



TRS-ActiveCare

benefits booklet

Everything you need to know about
**ActiveCare 1-HD, Select,
and 2 Health Plans**

Effective September 1, 2016



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Meeting Your Health Care Needs

TRS-ActiveCare provides health care coverage for 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. This booklet may be updated as needed throughout the plan year, please always refer to current version on the TRS-ActiveCare website for the latest edition. If you have questions, please feel free to call the TRS-ActiveCare Customer Service at 1-800-222-9205, refer to the website, or contact your [Benefits Administrator](#).

Important Phone Numbers

Customer Service

1-800-222-9205
Option 4 for Spanish
8 a.m. – 6 p.m. (Central Time)
Monday – Friday
1-800-628-3323 – TTY Number

Wait until option for Healthcare Professional has passed, then press:

Aetna Medical Customer Service, Option 1

Caremark Pharmacy, Option 2

Nurse Care Advocate Team: Option 3

Medical questions

Beginning Right

Condition Management

Behavioral Health, Option 4

Health concierge, Option 5

Websites

www.trs.texas.gov
www.trsactivecare.aetna.com
www.caremark.com/trsactivecare

Beginning Right Maternity Program

1-800-272-3531

24/7 Nurse Line

1-800-556-1555

Precertification

1-800-222-9205

Teladoc

1-800-teladoc (835-2362)

Open 24/7/365

Aetna

PO Box 981106

El Paso, TX 79998-1106

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

TRS-ActiveCare is administered by Aetna. Aetna provides claims payment services only and does not assume any financial risk or obligation with respect to claims. Prescription drug benefits are administered by Caremark. TRS has complete financial liability for the payment of benefits under this plan.

Read This First

What's New

- Visit the TRS-ActiveCare website –www.trsactivecare.aetna.com– to learn about great tools that will save you money!
- The pharmacy deductible, copays and coinsurance will count toward the medical Out-of-Pocket maximums for all the Aetna ActiveCare Plans.
- Out-of-Pocket expenses represent your cost share after the plan pays. There is an increase in the Out-of-Pocket maximums for the 2016-2017 plan year.
- ActiveCare 1-HD: Individual maximum is \$6,550 and Family maximum is \$13,100. There is now an Out-of-Pocket maximum at the individual level as well.
- ActiveCare 2, ActiveCare Select and Select with Aetna Whole Health : Individual maximum is \$6,850 and Family maximum is \$13,700
- All newborns must now enroll for coverage within 31 days of birth to be active in the Aetna ActiveCare plans. This new timeframe applies to all plans. You **must** complete and submit an enrollment form within the appropriate time period to add coverage for newborns and other new dependents, **even if you already have family or children coverage.**
- If a current employee transitions into full-time status (e.g., from an active employee working a minimum of 10 regularly scheduled hours or more per week, to an active contributing employee) during the plan year, the employee will now have a 31-day opportunity to enroll in TRS-ActiveCare. If your district participates in a Cafeteria 125 plan, check with your benefits administrator for eligibility rules.
- For the ActiveCare 1-HD plan, deductible and co-insurance will be waived for medications listed on the new Generics Only Preventive Therapy Drug List published by the Internal Revenue Service (IRS). This list of drugs is posted on the Aetna member website and Caremark website. The list is maintained by the IRS and may change from time to time.

Important

- TRS-ActiveCare is **not** subject to the Employee Retirement Income Security Act (ERISA), a federal law that sets minimum standards for most voluntarily established health plans in private industry.
- **TRS-ActiveCare is a self-funded health coverage plan, not an insurance policy.** That means the premiums collected must cover the cost of benefits utilized. It's your money...spend it wisely.
- **Do not depend on others to manage your coverage.** You are responsible for the decisions you make and for complying with the TRS-ActiveCare plan rules. If you have questions, refer to the website or call Customer Service.
- **Appeals are handled by Aetna and Caremark, and if appropriate, by an external review organization.** Remember, TRS-ActiveCare is not an insurance policy, so appeals are not handled by the Texas Department of Insurance. See page 91 for more information on medical appeals and page 67 for more information on appeals for prescription drug benefits.
- **In the absence of any benefit not specifically listed in this booklet,** TRS-ActiveCare defaults to the standard processing guidelines and policies of Aetna for claims administration.

- **Don't assume anything.** Refer to this booklet or call Customer Service if you have any questions about your coverage.
- If you enrolled in one of the ActiveCare Select with Aetna Whole Health plans (ACOs), you will receive a new "Gold" ID card. The Gold Card will alert providers that you are in an Aetna Whole Health plan.
- This plan **does not** pay for every medical or drug expense you may incur. You may be responsible for a share of the cost, so be an informed consumer. Read this booklet carefully. Refer to the website or call Customer Service with questions before you make health care decisions.
- Thousands of prescription drugs are covered by TRS-ActiveCare, but **some exclusions and limitations may apply** under the TRS-ActiveCare plan. Check the website or call Customer Service for specific drug coverage information.
- Some drug therapies may require a conversation between your doctor and Caremark, the pharmacy benefit manager for TRS-ActiveCare. You can check on many of these drugs on the TRS-ActiveCare website under "Prescription Management Programs" or call Customer Service.
- If you selected ActiveCare 1-HD or ActiveCare 2 and you use an out-of-network provider, regardless of the circumstances, you may have to pay more than the usual deductible and coinsurance amounts.
- If you enroll in an ActiveCare Select Plan, you will be placed in an Aetna Whole Health Select Plan if you live in one of the designated counties and must use the providers attached to their network. If not, you will be placed in the ActiveCare Select Plan not attached to an Aetna Whole Health Network.
- If you selected the ActiveCare Select Plan (Aetna Whole Health or Open Access Select), there are no out-of-network benefits except for emergency services.
- Some providers (such as radiologists, pathologists, anesthesiologists, neonatologists, ER physicians, etc.) may work at network hospitals but do not contract with any provider networks. These providers often charge more than TRS-ActiveCare will pay. You will be responsible for charges exceeding the Aetna Allowed Amount.
- You or your provider must submit and Aetna 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 Aetna within this 12-month period will not be considered for payment of benefits.
- To receive the additional 11 months of COBRA continuation coverage when the Social Security Administration (SSA) determines you are disabled, you must notify your plan administrator (Health Care Service Corporation/Aetna) before the end of the 18-month period of COBRA continuation coverage.



