



Benefits Booklet

2003-2004

Health Benefits

ActiveCare 1, 2 and 3

Health Plans



TRS-ActiveCare

TEACHER RETIREMENT SYSTEM OF TEXAS

www.frs.state.tx.us/trs-activecare

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

MEETING YOUR HEALTH CARE NEEDS

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

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

Important Phone Numbers

Customer Service

1-866-355-5999

8 a.m. - 8 p.m. (Central Time)

Monday through Friday

Precertification

1-800-441-9188

7:30 a.m. - 8 p.m. (Central Time)

Monday through Friday

INROADS® Behavioral Health

1-800-528-7264

8 a.m. - 5 p.m. (Central Time)

Monday through Friday

BlueCard PPO Access

1-800-810-BLUE (2583)

24 hours, seven days a week

Web Site

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

This Benefits Booklet applies to the 2003-2004 TRS-ActiveCare plan year and supersedes any prior version of the Benefits Booklet. However, prior versions of the Benefits Booklet remain in effect for the plan year to which they apply. In addition to TRS laws and regulations, the Benefits Booklet is TRS-ActiveCare's official statement about the matters contained in the Booklet and supersedes any other statement or representation made concerning TRS-ActiveCare, regardless of the source of that statement or representation.



TRS-ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

ACTIVECARE 1 BENEFITS SUMMARY

The benefits summary that follows shows what the plan pays for covered services and supplies, with a comparison of network and non-network benefits. The section on How Your Medical Plan Works found on page 8 explains in more detail the differences between network and non-network providers. When you use a network physician, there is a \$15 office visit copayment for preventive care only, up to the plan year maximum per individual; remaining charges will be subject to deductible and coinsurance. For covered services other than preventive care, the plan will pay benefits after you

meet the deductible. Network retail pharmacies will accept your TRS-ActiveCare ID card and charge you the negotiated Medco Health discounted price for up to a 30-day supply of your prescription. You may also obtain up to a 90-day supply of your prescription through the Medco Health Home Delivery Pharmacy Service. You will be required to pay in full when you receive your medication and submit a claim form to Blue Cross and Blue Shield of Texas. The plan will treat your prescription drug expense as a medical claim and will pay benefits after you meet the deductible.

General Provisions	Network	Non-Network
Deductible (per plan year)		
■ Individual		\$1,000
■ Family		\$3,000
Out-of-Pocket Maximum (per plan year; does not include deductible or copays)		
■ Individual		\$2,000
■ Family		\$6,000
Lifetime maximum benefit		Unlimited
Doctor and Lab Services		
Doctor office visits (includes immunizations, injections, diagnostic X-rays and lab tests)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Allergy injections	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Office surgery	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Outpatient surgery	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Inpatient doctor visits	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Contraceptive devices	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Preventive Care		
When using network physicians, benefits are paid at 100% after copay up to the first \$500 per individual, per plan year; remaining charges will be subject to deductible and coinsurance. Preventive care visits, network or non-network, are limited to one physical exam per plan year for age two and over; one OB/GYN well-woman exam per plan year; and one routine mammogram per plan year.		
Office visit (including lab, X-rays, immunizations)	\$15 copay	Plan pays 60%; you pay 40% after deductible
Routine eye exam (one per plan year)	\$15 copay	Plan pays 60%; you pay 40% after deductible
Hearing exams	\$15 copay	Plan pays 60%; you pay 40% after deductible
Lab and X-ray (outside the doctor's office)	Plan pays 100%	Plan pays 60%; you pay 40% after deductible
Immunizations (outside the doctor's office)	Plan pays 100%	Plan pays 60%; you pay 40% after deductible
Routine mammograms (outside the doctor's office)	Plan pays 100%	Plan pays 60%; you pay 40% after deductible
Hospital/Facility Services		
Inpatient hospital* (semi-private room and board or intensive care unit)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Other inpatient charges (including surgery)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Outpatient hospital/facilities	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Emergency room care within 48 hours of accident or medical emergency	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Emergency room care for all other conditions	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible

Extended Care Services	Network	Non-Network
Skilled nursing facility* (\$10,000 plan year maximum; up to \$7,000 may be non-network)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Home health care* (\$10,000 plan year maximum; up to \$7,000 may be non-network)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Hospice* (\$20,000 lifetime maximum; up to \$14,000 may be non-network)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Other Medical Services		
Physical therapy		
■ Office visit	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
■ All other services	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Chiropractic care (up to \$1,500 per plan year)		
■ Office visit	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
■ All other services	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Home Infusion Therapy*	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Hearing aids (up to \$1,000 per 36-month period)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Durable medical equipment	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Prosthetics	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Ambulance services (ground or air)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Behavioral Health (Mental Health and Chemical Dependency) * *		
Mental Health		
Inpatient facility* (up to 30 days per plan year)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Inpatient physician charges* (up to 30 visits per plan year)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Outpatient*/Office visit* (up to 30 visits per plan year; non-network limited to \$60 allowable per visit)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Chemical Dependency (maximum of two separate series per lifetime)		
Inpatient facility*	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Inpatient physician charges*	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Outpatient*	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Office visit*	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Serious Mental Illness		
Inpatient facility* (up to 45 days per plan year)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Inpatient physician* (up to 45 visits per plan year)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Outpatient*/Office visit* (up to 60 visits per plan year for all outpatient and office visits)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Prescription Drugs		
Retail (up to a 30-day supply)		
■ Generic	You pay 100% of the discounted cost at the time of purchase and will be reimbursed 80% after deductible	You pay 100% at the time of purchase and will be reimbursed 80% after deductible
■ Preferred brand		
■ Non-preferred brand		
Home Delivery Pharmacy Service (up to a 90-day supply)		
■ Generic	You pay 100% of the discounted cost at the time of purchase and will be reimbursed 80% after deductible	N/A
■ Preferred brand		
■ Non-preferred brand		

* Precertification required.

** Behavioral health benefits are provided by INROADS® Behavioral Health Services of Texas, L.P., a Magellan Behavioral Health Company.

ACTIVECARE 2 BENEFITS SUMMARY

The benefits summary that follows shows what the plan pays for covered services and supplies, with a comparison of network and non-network benefits. The section on How Your Medical Plan Works found on page 8 explains in more detail the differences between network and non-network providers. When you use a network physician, you pay \$25 for a primary care office visit and \$35 for an office visit with a specialist. A specialist is any physician other than a family practitioner, internist, OB/GYN or pediatrician. There is also a \$25 primary care copayment (\$35 for specialist) for preventive care, up to the plan year maximum per individual; any remaining charges will be subject to deductible and

coinsurance. For covered services other than preventive care, the plan will begin to pay benefits after you meet the deductible.

Network retail pharmacies will accept your TRS-ActiveCare ID card and charge you a copayment for up to a 30-day supply of your prescription. For non-network pharmacies, you will pay in full when you receive your medication and submit a claim form to Medco Health. You will be reimbursed the amount that would have been charged by a network pharmacy, less the required copayment. Medco Health Home Delivery Service will charge you a copayment for up to a 90-day supply of your prescription.

General Provisions

Deductible (per plan year)
■ Individual
■ Family
Out-of-Pocket Maximum (per plan year; does not include deductible or copays)
■ Individual
■ Family
Lifetime maximum benefit

Network	Non-Network
	\$500
	\$1,500
	\$2,000
	\$6,000
	Unlimited

Doctor and Lab Services

Doctor office visits (includes immunizations, injections, diagnostic X-rays and lab tests when performed during an office visit)
Immunizations, diagnostic X-rays and lab tests (when no office visit is billed)
Allergy injections (when no office visit is billed)
Office surgery
Outpatient surgery
Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges)
Inpatient doctor visits
Contraceptive devices

\$25 copay for primary \$35 copay for specialist	Plan pays 60%; you pay 40% after deductible
Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
\$25 copay for primary \$35 copay for specialists (for initial visit only; for delivery, plan pays 80% and you pay 20% after deductible)	Plan pays 60%; you pay 40% after deductible
80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible

Preventive Care

When using network physicians, benefits are paid at 100% after copay up to the first \$500 per individual, per plan year; remaining charges will be subject to deductible and coinsurance. Preventive care visits--network or non-network--are limited to one physical exam per plan year for age two and over; one OB/GYN well-woman exam per plan year; and one routine mammogram per plan year.
Office visit (including lab, X-rays, immunizations)
Routine eye exam (one per plan year)
Hearing exams
Lab and X-ray (outside the doctor's office)
Immunizations (outside the doctor's office)
Routine mammograms (outside the doctor's office)

