not determined to be medically necessary or appropriate for the specific treatment of the illness or injury.
- Physical examinations provided solely for the purpose of travel, employment or school.
- Prescription medications, unless (i) furnished by a hospital during a hospital stay, (ii) specifically listed in the "covered services" section of the Legacy Health Solutions Certificate of Coverage, or (iii) such drugs are covered by a rider to the group contract.
- Services and supplies furnished in connection with conditions that state or local law requires be treated in a public facility.
- School-based therapy services.
- Certain services and supplies which are deemed unnecessary.
- All services, medications and/or supplies furnished in conjunction with the sex change process.
- Any service furnished in connection with a smoking cessation program, unless covered by a rider to the group contract.
- Vocational rehabilitation.

Important: This list does not contain all of the limitations and exclusions. The TRS-ActiveCare Benefits Booklet will be available online by September 1, 2007. If you choose an HMO, their Evidence of Coverage will have a complete list and description of plan coverage, limitations and exclusions. For additional information, call your plan's Customer Service number.

Legacy Health Solutions (continued)

- Reversal of a previous surgical procedure intended to induce permanent infertility.
- Drugs not approved by the United States Food and Drug Administration for use in humans or for the condition being treated.
- Drugs used for cosmetic purposes, including, but not limited to, drugs prescribed for hair loss, and Retin-A, except when used to treat acne in persons age 25 and under.
- Drugs used for treatments or medical conditions not covered by the Certificate of Coverage and schedule of benefits for your plan.
- Vitamins, prescription vitamins (except prescription prenatal vitamins), dietary supplements (except for phenylketonuria or other heritable diseases), cosmetic, health or beauty aids.
- Any initial or refill prescription dispensed more than one (1) year after the date of the physician's order.
- Drugs given or administered to a plan member while at a hospital in either an inpatient or outpatient capacity, extended care facility, nursing facility, or other similar institution that has a facility for providing drugs.
- Drugs or medications prescribed for an occupational injury or illness.
- Drugs or medications furnished by any government organization or agency unless there is an unconditional legal obligation on the part of the plan member to pay such expenses, except Medicaid.
- Prescriptions or refills which replace lost, stolen, spoiled, expired, spilled or otherwise misplaced or mishandled by the plan member.
- Biological and/or biotech products.
- Appetite suppressants or any other drugs prescribed for weight loss.
- Drugs whose primary purpose is deemed to be promoting life enhancement activities versus treatment of injury or illness. Life enhancement drugs include but are not limited to drugs used to treat impotency and erectile dysfunction, Ritalin or similar medications for adults over 18 years of age, and others.
- Medical care, services and supplies for which no charge is made or for which the participant is not, in the absence of this coverage, legally obligated to pay.
- Services and supplies intended primarily or partially for the treatment of obesity/morbid obesity, including but not limited to, stomach stapling, jaw wiring, gastric balloon or bypass surgery.
- All prescription and non-prescription drugs (including contraction medication and devices) not prescribed for use while the participant is an inpatient at a participating hospital, unless specified otherwise in a rider to this agreement.
- Services for in vitro fertilization.
- Custodial care, comprised mainly of assisting the individual with the routine activity of daily living or rest cures.
- Examinations or treatments not otherwise covered by the agreement for the purpose of obtaining or maintaining any license, or an examination required prior to engaging in recreational activities, or by court order.
- Examination or treatments not otherwise covered by the agreement.
- Charges which do not meet the Plan's definition of covered services, or which are not otherwise described as a covered service.
- Service provided or ordered by participant his/herself, a participant's relative, including spouse, sibling, parent, or child, or any person living in the same household, even if such individual is a participating provider.
- Services provided in connection with the treatment of corns, calluses, or toenail.
- Services or supplies, including orthotics, orthopedic shoes, and other supportive appliances for feet.
- Dental implants.
- Rehabilitative services that are considered educational in nature.
- Injury or illness resulting from any act or incident of war.
- Eyeglasses, contact lenses, or the fitting of eyeglasses or contact lenses.
- Cosmetic or reconstructive surgery.
- Transportation expenses, other than ambulance services.
- Vitamins (other than those prenatal vitamins prescribed for a participant who is then pregnant) when not confined in a hospital, except those, which are medically necessary and approved.
- Massage therapy, homeopathy, acupuncture, orthoptic exercise, herbal remedies, and ayurvedic therapies.

Mercy Health Plans

- Services or supplies, that are provided by a hospital or facility operated by a governmental agency or any agency thereof.
- Reversal of elective surgical sterilization procedure, or invitro fertilization (unless covered by a rider).
- Services for sex change operations or any related services.
- Services covered under Workers' Compensation.
- Experimental organ transplants and services.