ActiveCare 1-HD Benefits Summary

General Plan Provisions	Annual	Individual	Family
	<u>Deductible</u>	\$2,500	\$5,000 (Employee and spouse and/or family)
	Out-of-Pocket Maximum (per <u>plan year</u> , includes medical and pharmacy deductible, <u>copay</u> and <u>coinsurance</u>)	\$6,550	\$13,100
	Lifetime Maximum Benefit	Unlimited	
Benefit Levels			
Preventive Services	When using network physicians, benefits for certain age-specific and gender-specific preventive care services are paid at 100%. The deductible will be waived; however covered services under this benefit must be billed by the doctor as “preventive care.” Preventive care visits—network or out-of-network—are limited to one physical exam per plan year; one OB/GYN well-woman exam per plan year; and one routine mammogram per plan year. See pages 30-53 for more information on covered services.		
	Benefit Categories	In-Network	Out-of-Network
	Routine Annual Physical age 12 and over Immunizations Well-child care unlimited up to age 12 Well woman exam & pap smear age 18 & over Routine mammograms <i>(Plan limit: 1 every year age 35 and over)</i> Routine colonoscopies <i>(Plan limit1 every 10 years, age 50 and over)</i> Bone density screening <i>(Plan limit: age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors)</i> Screening for prostate cancer <i>(Plan limit: 1 per year age 50 and over,40 and over if there is family history)</i> Smoking cessation counseling services <i>(Plan limit: 8 visits per 12 months)</i> Healthy diet/Obesity screening/ Counseling <i>(Plan limit: Ages 0-21 no limit, Age 22 & over 26 visits per 12 months)</i> Female sterilization procedures Female contraception Breastfeeding support, services, supplies <i>(Plan limit: 6 lactation counseling visits per 12 months; Electric breast pumps – 2 per calendar year)</i>	Plan pays 100% (deductible waived)	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Routine eye exam (one per plan year)	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Hearing exam		

ActiveCare 1-HD Benefits Summary

Physician and Lab services	Doctor office visits (includes most injections, diagnostic X-rays and lab tests) Walk in clinics Urgent Care Centers	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Teladoc (per consult, per member) See page 53 for more details	Consult fee of \$40 applies to deductible. After deductible, plan pays 80%; you pay 20%.	N/A
	Allergy injections	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Office surgery	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Outpatient surgery		
	Maternity Care (doctor charges only; see Hospital/Facility Services for inpatient charges)		
	Prenatal Care	100% coverage, no deductible	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Inpatient doctor visits	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	High-tech radiology (CT scan, MRI, nuclear medicine, etc.) (preauthorization required)	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
Hospital/Facility Services	Bariatric surgery (per person, per procedure for surgeon charges only; services must be performed at IOQ facility)	\$5,000 copay plus 20% after deductible (in addition to applicable inpatient and outpatient copays, deductible and coinsurance for the hospital/facility charges)	Not covered
	Inpatient hospital (semi-private room and board or intensive care unit; preauthorization required)	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Outpatient surgery		
	Outpatient hospital/facilities		
	Emergency room care for an accident or onset of a medical emergency		
	Emergency room care for all other conditions		
Extended Care Service	Skilled nursing facility (25 days per plan year maximum; preauthorization required)	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Home health care (60 visits per plan year maximum)		
	Hospice		

ActiveCare 1-HD Benefits Summary

Other Medical Services	Physical therapy - Office visit - All other services	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Chiropractic care (up to 35 visits per plan year) - Office visits - All other services		
	Home Infusion Therapy (preauthorization required)		
	Hearing aids (up to \$1,000 paid per 36-month period)	After deductible, plan pays 80%; you pay 20%	
	Durable medical equipment	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Prosthetics		
	Ambulance services (ground or air when medically necessary)	After deductible, plan pays 80% of the allowed amount; you pay the remaining 20% plus any charges exceeding the allowed amount billed by out-of-network providers	
Behavioral Health (Mental Health and Chemical Dependency)			
Mental Health (preauthorization required for all inpatient services and some outpatient; see page 23)			
Mental Health	Inpatient facility	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Inpatient physician charges		
	Outpatient/office visits		
Chemical Dependency (preauthorization required for all inpatient services and some outpatient; see page 23)			
Chemical Dependency	Inpatient facility	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Inpatient physician charges		
	Outpatient/office visits		
Serious Mental Illness (preauthorization required for all inpatient services and some outpatient; see page 23)			
Serious Mental Illness	Inpatient facility	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Inpatient physician		
	Outpatient/office visit		