\$25 copay for primary \$35 copay for specialist	Plan pays 60%; you pay 40% after deductible
\$25 copay for primary \$35 copay for specialist	Plan pays 60%; you pay 40% after deductible
\$25 copay for primary \$35 copay for specialist	Plan pays 60%; you pay 40% after deductible
Plan pays 100%	Plan pays 60%; you pay 40% after deductible
Plan pays 100%	Plan pays 60%; you pay 40% after deductible
Plan pays 100%	Plan pays 60%; you pay 40% after deductible

Hospital/Facility Service

Inpatient hospital* (semi-private room and board or intensive care unit)
Other inpatient charges (including surgery)
Outpatient hospital/facilities
Emergency room care within 48 hours of accident or medical emergency
Emergency room care for all other conditions

Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Plan pays 80%; you pay 20% after deductible	Plan pays 80%; you pay 20% after deductible
Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible

Extended Care Services

	Network	Non-Network
Skilled nursing facility* (\$10,000 plan year maximum; up to \$7,000 may be non-network)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Home health care* (\$10,000 plan year maximum; up to \$7,000 may be non-network)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Hospice* (\$20,000 lifetime maximum; up to \$14,000 may be non-network)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible

Other Medical Services

	Network	Non-Network
Physical therapy		
■ Office visit	\$25 copay for primary \$35 copay for specialist	Plan pays 60%; you pay 40% after deductible
■ All other services	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Chiropractic care (up to \$1,500 per plan year)		
■ Office visit	\$35 copay for specialist	Plan pays 60%; you pay 40% after deductible
■ All other services	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Home Infusion Therapy*	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Hearing aids (up to \$1,000 per 36-month period)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Durable medical equipment	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Prosthetics	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Ambulance services (ground or air)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible

Behavioral Health (Mental Health and Chemical Dependency) **

	Network	Non-Network
Mental Health		
Inpatient facility* (up to 30 days per plan year)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Inpatient physician charges* (up to 30 visits per plan year)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Outpatient*/Office visit* (up to 30 visits per plan year; non-network limited to \$60 allowable per visit)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Chemical Dependency (maximum of two separate series per lifetime)		
Inpatient facility*	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Inpatient physician charges*	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Outpatient*	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Office visit*	\$25 copay for primary \$35 copay for specialist	Plan pays 60%; you pay 40% after deductible

Serious Mental Illness

	Network	Non-Network
Inpatient facility* (up to 45 days per plan year)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Inpatient physician* (up to 45 visits per plan year)	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Outpatient*	Plan pays 80%; you pay 20% after deductible	Plan pays 60%; you pay 40% after deductible
Office visit* (up to 60 visits per plan year for all outpatient and office visits)	\$25 copay for primary \$35 copay for specialist	Plan pays 60%; you pay 40% after deductible

Prescription Drugs***

	Network	Non-Network
Retail (up to a 30-day supply)		
■ Generic	\$10 copay	You will be reimbursed the amount that would have been charged by a network pharmacy less the required copay
■ Preferred brand	\$25 copay	
■ Non-preferred brand	\$45 copay	
Home Delivery Pharmacy Service (up to a 90-day supply)		
■ Generic	\$20 copay	N/A
■ Preferred brand	\$50 copay	
■ Non-preferred brand	\$90 copay	

* Precertification required.

** Behavioral health benefits are provided by INROADS® Behavioral Health Services of Texas, L.P., a Magellan Behavioral Health Company.

*** 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.

ACTIVECARE 3 BENEFITS SUMMARY

The benefits summary that follows shows what the plan pays for covered services and supplies, with a comparison of network and non-network benefits. The section on How Your Medical Plan Works found on page 8 explains in more detail the differences between network and non-network providers. There is no deductible to meet when using network providers. When using a network physician, there is a \$20 copayment for a primary care office visit and a \$30 copayment for an office visit with a specialist. A specialist is any physician other than a family practitioner, internist, OB/GYN or pediatrician. You will pay any applicable coinsurance for other covered services. When using non-network

providers, the plan begins to pay benefits for covered services after you meet the deductible.

Network retail pharmacies will accept your TRS-ActiveCare ID card and charge you a copayment for up to a 30-day supply of your prescription. For non-network pharmacies, you will pay in full when you receive your medication and submit a claim form to Medco Health. You will be reimbursed the amount that would have been charged by a network pharmacy, less the required copayment. Medco Health Home Delivery Service will charge you a copayment for up to a 90-day supply of your prescription.

General Provisions

Deductible (per plan year)

- Individual
- Family

Out-of-Pocket Maximum (per plan year; does not include deductible or copays)

- Individual
- Family

Lifetime maximum benefit

Network

Non-Network

Individual	None	\$500
Family	None	\$1,500
Individual	\$1,000	\$3,000
Family	N/A	N/A
Lifetime maximum benefit	Unlimited	\$1,000,000

Doctor and Lab Services

Doctor office visits (includes immunizations, injections, diagnostic X-rays and lab tests when performed during an office visit)

Immunizations, diagnostic X-rays and lab tests (when no office visit is billed)

Allergy injections (when no office visit is billed)

Office surgery

Outpatient surgery

Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges)

Inpatient doctor visits

Contraceptive devices

\$20 copay for primary	Plan pays 65%; you pay 35% after deductible
\$30 copay for specialist	Plan pays 65%; you pay 35% after deductible
Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
\$20 copay for primary	Plan pays 65%; you pay 35% after deductible
\$30 copay for specialist	Plan pays 65%; you pay 35% after deductible
(for initial visit only; for delivery, plan pays 85% and you pay 15%)	
Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible

Preventive Care

Office visit copay includes all preventive care services billed with an office visit by a network doctor. Preventive care visits — network or non-network — are limited to one physical exam per plan year for age two and over; one OB/GYN well-woman exam per plan year; and one routine mammogram per plan year. Network services billed without an office visit will be paid at 85%.

Office visit (including lab, X-rays, immunizations)

Routine eye exam (one per plan year)

Hearing exams

Lab and X-ray (without an office visit)

Immunizations (without an office visit)

Routine mammograms (without an office visit)

\$20 copay for primary	Plan pays 65%; you pay 35% after deductible
\$30 copay for specialist	Plan pays 65%; you pay 35% after deductible
\$20 copay for primary	Plan pays 65%; you pay 35% after deductible
\$30 copay for specialist	Plan pays 65%; you pay 35% after deductible
\$20 copay for primary	Plan pays 65%; you pay 35% after deductible
\$30 copay for specialist	Plan pays 65%; you pay 35% after deductible
Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible

Hospital/Facility Services

Inpatient hospital* (semi-private room and board or intensive care unit)

Other inpatient charges (including surgery)

Outpatient hospital/facilities

Emergency room care within 48 hours of accident or medical emergency

Emergency room care for all other conditions

Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Plan pays 85%; you pay 15% after \$50 copay (copay waived if admitted)	
Plan pays 85%; you pay 15% after \$50 copay (copay waived if admitted)	Plan pays 65%; you pay 35% after deductible

Extended Care Services	Network	Non-Network
Skilled nursing facility* (\$10,000 plan year maximum; up to \$7,000 may be non-network)	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Home health care* (\$10,000 plan year maximum; up to \$7,000 may be non-network)	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Hospice* (\$20,000 lifetime maximum; up to \$14,000 may be non-network)	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Other Medical Services		
Physical therapy		
■ Office visit	\$20 copay for primary \$30 copay for specialist	Plan pays 65%; you pay 35% after deductible
■ All other services	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Chiropractic care (up to \$1,500 per plan year)		
■ Office visit	\$30 copay for specialist	Plan pays 65%; you pay 35% after deductible
■ All other services	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Home Infusion Therapy*	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Hearing aids (up to \$1,000 per 36-month period)	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Durable medical equipment	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Prosthetics	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Ambulance services (ground or air)	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Behavioral Health (Mental Health and Chemical Dependency)**		
Mental Health		
Inpatient facility* (up to 30 days per plan year)	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Inpatient physician charges* (up to 30 visits per plan year)	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Outpatient*/Office visit* (up to 30 visits per plan year; non-network limited to \$60 allowable per visit)	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Chemical Dependency (maximum of two separate series per lifetime)		
Inpatient facility*	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Inpatient physician charges*	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Outpatient*	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Office visit*	\$20 copay for primary \$30 copay for specialist	Plan pays 65%; you pay 35% after deductible
Serious Mental Illness		
Inpatient facility*	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Inpatient physician*	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Outpatient*	Plan pays 85%; you pay 15%	Plan pays 65%; you pay 35% after deductible
Office visit*	\$20 copay for primary \$30 copay for specialist	Plan pays 65%; you pay 35% after deductible
Prescription Drugs***		
Retail (up to a 30-day supply)		
■ Generic	\$10 copay	You will be reimbursed the amount that would have been charged by a network pharmacy less the required copay
■ Preferred brand	\$25 copay	
■ Non-preferred brand	\$40 copay	
Home Delivery Pharmacy Service (up to a 90-day supply)		
■ Generic	\$20 copay	N/A
■ Preferred brand	\$50 copay	
■ Non-preferred brand	\$80 copay	

* Precertification required.