Important: This list does not contain all of the limitations and exclusions. After you enroll in TRS-ActiveCare, you will receive a Benefits Booklet/Evidence of Coverage that will have a complete list and description of plan coverage, limitations and exclusions. For additional information, call Customer Service.

Scott & White Health Plan

- Altered sexual characteristics including sex change operations or any related services.
- Blood, blood plasma, and other blood products.
- Chiropractic care.
- Cosmetic and reconstructive procedures and treatments undertaken to improve or modify a plan participant's appearance except for mastectomy reconstruction following breast cancer surgery.
- Custodial or domiciliary care.
- Dental care.
- Elective abortions, which are not necessary to preserve the health of the plan participant.
- Elective treatment or elective surgery.
- Experimental or investigational treatment.
- Genetic testing.
- Infertility diagnosis and treatment including any drug whose primary purpose is the treatment of infertility.
- Mental health services or disorders are limited to those described in your evidence of coverage.
- Non-covered benefits or services.
- Cost of services in excess of the usual, customary, and reasonable charges.
- Personal comfort items.
- Physical and mental exams for employment, licenses, insurance, educational purposes or services for non-medically necessary special education and developmental programs.
- Reversal of voluntary surgically-induced sterility, artificial insemination or in-vitro fertilization or family planning therapies.
- Rehabilitation services and therapies are limited to those recommended by a participating or referral physician as medically necessary.
- Storage of bodily fluids and other body parts.
- Take-home prescription drugs.
- Experimental organ transplants and associated donor/procurement costs and artificial organs; e.g., heart.
- Treatment received in State or Federal facilities or institutions or services or supplies provided by an employer or governmental agency or entity.
- Vision corrective surgery including laser application.
- War, insurrection, riot, disaster or epidemic.
- Weight reduction surgery.

Valley Baptist Health Plans

- Cosmetic or other reconstructive procedures.
- All dental care.
- Inpatient or outpatient custodial care.
- All surgical procedures for snoring and sleep apnea.
- Mental health services for the specific conditions. Marriage counseling is not a covered health service. Court ordered evaluation, diagnosis and treatment for mental conditions are excluded unless the Evidence of Coverage would otherwise cover such services.
- Reversal of voluntary sterilization and infertility treatment unless specified in the Evidence of Coverage.
- Any and all transplants of organs, cells, and other tissues, except for those listed in the Evidence of Coverage.
- Experimental or investigational drugs, devices, treatments or procedures.
- Health care services for any work-related injury or illness, if any other source of coverage or reimbursement is (or was) available.
- Disposable or consumable outpatient supplies (except supplies used in the treatment of diabetes and allergy syringes).
- Elective, non-therapeutic termination of pregnancy (abortions) including any abortion-inducing medications.
- Charges for the normal delivery of a baby outside our plan's service area if the delivery is within 30 days of the due date.
- Educational testing and therapy, including the treatment of learning disabilities, motor or language skills, behavioral disorders or services that are educational in nature or are for vocational testing or training.
- Treatments and evaluations required by a third party.
- Eyeglasses (including eyeglasses and contact lenses prescribed following vision surgery), contact lenses, except for treatment of keratoconus, and any other items or services for the correction of your eyesight unless specifically provided in the Evidence of Coverage.
- Services intended primarily to treat obesity.
- Sex-change surgery and related treatment, including hormone therapy and medical or psychological counseling.
- Acupuncture, naturopathy, hypnotherapy and Christian Science Practitioner services.
- Comfort or convenience items in a hospital or other inpatient facility.
- Transportation, except for ambulance or air ambulance used for transport in a medical emergency or pre-approved services for medical transport purposes only.
- If a service is not covered under the plan, we will not cover any services that are related to it.

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Valley Baptist Health Plans (continued)

- Special duty nursing.
- Nutritional counseling and diet planning, unless pre-approved.
- Growth hormone drugs for persons 18 years of age or older. However, growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred, is covered when services are pre-authorized.
- Genetic counseling and testing, except medically necessary perinatal genetic counseling and testing.
- Biofeedback services, except for the treatment of acute brain injury and for rehabilitation of acute brain injury.
- Implanted neurological stimulators.
- Mastectomy for relief of pain, to prevent breast cancer (except when you have been previously diagnosed with breast cancer), or due to any disease or illness other than for the treatment of breast cancer.
- Massage therapy, unless associated with a physical therapy modality provided by a licensed physical therapist.
- Sports cords.
- Repair or replacement of hearing aids due to normal wear, loss, or damage, hearing aid batteries.
- Orthotic devices, except for the treatment of diabetes and those described in Evidence of Coverage.
- Equine or Hippo therapy.
- Electron Beam Tomography (EBT).
- Medications prescribed for non-FDA-approved indications, referred to as off-label drug use.
- Certain medications are subject to dispensing limitations.
- Certain medications are subject to prior authorization.
- Brand-name prescription drugs will not be covered as preferred drugs when a generic equivalent prescription drug is available.
- Prescriptions written in connection with any treatment or service which is not a covered benefit are excluded.
- Appetite suppressants, anti-smoking aids, medications used for cosmetic improvement, uncomplicated nail fungus and hair loss are excluded.
- Experimental drugs are excluded.
- Prescriptions or refills which replace lost, stolen, spoiled, expired, spilled or are otherwise misplaced or mishandled are excluded.
- Prescriptions written for the treatment of infertility are excluded.