ActiveCare 1-HD Benefits Summary

Prescription Drugs			
Prescription Drugs	Deductible (per person, per plan year)	Subject to plan year deductible for all medical and prescription benefits	
	Retail Short-Term (up to a 31-day supply) <ul style="list-style-type: none"> - Generic - Preferred brand - Non-preferred brand 	After deductible, plan pays 80%; you pay 20% (deductible and coinsurance waived for certain generic preventive drugs. Go to www.trsactivecareetna.com/coverage to view the list).	You pay 100% of the full cost at the time of purchase, and after the deductible is met, you will be reimbursed 80% of the allowed amount as determined by Caremark (must submit claim to Caremark within 12 months of service date to be reimbursed)
	Mail Order Pharmacy (up to a 60-90 day supply) <ul style="list-style-type: none"> - Generic - Preferred brand - Non-preferred brand - Specialty medications 	After deductible, plan pays 80%; you pay 20% (deductible and coinsurance waived for certain generic preventive drugs. Go to www.trsactivecareetna.com/coverage to view the list).	N/A
	Retail-Plus Network (60-90 day supply at Retail-Plus participating pharmacies) <ul style="list-style-type: none"> - Generic - Preferred brand - Non-preferred brand 		

ActiveCare Select Benefits Summary

General Plan Provisions	Annual	Individual	Family
	<u>Deductible</u>	\$1,200	\$3,600 (Employee and spouse and/or family)
	Out-of-Pocket Maximum (per <u>plan year</u> , includes medical and pharmacy deductible, <u>copay</u> , and <u>coinsurance</u>)	\$6,850	\$13,700
	Lifetime Maximum Benefit	Unlimited	
Benefit Levels			
Preventive Services	When using network physicians, benefits for certain age-specific and gender-specific preventive care services are paid at 100%. No copayment is required; however, covered services under this benefit must be billed by the doctor as “preventive care.” Preventive care visits—network or out-of-network—are limited to one physical exam per plan year; one OB/GYN well-woman exam per plan year; and one routine mammogram per plan year. See pages 30-53 for more information on covered services. Plan <u>Participants covered under the ActiveCare Select Plan do not have coverage for non-network providers unless the claim is <u>emergency</u> related or a prior approval was authorized.</u>		
	Benefit Categories		In-Network
	Routine Annual Physical age 12 and over Immunizations Well-child care unlimited up to age 12 Well woman exam & pap smear age 18 & over Routine mammograms <i>(Plan limit: 1 every year age 35 and over)</i> Routine colonoscopies <i>(Plan limit1 every 10 years, age 50 and over)</i> Bone density screening <i>(Plan limit: age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors)</i> Screening for prostate cancer <i>(Plan limit: 1 per year age 50 and over,40 and over if there is family history)</i> Smoking cessation counseling services <i>(Plan limit: 8 visits per 12 months)</i> Healthy diet/Obesity screening/ Counseling <i>(Plan limit: Ages 0-21 no limit, Age 22 & over 26 visits per 12 months)</i> Female sterilization procedures Female contraception Breastfeeding support, services, supplies <i>(Plan limit: 6 lactation counseling visits per 12 months; Electric breast pumps – 2 per calendar year)</i>	Plan pays 100% (no copay required)	
	Routine eye exam (one per plan year)	\$30 copay for primary	
	Hearing exam	\$60 copay for specialists	

ActiveCare Select Benefits Summary

Physician and Lab services	Doctor office visits (includes most injections, diagnostic X-rays and lab tests) Walk in clinics	\$30 copay for primary \$60 copay for specialists
	Urgent Care Centers	\$50 copay per visit
	Teladoc (per consult, per member) See page 53 for more details	Copay waived. Plan pays 100%
	Allergy injections	After deductible, plan pays 80%; you pay 20%
	Office surgery	After deductible, plan pays 80%, you pay 20%
	Outpatient surgery	
	Maternity Care (physician fees only) (Hospital/Facility copays and coinsurance described in section below)	For delivery, after deductible, plan pays 80% and you pay 20%)
	Prenatal Care	100% coverage, no deductible
	Inpatient doctor visits	After deductible, plan pays 80%; you pay 20%
	Inpatient hospital (physician/surgeon fees)	Plan pays 80%, you pay 20% after deductible
	High-tech radiology (CT scan, MRI, nuclear medicine, etc.) (preauthorization required) (Copay waived if performed in an emergency room or if admitted.)	After \$100 copay per service, plan pays 80%; you pay 20% after deductible.
	Bariatric surgery	Not covered
Hospital/Facility Services	Inpatient hospital (semi-private room and board or intensive care unit; preauthorization required)	After \$150 copay per day (\$750 maximum copay per admission), plan pays 80%; you pay 20% after deductible
	Outpatient surgery (there are limited situations, based on the diagnosis and service codes billed by the provider, where outpatient surgery is only subject to your deductible and coinsurance)	After \$150 copay per visit, plan pays 80%, you pay 20% after deductible
	Outpatient hospital/facilities	After deductible, plan pays 80%, you pay 20%
	Emergency room care for an accident or onset of a medical emergency	After \$150 copay per visit, plan pays 80%, you pay 20% after deductible (copay waived if admitted)
	Emergency room care for all other conditions	After \$150 copay per visit, plan pays 80%, you pay 20% after deductible
Extended Care Service	Skilled nursing facility (25 days per plan year maximum; preauthorization required)	After deductible, plan pays 80%; you pay 20%
	Home health care (60 visits per plan year maximum)	
	Hospice	