** Behavioral health benefits are provided by INROADS® Behavioral Health Services of Texas, L.P., a Magellan Behavioral Health Company.

*** 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.

HOW YOUR MEDICAL PLAN WORKS

Network vs. Non-Network Providers

You will receive the highest level of benefits offered under your plan when you use network doctors or hospitals, but you may choose non-network providers and pay a greater share of the cost. You have the freedom to choose any

provider when you need care. No referrals are required.

This diagram illustrates how TRS-ActiveCare works:

Each time you need care you may choose to:		
See a network provider	See a non-network provider	
	ParPlan provider	Other non-network provider
<ul style="list-style-type: none"> Receive network (highest) level of benefits File no claims in most cases; network provider will usually file claims for you No balance billing; network providers will not bill for costs exceeding the Blue Cross and Blue Shield of Texas allowable amount for covered services 	<ul style="list-style-type: none"> Receive non-network (reduced) level of benefits File no claims in most cases; ParPlan provider will usually file claims for you No balance billing; ParPlan providers will not bill for costs exceeding the Blue Cross and Blue Shield of Texas allowable amount for covered services 	<ul style="list-style-type: none"> Receive non-network (reduced) level of benefits File your own claims You may be billed for charges exceeding the Blue Cross and Blue Shield of Texas allowable amount for covered services <p>Note: Charges that exceed the allowable amount do not apply to your plan year deductible or out-of-pocket maximum.</p>

What is a ParPlan provider?

ParPlan providers and contracted facilities have agreed to accept the Blue Cross and Blue Shield of Texas allowable amount and/or negotiated rates for covered services. When using ParPlan providers and contracted facilities, you are covered at the non-network level and, in most cases, will not have to file your own claims.

Need to locate a network or ParPlan physician or hospital?

Log onto www.trs.state.tx.us/trs-activecare and click on Medical Benefits, then Provider Locator. Or call Customer Service at 1-866-355-5999 for assistance.

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

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

Note: Even if approved by Blue Cross and Blue Shield of Texas, non-network providers paid as network may balance bill for charges exceeding the Blue Cross and Blue Shield of Texas allowable amount for covered services.

Precertification Requirements

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

The following types of services require precertification:

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

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

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

How to precertify

Medical: Network providers will precertify services for you. *If you do not use a network provider for your medical care, you are responsible for precertification by calling Blue Cross and Blue Shield of Texas at **1-800-441-9188**.*

What happens if services are not precertified?

Blue Cross and Blue Shield of Texas will review the medical necessity of your treatment prior to the final benefit determination. If the treatment or service is not medically necessary, benefits will be denied. There is a \$250 penalty for failure to precertify a medically necessary admission to a non-network hospital. The penalty will be deducted from any benefit payment that may be due for the admission. The penalty does not apply to the deductible or out-of-pocket maximum.


Is there a time limit for precertifying hospital admissions?

All inpatient admissions should be precertified at least two working days before admission, or in the case of an emergency, within two working days after admission, or as soon as reasonably possible.

(The precertification telephone number also appears on your TRS-ActiveCare ID card.) This phone call is important. There is a \$250 penalty for failure to precertify a medically necessary admission to a non-network hospital. You, your provider, or a family member may call. The call should be made between 7:30 a.m. and 8 p.m. (Central Time) Monday through Friday. Calls made after working hours, on weekends, or holidays will be recorded and returned the next working day.

Serious mental illness, mental health and chemical dependency: Precertification for serious mental illness, mental health and chemical dependency should be obtained from INROADS Behavioral Health Services by calling **1-800-528-7264** between 8 a.m. and 5 p.m. (Central Time). All serious mental illness, mental health and chemical dependency care—network and non-network, inpatient and outpatient—should be precertified.

Accessing the BlueCard Program for Health Care Outside Texas

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

- If you are outside of Texas and need health care, refer to your TRS-ActiveCare ID card and call BlueCard Access at 1-800-810-BLUE (2583) for information on the nearest network doctors and hospitals.
- Although network providers outside of Texas may precertify those services that require

precertification (such as a hospital admission), it is ultimately your responsibility to obtain precertification by calling the appropriate number on the back of your TRS-ActiveCare ID card.

- When you arrive at the doctor's office or hospital, present your TRS-ActiveCare ID card and the doctor or hospital will verify eligibility and coverage information.
- After you receive medical attention, the network provider will file claims for you.
- You will be responsible for paying any applicable deductible, copayment or coinsurance amounts, as well as any charges for non-covered services. BlueCard providers have agreed to accept the Blue Cross and Blue Shield Plan's allowable amount for covered services and will not balance bill you for any cost exceeding the allowable amount.

Does TRS-ActiveCare provide benefits for medical services outside the United States?

Yes. Through the BlueCard Worldwide program, you have access to hospitals on almost every continent and to a broad range of medical assistance services when you travel or live outside the United States. BlueCard Worldwide provides the following services:

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

If you need to locate a doctor or hospital, or need medical assistance, call BlueCard Access at 1-800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. A medical assistance coordinator, in conjunction with a medical professional, will arrange hospitalization, if necessary. Network benefits will apply for inpatient care at BlueCard Worldwide hospitals.

In an emergency, go directly to the nearest hospital.

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

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

If you do not use a BlueCard Worldwide provider for care, you will need to pay the doctor or hospital at the time of service. Then, you will need to complete an international claim form and send it to the BlueCard Worldwide Service Center. The claim form is available online at www.trs.state.tx.us/trs-activecare. Non-network benefits will apply towards covered expenses.

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

How to request or replace an ID card

To request additional cards or to replace lost or damaged cards, call Customer Service at 1-866-355-5999. There is no charge for ID cards.

What the Medical Plan Covers

The following medical expenses are covered by TRS-ActiveCare. The descriptions have been alphabetized for quick reference. Covered services may be subject to other plan limitations. **Refer to the specific Benefits Summary for the TRS-ActiveCare plan you selected on pages 2-7 of this booklet for more detailed information, including the applicable copay, deductible and coinsurance.**

Acquired Brain Injury

Benefits for eligible expenses incurred for medically necessary treatment of an acquired brain injury will be determined on the same basis as treatment for any other physical condition. Eligible expenses include neurobehavioral, neurophysiological, and neuropsychological services, and psychophysiological testing or treatment as a result of and related to an acquired brain injury.

Allergy Care

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

Chemical Dependency Treatment (precertification required)

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

There is a maximum limit of two separate series of chemical dependency treatments per lifetime. A series of treatments is a planned, structured, and organized program to promote chemical-free status. A program may include different facilities or modalities, such as inpatient detoxification, inpatient

What is the allowable amount?

Covered medical expenses are payable at the Blue Cross and Blue Shield of Texas allowable amount. The allowable amount is the maximum amount that will be paid by TRS-ActiveCare for a medical service or supply. The allowable amount is based on either the negotiated rates with providers or charges made for the same service by providers in the same geographic area with similar training, experience, and facilities as determined by Blue Cross and Blue Shield of Texas. For multiple surgeries performed on the same patient on the same day, the allowable amount will be the amount for the single procedure with the highest allowable amount, plus one half of the allowable amount for each of the other procedures performed.

What does medically necessary mean?

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

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

Medically necessary charges do not include charges for:

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

rehabilitation/treatment, partial hospitalization or intensive outpatient treatment or a series of these levels of treatments without a lapse in treatment. A series is complete when a participant is discharged on medical advice or when a participant fails to materially comply with the treatment program for a period of 30 days.

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

Chiropractic Care

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

Cosmetic, Reconstructive, or Plastic Surgery

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

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

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

Dental Services and Covered Oral Surgery

General dental services are not covered by TRS-ActiveCare. When prescribed by your doctor, covered oral surgery is limited to:

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

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

Diabetic Management Services

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

Diabetic Equipment and Supplies

- Covered under your Medical Benefits: Insulin pumps and necessary accessories, infusion devices, and podiatric appliances for the prevention of complications associated with diabetes. Non-prescriptive oral agents are also covered.
- Covered under your Pharmacy Benefits: Insulin, blood glucose monitors (up to \$100 per year), test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin analogs, injection aids, syringes, and glucagon emergency kits.

Diabetes Self-management Training Programs (Covered under your Medical Benefits):

- Training provided after the initial diagnosis of diabetes and the care and management of that condition, including nutritional counseling and proper use of diabetic equipment and supplies;
- Additional training provided after a diagnosed significant change in symptoms or condition that requires changes in the self-management program; and
- Training as warranted by the development of new techniques and treatments for diabetes.