General Notice of Special Enrollment Rights and Preexisting Condition Exclusion

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your group health plan is required to provide you this notice explaining your group health plan's procedures for your special enrollment rights and imposing preexisting condition exclusions.

- **Your Special Enrollment Rights** – If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, 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, provided that you request enrollment within 31 days after the marriage, birth*, adoption, or placement for adoption.
- **Preexisting Condition Exclusions** – Under HIPAA, a “preexisting condition” is a condition for which medical advice, diagnosis, care, or treatment was recommended and received within the six-month period ending on the enrollment date in a health plan (the look-back period). Taking prescription medications during the look-back period constitutes receiving treatment.

Your plan may deny benefits for a preexisting condition during a 12-month waiting period beginning on your enrollment date. (If you do not enroll in a timely manner, the maximum waiting period is 12 months from the date coverage begins.) A preexisting condition exclusion does not apply to a pregnancy or to a newborn child or adopted child under age 18 who becomes covered within 31 days of birth* or adoption. A genetic condition without advice, care, or treatment is not a preexisting condition.

The existence of a preexisting condition will be determined using information obtained relating to an individual's health status before his or her enrollment date. An individual's enrollment date remains the same even if the individual changes benefit package options, as permitted by plan rules.

The preexisting condition waiting period is reduced by any creditable coverage (prior coverage under various plans including, but not limited to, group health plans, individual health policies, Medicare, and Medicaid). You may obtain a certificate of creditable coverage from a prior plan sponsor or health insurance issuer. Should you disagree with the length of creditable coverage determined by TRS-ActiveCare, you have the right to appeal that determination and provide additional evidence of creditable coverage.

For further information, contact your Benefits Administrator.

**Special rules apply to newborns; see page 9.*

HIPAA Notice of Election of Exemption

Title 1 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans including:

1. Limitations on a preexisting condition exclusion period
2. Special enrollment periods for individuals (and dependents) losing other coverage
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

HIPAA also permits certain self-funded, governmental group health plans the right of exemption from certain provisions of this federal law. For the 2007- 2008 plan year beginning September 1, 2007 and ending August 31, 2008, the Teacher Retirement System of Texas (TRS) has elected to exempt TRS-ActiveCare 1, 2 and 3 plans from HIPAA provisions 2 and 3 above. The election may be renewed for subsequent plan years.

Any use of special enrollment periods or health status under TRS-ActiveCare will be defined by TRS-ActiveCare plan documents, rather than requirements under HIPAA for the 2007-2008 plan year.

This election by TRS to opt the TRS-ActiveCare 1, 2 and 3 Plans out of certain HIPAA provisions does not apply to the five insured health maintenance organizations (HMO) participating in TRS-ActiveCare for the 2007-2008 plan year. They will continue to comply with all the provisions of HIPAA, including those listed in this notice.

HIPAA also requires TRS-ActiveCare 1, 2 and 3 to provide covered employees and dependents with a “certificate of creditable coverage” when they cease to be covered under TRS-ActiveCare 1, 2 or 3. There is no exemption from this requirement. The certificate provides evidence that you were covered under TRS-ActiveCare 1, 2 or 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 employer's health plan, or if you wish to purchase an individual health insurance policy.

Medicare Beneficiaries and Medicare Part D

On January 1, 2006, a new Medicare prescription drug plan, called Medicare Part D, now 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 to be your primary coverage; Medicare Part D will be secondary. However, the TRS-ActiveCare plan you have may influence your decision on whether or not to enroll in Medicare Part D. The Centers for Medicare & Medicaid Services (CMS) administers Medicare and a link to their Web Site is available on the TRS-ActiveCare page of the TRS Web site: www.trs.state.tx.us. If you or your dependent is covered by TRS-ActiveCare and is at least age 65, you will receive additional information on Medicare Part D from TRS (if covered by ActiveCare 1, 2 and 3) or from your HMO plan before the end of the calendar year 2007.