ActiveCare Select Benefits Summary

Other Medical Services	Physical therapy - Office visit - All other services	- \$60 copay for specialist - After deductible plan pays 80%, you pay 20%
	Chiropractic care (up to 35 visits per plan year) - Office visits - All other services	- \$60 copay for specialist - After deductible plan pays 80%, you pay 20%
	Home Infusion Therapy (preauthorization required)	After deductible, plan pays 80%, you pay 20%
	Hearing aids (up to \$1,000 paid per 36-month period)	After deductible, plan pays 80%; you pay 20%
	Durable medical equipment Prosthetics	After deductible, plan pays 80%; you pay 20%
	Ambulance services (ground or air when medically necessary)	After deductible, plan pays 80% of the allowed amount; you pay the remaining 20% plus any charges exceeding the allowed amount billed by out-of-network providers
Behavioral Health (Mental Health and Chemical Dependency)		
Mental Health (preauthorization required for all inpatient services and some outpatient; see page 23)		
Mental Health	Inpatient facility (\$2,250 maximum copay per plan year for network and out-of-network benefits combined)	After \$150 copay per day (\$750 maximum copay per admission), plan pays 80%; you pay 20% after deductible
	Inpatient physician charges	After deductible, plan pays 80%; you pay 20%
	Outpatient	
	Office visits	\$30 copay for primary \$60 copay for specialist
Chemical Dependency (preauthorization required for all inpatient services and some outpatient; see page 23)		
Chemical Dependency	Inpatient facility (\$2,250 maximum copay per plan year for network and out-of-network benefits combined)	After \$150 copay per day (\$750 maximum copay per admission), plan pays 80%; you pay 20% after deductible
	Inpatient physician charges	After deductible, plan pays 80%; you pay 20%
	Outpatient	
	Office visits	\$30 copay for primary \$60 copay for specialist
Serious Mental Illness (preauthorization required for all inpatient services and some outpatient; see page 23)		
Serious Mental Illness	Inpatient facility (\$2,250 maximum copay per plan year for network and out-of-network benefits combined)	After \$150 copay per day (\$750 maximum copay per admission), plan pays 80%; you pay 20% after deductible
	Inpatient physician	After deductible, plan pays 80%; you pay 20%
	Outpatient	
	Office visit	\$30 copay for primary \$60 copay for specialist

ActiveCare Select Benefits Summary

Prescription Drugs*		
Prescription Drugs	Deductible (per person, per plan year)	\$0 for generic drugs, \$200 per individual for brand-name drugs
	Retail Short-Term (up to a 31-day supply) - Generic - Preferred brand - Non-preferred brand	\$20 copay \$40 copay 50% coinsurance
	Retail Maintenance (after first fill, up to a 31-day supply) - Generic - Preferred brand - Non-preferred brand	\$35 copay \$60 copay 50% coinsurance
	Mail Order Pharmacy (up to a 60-90 day supply) - Generic - Preferred brand - Non-preferred brand - Specialty medications	\$45 copay \$105 copay 50% coinsurance 20% coinsurance per fill
	Retail-Plus Network (60-90 day supply at Retail-Plus participating pharmacies) - Generic - Preferred brand - Non-preferred brand	\$45 copay \$105 copay 50% coinsurance

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

* If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug. This amount does not count toward the \$200 drug deductible for brand-name drugs.

ActiveCare 2 Benefits Summary

General Plan Provisions	Annual	Individual	Family
	Deductible	\$1,000	\$3,000 (Employee and spouse and/or family)
	Out-of-Pocket Maximum (per plan year , includes medical and pharmacy deductible, copay (excluding bariatric) , and coinsurance)	\$6,850	\$13,700
	Lifetime Maximum Benefit	Unlimited	
Benefit Levels			
Preventive Services	When using network physicians, benefits for certain age-specific and gender-specific preventive care services are paid at 100%. No copayment is required; however, covered services under this benefit must be billed by the doctor as “preventive care.” Preventive care visits—network or out-of-network—are limited to one physical exam per plan year; one OB/GYN well-woman exam per plan year; and one routine mammogram per plan year. See pages 30-53 for more information on covered services.		
	Benefit Categories	In-Network	Out-of-Network
	Routine Annual Physical age 12 and over Immunizations Well-child care unlimited up to age 12 Well woman exam & pap smear age 18 & over Routine mammograms <i>(Plan limit: 1 every year age 35 and over)</i> Routine colonoscopies <i>(Plan limit1 every 10 years, age 50 and over)</i> Bone density screening <i>(Plan limit: age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors)</i> Screening for prostate cancer <i>(Plan limit: 1 per year age 50 and over,40 and over if there is family history)</i> Smoking cessation counseling services <i>(Plan limit: 8 visits per 12 months)</i> Healthy diet/Obesity screening/ Counseling <i>(Plan limit: Ages 0-21 no limit, Age 22 & over 26 visits per 12 months)</i> Female sterilization procedures Female contraception Breastfeeding support, services, supplies <i>(Plan limit: 6 lactation counseling visits per 12 months; Electric breast pumps – 2 per calendar year)</i>	Plan pays 100% (no copay required)	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Routine eye exam (one per plan year)	\$30 copay for primary \$50 copay for specialists	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Hearing exam		

ActiveCare 2 Benefits Summary

Physician and Lab services	Doctor office visits (includes most injections, diagnostic X-rays and lab tests) Walk in clinics	\$30 copay for primary \$50 copay for specialists	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Urgent Care Centers	\$50 copay per visit	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Teladoc (per consult, per member) See page 53 for more details	Copay waived. Plan pays 100%	N/A
	Allergy injections	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Office surgery	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Outpatient surgery	After deductible, plan pays 80%, you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Maternity Care (physician fees only) (Hospital/Facility copays and coinsurance described in section below)	For initial visit only; for delivery, after deductible, plan pays 80% and you pay 20%)	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Prenatal Care	100% coverage, no deductible	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Inpatient doctor visits	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	High-tech radiology (CT scan, MRI, nuclear medicine, etc.) (preauthorization required) (Copay waived if performed in an emergency room or if admitted.)	After \$100 copay per service, plan pays 80%; you pay 20% after deductible	After \$100 copay per service, plan pays 60%; you pay 40% after deductible
	Bariatric surgery (per person, per procedure for surgeon charges only; copay does not apply to plan year deductible or to out-of-pocket maximum; services must be performed at IOQ facility)	\$5,000 copay plus 20% after deductible (in addition to applicable inpatient and outpatient copays, deductible and coinsurance for the hospital/facility charges)	Not covered