Durable Medical Equipment

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

What is an emergency?

- An emergency is the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate care could result in:
 - Placing the person's health in serious jeopardy
 - Serious impairment to bodily functions
 - Serious dysfunction of any bodily organ or part
 - Serious disfigurement, or
 - In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

Emergency Care

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

- **Inpatient care:** If you are admitted to a network hospital, network providers will precertify your hospital admission and you will receive the network level of benefits. If you are admitted to a non-network hospital, the hospital admission must be precertified within 48 hours by calling 1-800-441-9188. If the non-network hospital admission is not precertified, there is a \$250 penalty and benefits will be paid at the non-network level. If the admission was medically necessary and due to an accident or emergency, you can appeal the original decision for payment at the network level of benefits.

Emergency Care (cont.)

- **Outpatient care:** Network benefits are available for treatment received within the first 48 hours following an accident or medical emergency (even in a non-network facility). Treatment received after 48 hours of an onset of an accident or medical emergency in a non-network facility will be paid at the non-network level of benefits.

Family Planning

Covered services include:

- Insertion and removal of an intrauterine device (IUD)
- Fitting a diaphragm
- Vasectomy
- Tubal ligation
- Insertion or removal of birth control device implanted under the skin

Oral contraceptives are included under the TRS-ActiveCare prescription drug benefit.

Hearing Aids

Benefits are available for hearing aids, including fittings and molds, up to \$1,000 per 36-month period. Hearing aids must be paid for in advance and claims for covered expenses must be submitted to Blue Cross and Blue Shield of Texas for reimbursement.

TRS-ActiveCare does not cover replacement for loss, damage or functional defect. Hearing aid repair and batteries are also **not** covered.

Home Health Care (precertification required)

TRS-ActiveCare covers medically necessary services and supplies provided in the patient's home during a visit from a home health agency as part of a physician's written home health care plan. Coverage includes:

- Part-time or intermittent nursing care by a registered nurse (RN) or licensed vocational nurse (LVN)
- Part-time or intermittent home health aide services for patient care
- Physical, occupational, speech, and respiratory therapy services provided by licensed therapists, and
- Supplies and equipment routinely provided by the home health agency

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

Home Infusion Therapy (precertification required)

TRS-ActiveCare covers the administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous (IV) or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home infusion therapy includes:

- Drugs and IV solutions
- Pharmacy compounding and dispensing services
- All equipment and ancillary supplies necessitated by the defined therapy
- Delivery services
- Patient and family education, and
- Nursing services

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

Hospice Care (precertification required)

TRS-ActiveCare covers services provided by a hospice to patients confined at home or in a hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

The following services are covered for **home** hospice care:

- Part-time or intermittent nursing care by a registered nurse (RN) or licensed vocational nurse (LVN)
- Part-time or intermittent home health aide services for patient care
- Physical, respiratory, and speech therapy by licensed therapists, and
- Homemaker and counseling services, including bereavement counseling

Covered **facility** hospice care includes:

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

Hospital Admission (precertification required)

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

Infertility Services

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

Note: Services or supplies provided for, in preparation for, or in conjunction with in vitro fertilization and artificial insemination are not covered. See page 20 for additional exclusions.

What happens if lab and X-ray work are performed outside the doctor's office?

■ **ActiveCare 1 and ActiveCare 2:** If the lab and X-ray services performed outside the doctor's office are for preventive care, they will be paid at 100% of the allowable amount up to a \$500 maximum per plan year when using network physicians. Charges over the \$500 maximum will be subject to deductible and coinsurance (plan pays 80%; you pay 20%). Non-preventive diagnoses will also be subject to deductible and coinsurance.

■ **ActiveCare 3:** For lab and X-ray services performed outside the doctor's office, the plan pays 85% of the allowable amount and you pay 15% for covered services when using network physicians.

Are non-network radiologists and pathologists covered at the network level of benefits if the hospital or surgeon is in the network?

■ These services will be paid at the network benefits level. However, the non-network provider can bill for charges exceeding the allowable amount for covered medical expenses.

Lab and X-Ray Services

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

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

Lab and X-Ray Services (cont.)

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

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

Maternity Care

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

Maternity care includes diagnosis of pregnancy, pre- and post-natal care, and delivery (including delivery by Caesarean section). TRS-ActiveCare covers inpatient care for the mother and newborn child in a health care facility for a minimum of 48 hours following an uncomplicated vaginal delivery, and 96 hours following an uncomplicated delivery by Caesarean section.

Inpatient hospital expenses incurred by the mother for delivery of a child will not include charges for routine well-baby nursery care of the newborn child during the mother's hospital admission for the delivery. These charges will be considered expenses of the child and will be subject to the benefit provisions and benefit maximums described in the Benefits Summary of the specific TRS-ActiveCare plan you selected.

How is maternity care covered?

■ **ActiveCare 1:** Maternity care is subject to the applicable deductible and coinsurance.

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

How is a newborn child covered under TRS-ActiveCare?

■ TRS-ActiveCare automatically provides coverage of a newborn child of a covered employee for the first 31 days following birth. For coverage to continue beyond this time, you must sign, date and submit an *Enrollment Application and Change Form* to your Benefits Administrator within 60 days after the date of birth to add coverage for the newborn. If the application is submitted after the 60-day period, the request to add coverage will be denied—even if there would be no change in premium.

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

Mental Health Care (precertification required)

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

- Diagnosis or treatment of a symptom, disease, disorder, or condition (as defined by the American Psychiatric Association in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association* or any other diagnostic coding system used by Blue Cross and Blue Shield of Texas) whether or not the cause of the disease, disorder or condition is physical, chemical or mental in nature or origin

- Diagnosis or treatment of any symptom, condition, disease or disorder by a provider, or any person working under the supervision of a provider, when the eligible expense is:
 - Individual, group, family, or conjoint psychotherapy
 - Counseling
 - Psychoanalysis
 - Psychological testing and assessment
 - For administering or monitoring of psychotropic drugs
 - Hospital visits or consultations in a facility providing such care
- Electroconvulsive treatment
- Psychotropic drugs (*covered under your pharmacy benefits*)

All mental health care—inpatient and outpatient, network or non-network—must be precertified. Refer to the Benefits Summary of the TRS-ActiveCare plan you selected for day or visit limitations that apply. Medically necessary mental health care in a psychiatric day treatment facility, a crisis stabilization unit or facility, or a residential treatment center for children and adolescents, in lieu of hospitalization, will be considered inpatient hospital expense. Each full day of mental health care in a psychiatric day treatment facility, crisis stabilization unit or facility, or residential treatment center for children and adolescents will count as a half day of inpatient care.

Newborn Screening Tests for Hearing Impairment

TRS-ActiveCare covers screening tests for hearing loss from birth through the date the child is 30 days old and necessary diagnostic follow-up care related to screening tests from birth through the date the child is 24 months old.

Organ and Tissue Transplants (precertification required)

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

- Transplant is not experimental/investigational in nature
- Donated human organs or tissue are used
- Recipient or donor is a participant under TRS-ActiveCare
- Transplant procedure is precertified
- Recipient meets all of the criteria established by Blue Cross and Blue Shield of Texas in its written medical policy guidelines, and
- Recipient meets all of the protocols established by the hospital in which the transplant is performed

Covered services and supplies include:

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

Services and supplies not covered by TRS-ActiveCare include:

- Living and/or travel expenses of the live donor or recipient
- Donor search and acceptability testing of potential living donors
- Expenses related to maintenance of life for purposes of organ or tissue donation
- Purchase of the organ or tissue

Orthotics

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

Noncovered items include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a physician in a non-hospital setting or purchased over-the-counter for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace; specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot; or foot alignment, arch supports, elastic stockings and garter belts.

Note: Foot orthotics are covered for the treatment of diabetes.

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

Outpatient Facility Services

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

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

Who are covered health providers?



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

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

Preventive Care

TRS-ActiveCare encourages preventive care and maintenance of good health. Preventive care benefits include:

- Routine physical exams (*limited to one physical exam per plan year for persons age two and over and one well-woman exam per plan year*)
- Routine mammograms (*one per plan year*)
- Immunizations (*injections for allergies are not considered immunizations*)
- Well baby exams
- Vision exams (*one per plan year*)
- Hearing exams
- Prostate (PSA) screenings
- Colorectal cancer screenings
- Osteoporosis screenings

Professional Services

Covered services must be medically necessary and provided by a licensed doctor. Services may also be provided by other covered health providers. See box above. Benefits for services for diagnosis and treatment of illness or injury are available on an inpatient or an outpatient basis or in a provider's office.