ActiveCare 2 Benefits Summary

Hospital/Facility Services	Inpatient hospital (semi-private room and board or intensive care unit; preauthorization required) \$2,250 maximum copay per plan year for network and out-of-network benefits combined	After \$150 copay per day (\$750 maximum copay per admission), plan pays 80%; you pay 20% after deductible	After \$150 copay per day (\$750 maximum copay per admission), plan pays 60%; you pay 40% of the allowed amount after deductible
	Outpatient surgery (there are limited situations, based on the diagnosis and service codes billed by the provider, where outpatient surgery is only subject to your deductible and coinsurance)	After \$150 copay per visit, plan pays 80%, you pay 20% after deductible	After \$150 copay per visit, plan pays 60%, you pay 40% of the allowed amount after deductible
	Outpatient hospital/facilities	After deductible, plan pays 80%, you pay 20%	After deductible, plan pays 60%, you pay 40% of the allowed amount
	Emergency room care for an accident or onset of a medical emergency	After \$150 copay per visit, plan pays 80%, you pay 20% after deductible (copay waived if admitted)	
	Emergency room care for all other conditions	After \$150 copay per visit, plan pays 80%, you pay 20% after deductible	After \$150 copay per visit, plan pays 60%, you pay 40% of the allowed amount after deductible
Extended Care Service	Skilled nursing facility (25 days per plan year maximum; preauthorization required)	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Home health care (60 visits per plan year maximum)		
	Hospice		
Other Medical Services	Physical therapy - Office visit - All other services	- \$50 copay for specialist - After deductible plan pays 80%, you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Chiropractic care (up to 35 visits per plan year) - Office visits - All other services	- \$50 copay for specialist - After deductible plan pays 80%, you pay 20%	
	Home Infusion Therapy (preauthorization required)	After deductible, plan pays 80%, you pay 20%	
	Hearing aids (up to \$1,000 paid per 36-month period)	After deductible, plan pays 80%; you pay 20%	
	Durable medical equipment	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Prosthetics		
	Ambulance services (ground or air when medically necessary)	After deductible, plan pays 80% of the allowed amount; you pay the remaining 20% plus any charges exceeding the allowed amount billed by out-of-network providers	

ActiveCare 2 Benefits Summary

Behavioral Health (Mental Health and Chemical Dependency)			
Mental Health (preauthorization required for all inpatient services and some outpatient; see page 23)			
Mental Health	Inpatient facility (\$2,250 maximum copay per plan year for network and out-of-network benefits combined)	After \$150 copay per day (\$750 maximum copay per admission), plan pays 80%; you pay 20% after deductible	After \$150 copay per day (\$750 maximum copay per admission), plan pays 60%; you pay 40% of the allowed amount after deductible
	Inpatient physician charges	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Outpatient		
	Office visits	\$30 copay for primary \$50 copay for specialist	
Chemical Dependency (preauthorization required for all inpatient services and some outpatient; see page 23)			
Chemical Dependency	Inpatient facility (\$2,250 maximum copay per plan year for network and out-of-network benefits combined)	After \$150 copay per day (\$750 maximum copay per admission), plan pays 80%; you pay 20% after deductible	After \$150 copay per day (\$750 maximum copay per admission), plan pays 60%; you pay 40% of the allowed amount after deductible
	Inpatient physician charges	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Outpatient		
	Office visits	\$30 copay for primary \$50 copay for specialist	
Serious Mental Illness (preauthorization required for all inpatient services and some outpatient; see page 23)			
Serious Mental Illness	Inpatient facility (\$2,250 maximum copay per plan year for network and out-of-network benefits combined)	After \$150 copay per day (\$750 maximum copay per admission), plan pays 80%; you pay 20% after deductible	After \$150 copay per day (\$750 maximum copay per admission), plan pays 60%; you pay 40% of the allowed amount after deductible
	Inpatient physician	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the allowed amount
	Outpatient		
	Office visit	\$30 copay for primary \$50 copay for specialist	

Prescription Drugs*			
Prescription Drugs	Deductible (per person, per plan year)	\$0 for generic drugs, \$200 per individual for brand-name drugs	
	Retail Short-Term (up to a 31-day supply) - Generic - Preferred brand - Non-preferred brand	\$20 copay \$40 copay \$65 copay	You will be reimbursed the allowed amount as determined by Caremark for the amount that would have been charged by a network pharmacy less the required copay after the drug deductible is met (Must submit claim to Caremark within 12 months of service date to be reimbursed)
	Retail Maintenance (after first fill, up to a 31-day supply) - Generic - Preferred brand - Non-preferred brand	\$35 copay \$60 copay \$90 copay	
	Mail Order Pharmacy (up to a 60-90 day supply) - Generic - Preferred brand - Non-preferred brand - Specialty medications	\$45 copay \$105 copay \$180 copay \$200 per fill up to 31-day supply; \$450 per fill 32-90-day supply	N/A
	Retail-Plus Network (60-90 day supply at Retail-Plus participating pharmacies) - Generic - Preferred brand - Non-preferred brand	\$45 copay \$105 copay \$180 copay	

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

* If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug. This amount does not count toward the \$200 drug deductible for brand-name drugs.

What Type of Plans Are Offered Through TRS-ActiveCare?

ActiveCare 1-HD

ActiveCare 1-HD is a high deductible Health Plan plan (HDHP). HDHP medical plans are governed by Internal Revenue Service (IRS) regulations. The IRS sets deductible and out-of-pocket maximum limits each year for a medical plan to qualify as a HDHP. **New this year:** The ActiveCare 1-HD out-of-pocket maximum will work the same as the maximum in other plan options. That is, it will apply to each covered person individually. The individual out-of-pocket maximum only includes covered expenses incurred by that individual. After a covered person meets his/her individual out-of-pocket maximum, the plan pays 100% of the benefits for that person. The plan will pay 80% for all other covered family members until the family OOP maximum is met.

In an HDHP, a family can combine all of their medical expenses together to meet the \$5000 deductible or one person in the family could meet the \$5000 deductible.

This plan is designed to pay for services after the plan deductible has been met. Preventive services, certain eligible generic preventive medications and prenatal care are covered at 100% even before deductible is met when services are rendered by an in-network provider. Participants are not required to select a PCP and referrals are not required. This plan has in and [out-of-network](#) benefits. Using a network provider will help you maximize your benefits and save you money. Using an out-of-network provider can have a significant impact on your finances. It will increase your out-of-pocket costs and the provider may bill you for balances not paid by your insurance plan.

Aetna Select Plan(s)

There are two distinct Aetna Select Plans, Aetna Whole Health and Open Access Select. There are four regional networks within the Aetna whole Health plan and one limited nationwide network for the Aetna Select (Open Access) plan. Where you live determines which network you will be in. Participants who enroll in ActiveCare Select and live in an area with one of the four *regional* networks, will receive health care through the providers in that regional network. It is important to remember that there is no coverage for out of network providers, except for a true medical emergency in an emergency room setting. Staying in your network saves you from higher out-of-pocket health costs.

Note: Using an out-of-network facility or provider, *even in an emergency situation*, will increase your financial liability. The plan only allows 80% of a **reduced** allowable amount for out-of-network providers.

Aetna Select/Aetna Whole Health

The Aetna Select/Aetna Whole Health plan is offered to participants residing in specific major metropolitan counties. It is a participant-centered approach that may differ from care you have had in the past. Aetna Whole Health is supported by an Accountable Care Network. When searching for providers in DocFind, choose the ActiveCare Select/Aetna Whole Plan based on where you live.

With Aetna Whole Health you have a health care team of doctors, nurses, therapists, and other providers whose goal is to work with you to meet your unique needs and keep you healthy. This plan is designed to enhance the patient

experience. It offers collaboration of providers to deliver the triple aim of better health, better care, and better cost to you.

There are four Aetna Whole Health accountable care networks (ACN) in four major metropolitan areas, as outlined in the chart above. The **DFW (Dallas) area** and surrounding counties will have **Baylor Scott & White Quality Alliance**. The **Houston area** and surrounding counties will use the **Memorial Hermann Accountable Care Network**. The **Austin area** and surrounding counties will use the **Seton Health Alliance**. The **San Antonio area** and surrounding counties will use the **Baptist Health System and HealthTexas Medical Group**.

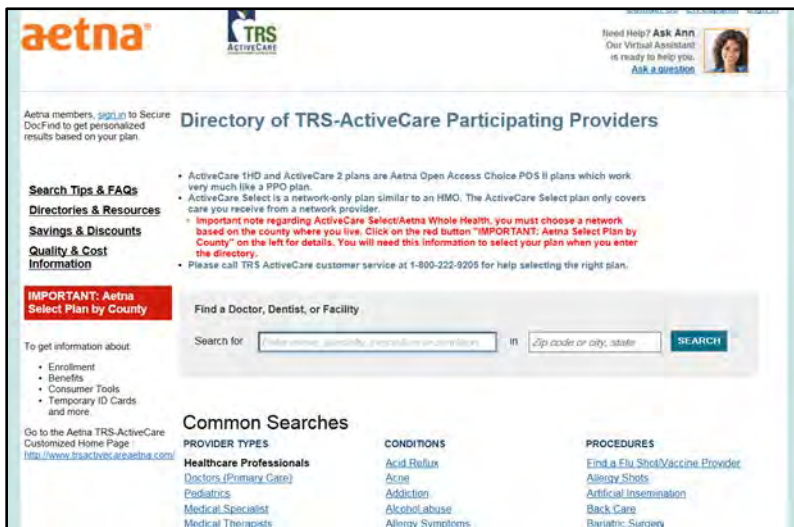
If you live in a county not listed in the chart above, you will choose the “ActiveCare Select/Open Access” plan as you are not eligible for the Aetna Whole Health plans.

If you live in one of these counties:	Your Regional AWH Select Plan Network is:
Bexar, Comal, Guadalupe, Kendall	Baptist Health Health System and Health Texas Medical Group
Colin, Dallas, Denton, Ellis, Parker, Rockwall, Tarrant	Baylor Scot & White Quality Alliance
Ft. Bend, Harris, Montgomery	Memorial Hermann Accountable Care Network
Hays, Travis, Williamson	Seton Health Alliance
If you do not live in a county listed above:	Your Select Plan Network is:
All other counties	ActiveCare Select/Open Access

Aetna Select/Open Access

Aetna Select/Open Access plan is supported by a closed provider network (Open Access Select network). With ActiveCare Select/Open Access, you are free to see any **network** provider without a referral. However, you must see providers in the network. You will have **no** coverage if you see a provider who is not in the plan network, except for true medical emergency services. Seeing a non-network provider can have significant financial implications on you, as the participant.