Prosthetic Devices

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

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

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

Rehabilitation Services (Physical, Speech and Occupational Therapies)

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

Serious Mental Illness (precertification required)

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

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

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

Skilled Nursing Facility (precertification required)

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

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

Transitional Care

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

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

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

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

If your doctor is in the network, you do not have to complete a Transitional Care Request Form.

What the Medical Plan Does Not Cover

In addition to the limitations and exclusions set out in the description of What the Medical Plan Covers, beginning on page 11, TRS-ActiveCare does not cover medical expenses for the following:

- Services or supplies which 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, reconstructive, or plastic surgery except as provided for on page 12 of the benefits booklet
- General dental services
- Any items of medical/surgical expense incurred for dental care and treatment, dental surgery, or dental appliances unless medically necessary
- 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 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, there is a diagnosed fetal anomaly, or the pregnancy is caused by a criminal act such as rape or incest
- Transplant procedures which Blue Cross and Blue Shield of Texas considers experimental and/or investigational in nature
- Medical social services, bereavement counseling (except as part of a precertified 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 which are covered under a separate prescription drug program with its own limitations and exclusions
- Acupuncture, videofluoroscopy, 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
- Any services or supplies not specifically defined as eligible expenses, unless through case management
- Services or supplies for custodial care as determined by Blue Cross and Blue Shield of Texas
- Telemedicine services provided by telephone or fax machine

What are preexisting conditions?

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

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

The preexisting condition provision does not apply to:

- A newborn child added within 60 days of the child's birth
- A person who was covered for 12 months under creditable coverage
- Pregnancies
- Conditions resulting from domestic violence
- Genetic information without a diagnosis of a specific condition

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

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

It depends. If you enrolled in ActiveCare 1, 2 or 3 when you were first eligible for coverage during the 2002-2003 plan year, you may choose any option for the 2003-2004 plan year without preexisting condition exclusions. If you declined coverage in 2002-2003, preexisting condition exclusions will apply to ActiveCare 1, 2 and 3 plans, but not for HMO coverage. (There are never preexisting condition exclusions for HMO coverage.) For initial enrollees (those eligible employees and dependents enrolling when TRS-ActiveCare is first made available though their participating district/entity) and new hires, there are no preexisting condition exclusions so long as you enroll when you are first eligible for coverage. If you do not enroll during your initial period of eligibility, preexisting condition exclusions may apply. Preexisting condition limitations will apply to the ActiveCare 1, 2 and 3 plans if you enroll for coverage during the plan year due to a special enrollment event. Prior creditable coverage may be used to offset a preexisting condition exclusion period.

Retail Pharmacies Services

For your short-term prescription needs: Your retail pharmacy service is most convenient when you need a medication for a **short period**. For example, if you need an antibiotic to treat an infection, you can go to one of the many pharmacies that participate in TRS-ActiveCare and get your medication on the **same day**.

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

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

Medco Health Home Delivery Pharmacy Service

The Medco Health Home Delivery Pharmacy Service offers you convenience and potential cost savings. For your long-term prescription needs: If you need medication on an ongoing basis, such as you might need to treat asthma or diabetes, you can ask your doctor to prescribe up to a **90-day supply** for home delivery, plus refills for up to one year. You will pay just **one copayment for each prescription or refill**. Since you get a larger supply of medication when you fill a prescription through the Home Delivery

Pharmacy Service than when you fill a prescription at a retail network pharmacy, **you may save money**.

With the Home Delivery Pharmacy Service:

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

Prescription Drug Formulary

ActiveCare 2 and ActiveCare 3 plans include a formulary, which is a list of drugs that are preferred by TRS-ActiveCare. This list includes a wide selection of drugs and is preferred because it offers you choice while helping keep the cost of your prescription drug benefit affordable. Each drug is Food and Drug Administration (FDA) approved and is also reviewed by an independent group of doctors and pharmacists for safety and efficacy. TRS-ActiveCare encourages the use of the preferred drugs on this list to help control rising prescription drug costs.

The Generic Drug Advantage

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

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

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

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

Exclusions from Pharmacy Benefits

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 is to promote or stimulate hair growth (e.g. Rogaine, Propecia) or for cosmetic purposes only (e.g. Renova, Vaniqua)
- Retin-A/Avita for use by individuals age 35 and over

Can prescription drug copayments be used to satisfy the plan year deductible and out-of-pocket maximum?

■ **ActiveCare 1:** Yes. The cost of your prescription drugs will apply to your medical plan year deductible and out-of-pocket maximum.

ActiveCare 2 and ActiveCare 3: No. Your prescription drug copayments do **not** apply to your medical plan year deductible or out-of-pocket maximum.

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

Prescription Limitations

Some drugs or therapeutic classes of drugs may have limitations based upon accepted clinical guidelines, dosage limitations, recommended standards of care and/or shelf life stability limits.

Consult the www.trs.state.tx.us/trs-activecare Web site for an updated list of these managed drug classes.

Employee Eligibility

Who can enroll in TRS-ActiveCare?

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

1. Is the individual an active, contributing TRS member?
2. Is the individual employed for 10 or more hours each week?

If the answer is yes to *either* question, then the employee is eligible for TRS-ActiveCare coverage unless the individual is 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 that has UT Select coverage as an employee with The University of Texas.
- Receiving health care coverage as an employee or retiree under the Texas Employee Uniform Group Insurance Benefits Act. Example: A school employee that 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.

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

Eligible Dependents

You may also enroll your eligible dependents at the same time you enroll for coverage. Eligible dependents of a covered employee include a spouse (including a common law spouse) and an unmarried child under the age of 25 described by any of the following:

- 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
- A grandchild whose primary residence is the household of the employee and who is a dependent of the employee for federal income tax purposes.

A child of a covered employee, regardless of age, may be eligible for dependent coverage if the child is either mentally retarded or physically incapacitated to such an extent as to be dependent on the employee on a regular basis and the child meets other requirements as determined by TRS.

Who is eligible for TRS-ActiveCare coverage?

Teachers, administrative personnel, permanent substitutes, bus drivers, librarians, crossing guards, cafeteria workers, and high school or college students are all eligible for coverage, provided no

exception applies, if they are employees, not volunteers, and are either active, contributing TRS members or are employed for 10 or more hours each week. True on-call substitutes, independent contractors, and volunteers are not employees and are therefore not eligible for TRS-ActiveCare coverage.

If an employee and spouse both work for a participating district/entity, the spouse may be covered as an employee or as a dependent of an eligible employee. Only one parent may enroll dependent children for coverage.

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

Making Changes/Special Enrollment Events

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

- You marry or divorce (if the divorce results in a loss of other coverage)
- A child is born, adopted, or is placed with you for adoption such that you have a legal obligation to support that child
- A child marries or reaches age 25
- A court orders you to provide health coverage for your child, or
- You or your dependent lose other health insurance coverage (and you originally declined TRS-ActiveCare coverage in writing because of coverage under another health benefit plan).

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

Changes in coverage must be made within 31 days of the special enrollment event.* 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.

** You have 60 days after the date of birth to add coverage for a newborn child.*

Can dependents be added throughout the plan year?

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

Can coverage be dropped throughout the plan year?

Unless restricted due to participation in an Internal Revenue Code Section 125 cafeteria plan, an employee can drop employee-only coverage or drop dependent coverage at any time. If coverage is dropped, the individual will not be eligible to re-enroll in TRS-ActiveCare until the next enrollment period or as a result of a special enrollment event. Preexisting limitations may apply.

Special HIPAA Rules Relating to Certain Dependents

The Health Insurance Portability and Accountability Act (HIPAA) includes special rules for employees to add coverage for themselves and/or certain dependents. The rules include:

- A covered employee can add a spouse (and spouse's eligible dependents) after marriage
- A covered employee can add a spouse and/or a new child after the birth, adoption, or placement for adoption of that child
- A covered employee can add a person who becomes a dependent of the employee through birth, adoption or placement for adoption of a new child
- An eligible, but not covered employee, may enroll himself/herself **or** himself/herself and a spouse after marriage
- An eligible, but not covered employee, may enroll himself/herself **or** himself/herself and a spouse **or** himself/herself and a child **or** enroll all three after the birth, adoption, or placement for adoption of a child

Changes in coverage must be made within 31 days of the special enrollment event. (You have 60 days after the date of birth to add coverage for a newborn child.)

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.