How to search for Select plan providers in TRS-ActiveCare Custom Doc Find:



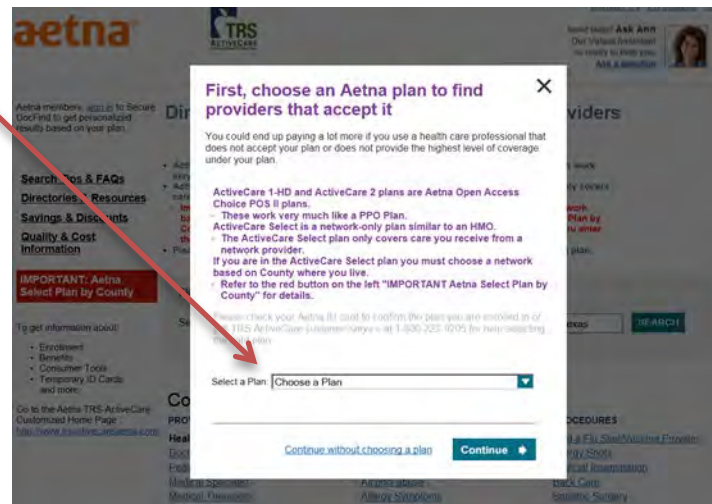
If you live in or around San Antonio, Dallas, Austin, or Houston (in one of the counties listed below) and elect ActiveCare Select as your 2016-17 plan option, you and your covered dependents, including any dependents who temporarily or permanently live outside the network area, will be **required** to use providers who belong to the Aetna Whole Health network.

To find a provider, start by going to the TRS-ActiveCare custom Doc Find.

When looking for a provider in one of the Select Plans, you will need to choose a plan based on what county you live in.

When the “Choose a Plan” box pops up, please choose the plan that best describes your situation. For example, if you live in one of the following counties, choose your plan name based on the county you live in.

If you live in one of these counties:	You would choose the following in Doc Find:
Bexar, Comal, Guadalupe, Kendall	Baptist Health Health System and Health Texas Medical Group
Colin, Dallas, Denton, Ellis, Parker, Rockwall, Tarrant	Baylor Scott & White Quality Alliance
Ft. Bend, Harris, Montgomery	Memorial Hermann Accountable Care Network
Hays, Travis, Williamson	Seton Health Alliance
If you do not live in a county listed above.....	Active Care Select



ActiveCare 2

TRS-ActiveCare 2 is an open access managed choice POS II (point of service) plan. [Participants](#) are not required to select a PCP and referrals are not required. It offers the same flexibility as a PPO plan. This plan offers [copays](#) on certain services.

In the ActiveCare 2 plan the individual plan year [deductible](#) applies separately to each participant. After covered expenses reach the individual plan year deductible the plan will begin to pay benefits for covered expenses. When participants incur expenses that apply to the individual deductible, these expenses also count toward the family deductible limit. To meet the family deductible, the combined covered expenses that the participants incur will also count toward the family deductible limit. When the family deductible has been met, the plan year deductibles for all covered participants will be considered to be met.

Preventive services and prenatal care are covered at 100% even before deductible is met when services are rendered by an in-network provider. Participants are not required to select a PCP and referrals are not required. This plan has in and [out-of-network](#) benefits. Using a network provider will help you maximize your benefits and save you money.

Allowed Amount

The [allowable amount](#) is the maximum amount of benefits Aetna will pay for eligible expenses you incur under TRS-ActiveCare. TRS/Aetna have established an allowable amount for [medically necessary services, supplies, and procedures](#) provided by providers that have contracted with Aetna and providers that have not contracted with Aetna. If you are enrolled in the ActiveCare 1-HD or ActiveCare 2 plans, and you choose to receive services, supplies, or care from a provider that does not contract with Aetna, you will be responsible for any difference between the allowable amount and the amount charged by the non-contracting/non-network provider. If you are enrolled in the ActiveCare Select plan, you will be responsible for the entire bill unless the claim was [emergency](#) related or if a Transition of Care Approval was previously authorized. You will also be responsible for charges for services, supplies, and procedures limited or not covered under TRS ActiveCare, [deductibles](#), any applicable [coinsurance](#), out-of-pocket maximum amounts, and [copay](#) amounts.

How is the allowable amount determined?

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

For hospitals and facility other providers, physicians, and professional other providers not contracting with Aetna: The allowable amount will be the lesser of the provider's billed charges, or the TRS/Aetna non-network allowable amount; except as otherwise provided in this section, the non-network allowable amount is developed from base Medicare participating reimbursements. Plan Participants covered under the ActiveCare Select Plan do not have coverage for non-network providers unless the claim is emergency related or a prior approval was authorized.

Aetna will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by non-network providers which may also alter the allowable amount for a particular service. The non-network allowable amount does not equate to the provider's billed charges and participants receiving services from a non-network provider will be responsible for the difference between the non-network allowable amount and the non-network provider's billed charge, and this difference may be considerable. To find out the TRS/Aetna non-network allowable amount for a particular service, participants may call customer service at 800-222-9205.

Notwithstanding the above, where applicable state or federal law requires another standard for a non-network claim, the allowable amount shall be the lesser of billed charge or the amount prescribed by law.

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

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

Predetermination of Benefits

As [participants](#) in TRS-ActiveCare, you and your covered dependents are entitled to a review by the Aetna Medical Division to determine the medical necessity of any proposed medical procedure. It will inform you in advance if Aetna considers the service to be [medically necessary](#) and, therefore, eligible for benefits. To have a predetermination conducted, have your physician provide Aetna a letter of medical necessity and any pertinent medical records supporting this position. After a decision is reached, you and your physician will be notified in writing.