Loss of coverage

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

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

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

- An increase in the premium cost
- A *reduction* in the employer's contribution to the premium
- Dropping COBRA continuation coverage before the coverage is exhausted
- Any other voluntary termination of coverage, including failure to pay your premium

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

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

Request for Exceptions

■ *Enrollment Application and Change Forms* submitted to your Benefits Administrator after the 31-day period for special enrollment events or after the 60-day period following the birth of your newborn child will be denied. You may submit a request to TRS for an exception by writing to: TRS-ActiveCare, 1000 Red River Street, Austin, TX 78701. Such requests will be reviewed on a case-by-case basis.

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

Court-ordered Dependent Children

Employees may add a court-ordered dependent child to coverage within **31 days from the date the district/entity receives notification of the court order or national medical support notice.** A court order or national medical support notice is not a special enrollment event for an employee. If you are not covered by TRS-ActiveCare at the time the district/entity receives the court order or notice, your court-ordered dependent child(ren) may be enrolled for coverage, but you cannot enroll for employee coverage until the next enrollment period or until you experience a special enrollment event.

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

Effective Date of Coverage

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

if...	Your effective date is...	Your eligible dependent's effective date is...	The preexisting condition exclusion applies...
Your district/entity first begins participation in TRS-ActiveCare on September 1, 2003 and you enroll for coverage during spring or summer enrollment...	September 1, 2003	September 1, 2003	No
Your district/entity begins participation in TRS-ActiveCare after September 1, 2003 and you enroll in coverage...	Your choice of: (1) the date the district/entity first begins participation in TRS-ActiveCare, or (2) the first of the month in which your TRS membership begins	The date the district/entity first begins participation in TRS-ActiveCare	No
You enroll for coverage during the 2003-2004 enrollment period and had originally declined coverage under TRS-ActiveCare...	September 1, 2003	September 1, 2003	Yes (unless enrolling in an HMO option)
You are a new hire of a participating district/entity and enroll for coverage within 31 days after your actively-at-work date...	Your choice of: (1) your actively-at-work date (2) the first of the month following your actively-at-work date, or (3) the first of the month in which your TRS membership begins <i>Premium is billed for the full month</i>	The same date as your effective date of coverage <i>In no event will the dependent's coverage become effective prior to your effective date</i>	No
Your status changes and you become eligible for coverage during the plan year (example: you increase hours and begin to work 10 or more hours per week) and enroll for coverage within 31 days after the date you become an eligible employee... <i>Note: If you meet eligibility requirements as regularly scheduled to work 10 or more hours per week and decline coverage, you may not elect coverage later during the plan year if changing status to a TRS member. (Changing TRS membership status is not an enrollment event.)</i>	Your choice of: (1) your eligibility date or (2) the first of the month following your eligibility date <i>Premium is billed for the full month</i>	The same date as the your effective date of coverage	No
You enrolled in an approved HMO and lose eligibility because you no longer live, work or reside in that HMO service area, you may enroll in another approved HMO (if applicable) or ActiveCare 1, 2 or 3 within 31 days after losing eligibility...	The first of the month following the event date.	The same date as your effective date of coverage	No
You return from military service and enroll (or re-enroll) in TRS-ActiveCare within 31 days after your actively-at-work date... <i>If you return to active employment within the same plan year and choose to re-enroll in TRS-ActiveCare, you must select the same plan option in which you were previously enrolled.</i>	Your choice of: (1) your actively-at-work date (2) the first of the month following your actively-at-work date, or (3) the first of the month in which your TRS membership begins <i>Premium is billed for the full month</i>	The same date as the your effective date of coverage	No

If ...	Your effective date is...	Your eligible dependent's effective date is...	The preexisting condition exclusion applies...
<p>You return from leave-without-pay status and enroll (or re-enroll) for coverage within 31 days after your actively-at-work date...</p> <p><i>If you return to active employment within the same plan year and choose to re-enroll in TRS-ActiveCare, you must select the same plan option in which you were previously enrolled.</i></p>	<p>Your choice of: (1) your actively-at-work date (2) the first of the month following your actively-at-work date, or (3) the first of the month in which your TRS membership begins</p> <p><i>Premium is billed for the full month</i></p>	<p>The same date as the your effective date of coverage</p>	<p>No</p>
<p>As a covered employee you have a newborn child and choose to enroll: (1) your newborn only, or (2) your spouse only, or (3) your spouse and your newborn within 60 days after the date of birth...</p> <p>(No other dependents can be added at this time.)</p>		<p>The newborn's date of birth</p> <p><i>If only enrolling the newborn, premium is waived for the first calendar month if the date of birth is other than the first of the month</i></p> <p><i>If enrolling the spouse only or newborn and spouse, premium is billed for the full month</i></p>	<p>No (for the newborn)</p> <p>Yes (for the spouse, unless enrolling in an HMO option)</p>
<p>As an eligible, but not covered employee, you have a newborn child and choose to enroll: (1) yourself only, or (2) you and your spouse, or (3) you and your newborn, or (4) you, your spouse and your newborn within 60 days after the date of birth...</p> <p>(No other dependents can be added at this time.)</p>	<p>The newborn's date of birth</p> <p><i>Premium is billed for the full month</i></p>	<p>The newborn's date of birth</p> <p><i>Premium is billed for the full month</i></p>	<p>No (for the newborn)</p> <p>Yes (for the employee and spouse, unless enrolling in an HMO option)</p>
<p>As a covered employee, you adopt a child and choose to enroll: (1) your adopted child only, or (2) your spouse only, or (3) your spouse and your adopted child within 31 days after the date of adoption or the date on which the child to be adopted is placed with you...</p> <p>(No other dependents can be added at this time.)</p>		<p>The date of adoption or the date on which the child to be adopted is placed with you</p> <p><i>If only enrolling your adopted child, premium is waived for the first calendar month if the date of adoption is other than the first of the month</i></p> <p><i>If enrolling your spouse only or your adopted child and spouse, premium is billed for the full month</i></p>	<p>No (for the adopted child)</p> <p>Yes (for the spouse, unless enrolling in an HMO option)</p>
<p>As an eligible, but not covered employee, you adopt a child and choose to enroll: (1) yourself only, or (2) you and your spouse, or (3) you and your adopted child, or (4) you, your spouse, or your adopted child within 31 days after the date of adoption or the date on which the child to be adopted is placed with you...</p> <p>(No other dependents can be added at this time.)</p>	<p>The date of adoption or the date on which the child to be adopted is placed with you</p> <p><i>Premium is billed for the full month</i></p>	<p>The date of adoption or the date on which the child to be adopted is placed with you</p> <p><i>Premium is billed for the full month</i></p>	<p>No (for the adopted child)</p> <p>Yes (for the employee and spouse, unless enrolling in an HMO option)</p>

If ...	Your effective date is...	Your eligible dependent's effective date is...	The preexisting condition exclusion applies...
If you become a legal guardian of an eligible dependent within 31 days after the date the legal guardianship is granted...		The date the guardianship was granted <i>Premium is waived for the first calendar month if the date of the guardianship is other than the first of the month</i>	Yes <i>(unless enrolling in an HMO option)</i>
You add a court-ordered eligible dependent within 31 days after the district/entity receives notice of the court order or national medical support notice...		The date the participating district/entity receives notification of the court order or national medical support notice <i>Premium is waived for the first calendar month if the date of notification is other than the first of the month</i>	Yes <i>(unless enrolling in an HMO option)</i>
You add an eligible newborn grandchild or another newborn child who is in a regular parent-child relationship with you within 31 days after the date of birth...		The newborn's date of birth <i>Premium is waived for the first calendar month if the date of birth is other than the first of the month</i>	No
You add an eligible grandchild or another child who is in a regular parent-child relationship with you within 31 days after notifying the district/entity the child qualifies as a dependent...		First of the month following the date the participating district/entity receives notification that the child qualifies as a dependent	Yes <i>(unless enrolling in an HMO option)</i>
As a covered employee, you get married and choose to enroll: (1) your spouse only (2) your spouse's eligible children or (3) your spouse and your spouse's eligible children within 31 days after the date of marriage... (No other dependents can be added at this time.)		The first of the month following the date of marriage	Yes <i>(unless enrolling in an HMO option)</i>
As an eligible, but not covered employee, you get married and choose to enroll: (1) yourself only, or (2) you and your spouse, (3) you and your spouse's eligible children, or (4) you, your spouse, or your spouse's eligible children within 31 days after the date of marriage... (No other dependents can be added at this time.)	The first of the month following the date of marriage	The first of the month following the date of marriage	Yes <i>(unless enrolling in an HMO option)</i>
You make changes to coverage due to other special enrollment events within 31 days after the qualifying event...	The first of the month following the event date	The first of the month following the event date	Yes <i>(unless enrolling in an HMO option)</i>

When Coverage Ends

Your TRS-ActiveCare employee coverage will end:

- The last day of the month in which your employment ends
- The last day of the month in which you are no longer eligible for TRS-ActiveCare coverage (such as your TRS retirement date)
- When you stop paying the required premium contributions
- The last day of the month in which you enter into active, full-time military, naval, or air service except as provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) or other applicable law
- When the TRS-ActiveCare program is terminated.

A dependent's coverage will end:

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

When does coverage for a dependent child terminate?

Coverage for a dependent child terminates at the end of the month the child turns 25 or marries, whichever occurs first, unless eligible as a disabled dependent. If an unmarried child becomes eligible for TRS-ActiveCare coverage as an employee and is a contributing TRS member, the child's coverage will also terminate. Refer to page 32 of this booklet for information on how to apply for COBRA coverage for the dependent.

Promptly notify your Benefits Administrator

You should notify your Benefits Administrator to:

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

When coverage is terminated, benefits for expenses incurred after termination will not be available. If you receive benefits to which you are not entitled, refunds will be requested. Also remember to notify your Benefits Administrator if you or your dependents change address.

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

If you (or a covered dependent) enter into active, full-time military, naval, or air service, TRS-ActiveCare coverage will continue through the last day of the month in which you or your covered dependent entered into military service. You and any covered dependents will be eligible for COBRA coverage. The provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 or other provisions of state law may also apply to provide you and your dependents with continued coverage. Once you return to active employment and meet eligibility requirements, you can re-enroll for TRS-ActiveCare coverage within 31 days. If you return to active employment within the same plan year and choose to re-enroll in TRS-ActiveCare, you must select the same plan option in which you were previously enrolled. Preexisting conditions will **not** apply.

Continuation of TRS-ActiveCare Coverage (COBRA)

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

Events Qualifying for 18-Month Continuation

- Loss of eligibility due to reduction of employee work hours
- Voluntary employee termination including retirement (early or disability)
- Employee layoff for economic reasons, or
- Employee discharge, except for discharge for gross misconduct

Events Qualifying for 29-Month Continuation

- Loss of coverage by employee or dependent if determined by the Social Security Administration to be disabled at any time during the first 60 days after employment terminated or hours were reduced

Events Qualifying for 36-Month Continuation

- Death of an employee
- Divorce or legal separation of an employee, so long as the spouse was previously enrolled as a covered participant
- Employee becomes eligible for Medicare, leaving dependents without group medical coverage (as in the case of an employee who reaches age 65, retires, and begins Medicare coverage), or
- Children who lose coverage due to plan provisions (for example, reaching the maximum age)

Eligibility

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

How to Apply for COBRA

When your group coverage ends, you or your covered dependents have 60 days to elect continuation coverage through COBRA. You, your spouse, or dependent child must first notify your Benefits Administrator. You then will be provided with information on your COBRA rights, including forms and general information on the continuation option. Coverage will be made retroactive to the date of the qualifying event; however, all back premiums must be paid before coverage is effective.

When COBRA Coverage Ends

COBRA coverage ends if:

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

What is the cost for COBRA coverage?

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

Who administers COBRA coverage?

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

How to File a Medical Claim

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

Who files claims?

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

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

Benefit payments will be made directly to network or contracting providers when they bill Blue Cross and Blue Shield of Texas. Written agreements between Blue Cross and Blue Shield of Texas and other providers may require payment directly to them.

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

Need a claim form?

Network providers and ParPlan providers will file claims for you.

However, if you use a non-network provider for your medical care, you will need to complete a claim form available from your Benefits

Administrator or Customer Service. You can also download a claim form from the Web site by logging on to www.trs.state.tx.us/trs-activecare.

Instructions for completing and mailing the claim are on the form.

However, if the benefit payments are for claims from providers with no written agreement with Blue Cross and Blue Shield of Texas, Blue Cross and Blue Shield of Texas may choose to pay either you or your provider. If you receive payment from Blue Cross and Blue Shield of Texas, it will be your responsibility to settle your account with your provider.

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

To file a medical claim, follow these steps:

1

Get a claim form

Claim forms are available from your Benefits Administrator, or you can download a claim form from the Web site by logging on to www.trs.state.tx.us/trs-activecare. Use a separate claim form for each individual; do not combine expenses for family members on one claim form.

2

Complete the claim form

Complete all information requested on the claim form. Any missing information, especially the items listed below, will cause a delay in processing your claim.

- Patient's name
- Subscriber identification number, including the alpha prefix (ISD)
- Correct address
- Diagnosis (preferably indicated by your provider on an itemized bill)
- Date of injury, illness, or pregnancy
- Whether the patient has other group health insurance coverage

3

Attach an itemized bill

Attach an itemized bill to the completed claim form. An itemized bill includes the following information that is critical to prompt processing of your claim:

- Name and address of the provider providing the services or supplies
- Date of service
- Type of service
- Charges for each service
- Patient's name
- Diagnosis

Keep a copy of the claim form and itemized bills for your records.

4

Mail the claim form and itemized bills

Send the claim form and itemized bills to: Blue Cross and Blue Shield of Texas, P.O. Box 660044, Dallas, TX 75266-0044. (The address also appears on the form.)

Do not send the claim form to TRS. This will only delay processing.

5

You will receive an Explanation of Benefits (EOB) after the claim is processed

The EOB will confirm if the expense is covered by TRS-ActiveCare and is eligible for payment. If so, you or the provider will receive a check. If your claim is denied, the EOB will state the reasons why. *You must file and Blue Cross and Blue Shield of Texas must receive claims for expenses within 12 months after the date the expense is incurred.*

Receipt of Claims

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

Interpretation of TRS-ActiveCare Provisions

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

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

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

Review of Claim Determinations

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

If a Claim Is Denied or Not Paid in Full: On occasion, all or part of your claim may be denied. There are a number of reasons why the claim may be denied or not paid in full. First read the Explanation of Benefits and then review this booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the payment decision, call Customer Service at 1-866-355-5999 or write to Blue Cross and Blue Shield of Texas to request a review of the decision.

Request for Reconsideration of Claim Determination

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

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

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

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

You will be notified in writing of Blue Cross and Blue Shield of Texas' decision and the reasons for it within 60 days of Blue Cross and Blue Shield of Texas' receipt of the request for review. If you are not in agreement with the Blue Cross and Blue Shield of Texas decision, you may request a second medical review.

Appeal to the Teacher Retirement System (TRS)

In the event your Request for Reconsideration is denied by Blue Cross and Blue Shield of Texas in writing, you may further appeal to the Teacher Retirement System of Texas (your plan sponsor) at the address below:

TRS-ActiveCare Grievance Administrator

Teacher Retirement System of Texas

1000 Red River Street

Austin, TX 78701

The appeal must be submitted in writing and accompanied by supporting written documents. Your written appeal must be submitted by U.S. Mail and be postmarked or received by TRS within 60 days from the date of the Blue Cross and Blue Shield of Texas letter notifying you of their decision on your Request for Reconsideration. TRS has the discretion to make an administrative decision regarding your appeal or forward it to an appeal committee. Upon receipt of a written appeal, TRS will advise you of any procedures available to you under TRS Rules and Laws.

Subrogation, Reimbursement and Third Party Recovery Provision

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

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

The employee or covered person agrees to sign any documents requested by TRS-ActiveCare, including but not limited to reimbursement and/or subrogation agreements the plan or its agent(s) may request. Also, the employee or covered person agrees to furnish any

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

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

TRS has the sole authority to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. If the employee or covered person takes no action to recover any money from any source, the employee or covered person agrees to allow the plan to initiate its own direct action for reimbursement.

Coordination of Benefits

TRS-ActiveCare includes a Coordination of Benefits (COB) provision that determines how benefits will be paid when you or your dependent is covered by more than one group health plan. When you have other group medical coverage (through your spouse's employer, for example), your TRS-ActiveCare benefits may be combined with others to pay covered charges. The COB provision eliminates duplicate payments for the same medical expenses. TRS-ActiveCare does not currently coordinate benefits for the prescription drug program under ActiveCare 2 and 3 plans. Coordination of Benefits does not apply to any individual policy you may have.

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

How to determine which plan is primary

These rules usually decide which plan is primary:

- The plan without a COB provision is considered primary. If both plans have COB, then the plan covering the individual as an employee rather than a dependent is primary.
- If a child is covered under both parents' plans, the plan of the parent whose birth date is earlier in the calendar year is primary. If both parents have the same birthday, the plan which has covered one parent longer is primary. If the other plan does not have this provision regarding birthdays, then the rules in that plan determine the order of benefits.

- Dependent children of divorced or separated parents receive benefits payments in this order from the plan of the:
 - Parent with custody
 - Stepparent with custody
 - Parent without custody

The parent with financial responsibility for the child's health care expenses under a court decree is primary. The other parent's plan would be secondary. In the case of joint custody with no specific requirements to provide health care expenses, the birthday rule as described above would apply.

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

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

How are COB benefits paid?

TRS-ActiveCare will pay the difference between the allowable amount and the benefit paid by the primary plan, not to exceed the amount TRS-ActiveCare would have paid in the absence of any other coverage.

How is the primary plan determined between a husband and wife?

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

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

Web Site Features

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

The chart below highlights online capabilities and features for TRS-ActiveCare participants. **To access online information, go to www.trs.state.tx.us/trs-activecare, select Medical and Pharmacy Benefits, then select the plan's Web site. Many of the most frequently requested features appear directly on the TRS-ActiveCare home page.**

Teacher Retirement System of Texas (TRS)	ActiveCare 1, ActiveCare 2 and ActiveCare 3 Blue Cross and Blue Shield of Texas and Medco Health	
Health Benefits	Health Benefits	Pharmacy Benefits
Provider Locator	Provider Finder	Pharmacy Benefits
Frequently Asked Questions	Enrollment Guide	Retail Pharmacy Locator
Enrollment Guide	Plan Comparison Tutorial	Drug Name Search
Enrollment Application and Change Form	Forms	Copays
Application Tutorial	Benefits Booklet	What are Possible Alternatives
	Healthy Living Information	Preferred Drug List
	Blue Access for Members (view claims)	View Formulary Alternatives
	Contact Information	

Blue Access for Members

With Blue Access for Members you can:

- check the status of a claim
- confirm who is covered under your plan
- view an explanation of medical benefits
- receive an e-mail when a claim is finalized

You and your dependents will also find practical, useful health and wellness information – whether you want to improve your overall health, manage a chronic health condition or prepare for a specific medical treatment.

Log onto www.trs.state.tx.us/trs-activecare. Click on "Medical Benefits," then under ActiveCare 1, 2, 3, click on "Medical administered by Blue Cross and Blue Shield of Texas," then "Blue Access."

The first time you log onto the site, you'll need your group and identification numbers (found on your TRS-ActiveCare ID card) to create a user ID. Then, for your added security, a password will be mailed to your home. This password will give you immediate, confidential access to your benefits information.

Visit Blue Access during these hours:
 6 a.m. to 3 a.m., Monday through Friday
 6 a.m. to 3 p.m., Saturday
 Not available Sundays and holidays

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

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

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

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

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

Creditable Coverage: Prior health coverage under various plans including, but not limited to, group health plans, individual health policies, Medicare, and Medicaid.

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

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

Deductible: The amount of out-of-pocket expense that must be paid for health care services by the covered person before becoming payable by the health plan.

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

- The drug or device has not received U.S. Food and Drug Administration approval both for marketing and as safe and efficacious at the time the drug or device is furnished; or
- The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or

- Reliable Evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy compared with the standard means of treatment or diagnosis; or
- Reliable Evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trails are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

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

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

Hospital: A short-term acute care facility which:

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

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

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

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

Participant: A person who is covered by TRS-ActiveCare.

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

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

Residential Treatment Center for Children and Adolescents: An institution appropriately licensed and accredited by the Joint Commission on Accreditation of Health Care Organizations or the American Association of Psychiatric Services for Children and/or is approved by Blue Cross and Blue Shield of Texas or INROADS Behavioral Health Services as a residential treatment center for certain mental health care services for emotionally disturbed children and adolescents.

Special Enrollment Event: An event as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or applicable state law that may provide a special enrollment period for individuals and dependents when there is a loss of other coverage or a gain of additional dependents.

Substance Abuse Facility: An institution which provides a program for the treatment of chemical dependency following a written treatment plan approved and monitored by a physician affiliated with a hospital under a contractual agreement with an established system for patient referral.

Any such facility must be licensed, certified, or approved as a chemical dependency treatment center by the appropriate state agency and be accredited by the Joint Commission on Accreditation of Health Care Organizations.

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

Health Insurance Portability and Accountability Act

In 1996 Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA impacts group health plans by improving the availability and portability of health coverage. HIPAA also requires that group health plan participants be given the following notices.

Notice of 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.

Notice of Preexisting Condition Exclusion

Under HIPAA, a "preexisting condition" is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date in a health plan.

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.

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 evidence of creditable coverage.

For further information, contact your district/entity's Benefits Administrator.

Women's Health and Cancer Notice

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

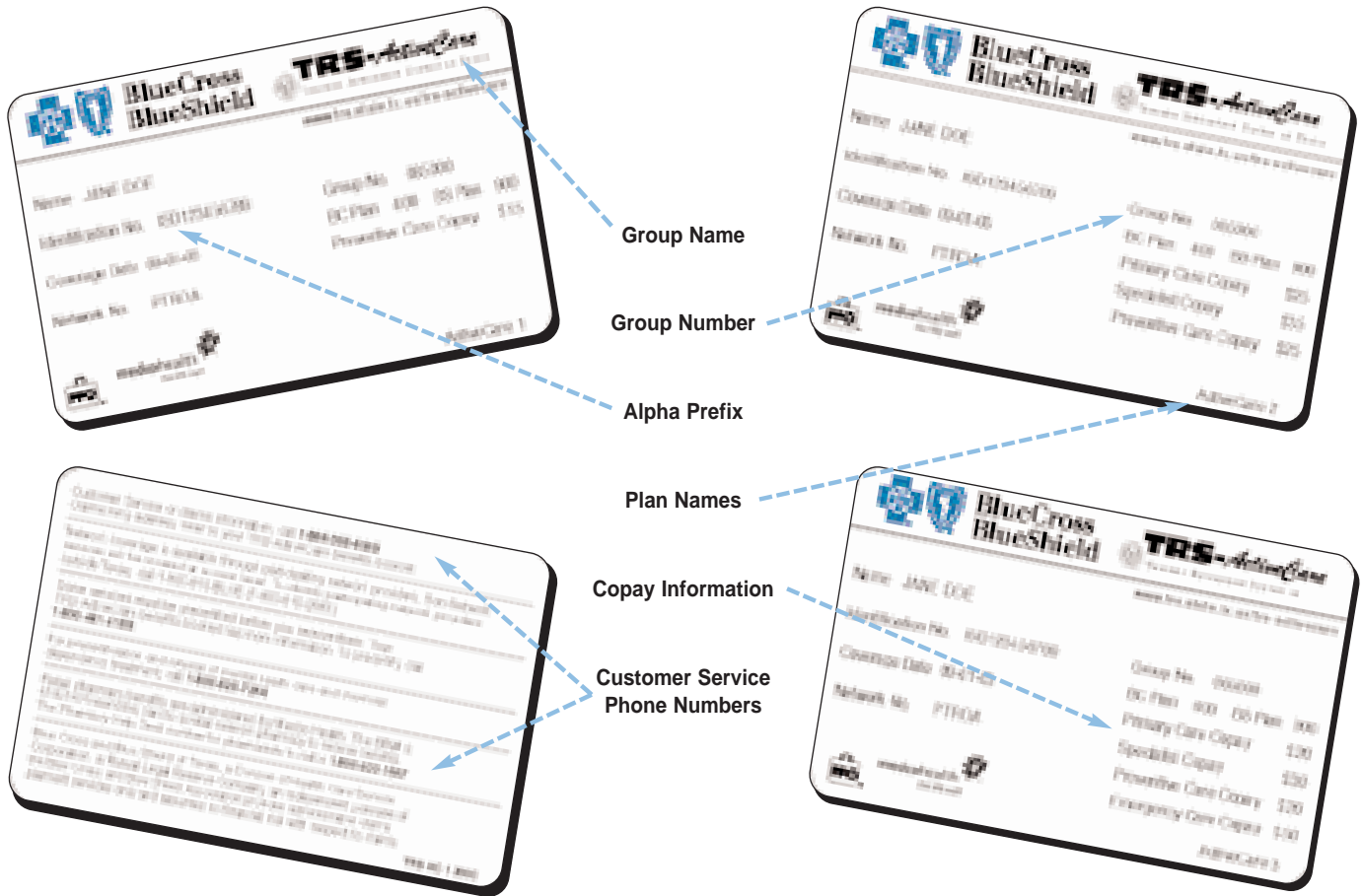
In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

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

**Under TRS-ActiveCare coverage, you have 60 days after the date of birth to add coverage for a newborn child.*

SAMPLE ID CARDS



Important Phone Numbers

Customer Service

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

Precertification

1-800-441-9188
 7:30 a.m. - 8 p.m. (Central Time)
 Monday through Friday

INROADS® Behavioral Health

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

BlueCard PPO Access

1-800-810-BLUE (2583)
 24 hours, seven days a week

Web Site

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