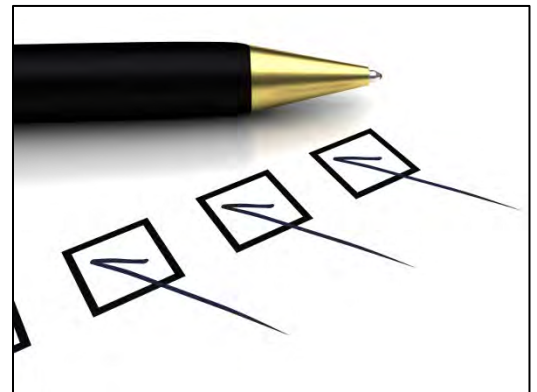
Predetermination is not a guarantee of payment. Benefits are always subject to other applicable requirements, such as preexisting conditions, limitations and exclusions, payment of premium, and eligibility at the time care and services are provided.

Continuity of Care

In the event a participant is under the care of a network provider at the time such provider stops participating in the network and at the time of the network provider's termination, the participant has special circumstances such as a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence, Aetna will continue providing coverage for that provider's services at the network benefit level, subject to the allowable amount for covered services.

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

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



Network vs. Non-Network Providers

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

See a Network Provider	See a Non-Network Provider (that is not a network provider)
<ul style="list-style-type: none"> You receive the higher level of benefits (network benefits) You are not required to file claim forms You are not balance billed; network providers will not bill for costs exceeding the Aetna allowable amount for covered services Your provider will preauthorize necessary services 	<ul style="list-style-type: none"> You receive non-network benefits for ActiveCare 1-HD and ActiveCare 2 (the lower level of benefits) Not covered if enrolled in the ActiveCare Select Plans unless emergency or prior authorization approved You may be required to file your own claim forms (must be filed within 12 months of the date of service) You may be billed for charges exceeding the allowable amount for covered services You must preauthorize necessary services

What happens if a non-network provider is used? (ActiveCare 1-HD and ActiveCare 2)

When you seek care from a network doctor or hospital, your TRS-ActiveCare PPO plan pays a larger portion of your health care costs than it pays for services by a non-network provider. If you are covered under the ActiveCare 1-HD or ActiveCare 2 Plans, and you receive care outside the network, you still have coverage, but you may pay more of the cost, including any charges exceeding allowable amount. For example, with ActiveCare 2, if a non-network doctor bills \$2,000 for a covered service and the allowable amount is \$1,000, assuming your deductible is already met, you would pay \$1,400 (\$1,000 x 40% coinsurance = \$400 plus the \$1,000 exceeding the allowable amount). In this example, if a network doctor is used, you would pay \$200 (\$1,000 x 20% coinsurance).

What happens if a non-network provider is used? ActiveCare Select

Non-Network providers are not covered under the ActiveCare Select Plan unless an emergency or if a Transition of Care Approval was previously authorized. You would be responsible for the full cost of the service provided by the non-network provider.

What happens if a non-network provider is used for Emergency Room Care?

When you receive care for covered services in an Emergency Room you may be billed if the provider charges more than the [allowable amount](#).

Emergency Room Care – In-Network Provider	Emergency Room Care - Non-Network Provider (that is not a network provider)
<ul style="list-style-type: none"> You receive the higher level of benefits (in network benefits) You are not required to file claim forms You are not balance billed; network providers will not bill for costs exceeding the Aetna allowable amount for covered services 	<ul style="list-style-type: none"> You receive in network benefits. You may be billed for charges exceeding the allowable amount for covered services You may be required to file your own claim forms (must be filed within 12 months of the date of service)

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

If care is not available from a network provider as determined by Aetna, and Aetna pre-authorizes your visit to a non-network provider prior to the visit, network benefits will be paid. Otherwise, non-network benefits will be considered if applicable by the plan, and the claim will have to be resubmitted for review and adjustment, if appropriate.

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

Need to locate a network provider, doctor, or hospital?

Log onto www.trsactivecareetna.com and click on Find a Doctor or Facility. Be sure you know what plan you are enrolled in in order to view the correct provider's attached to your plan. Of course, you can always call Customer Service at 1-800-222-9205 to confirm network status.

Use of Non-Network Providers

Use of non-network providers (including facilities) can have **significant** financial implications on you, as the participant. TRS ActiveCare has a non-network allowable fee schedule. The non-network allowable amount is developed from base Medicare rates. When you choose to receive services, supplies, or care from a provider that does not contract with Aetna (a non-network provider), you receive non-network benefits if applicable (the lower level of benefits or no benefits, depending on the plan you are enrolled in). For the ActiveCare 1-HD and ActiveCare 2 Plans, benefits for covered services will be reimbursed based on the non-network allowable amount. The non-network provider is not required to accept the non-network allowable amount as payment in full and may balance bill you for the difference between the non-network allowable amount and the non-network provider's billed charges.

You will be responsible for this balance bill amount, which may be considerable.

You will also be responsible for charges for services, supplies and procedures limited or not covered under TRS-ActiveCare and any applicable deductibles, coinsurance amounts, and copayment amounts. Non-network providers are not covered under the ActiveCare Select Plan unless an [emergency](#) or if a Transition of Care Approval was previously authorized.

Preauthorization Requirements

TRS-ActiveCare requires advance approval (preauthorization) by Aetna for certain services. Preauthorization establishes in advance the medical necessity of certain care and services covered under TRS-ActiveCare. Preauthorization ensures that care and services will not be denied on the basis of medical necessity. However, preauthorization does not guarantee payment of benefits. Benefits are always subject to other applicable requirements such as, limitations and exclusions, payment of premium, and eligibility at the time care and services are provided.

The following types of services require preauthorization:

- All inpatient admissions;
- Extended care expenses, such as in a skilled nursing facility, through [home health care](#) or through hospice;
- Home infusion therapy;
- If you transfer to another facility or to or from a specialty unit within the facility;
- All inpatient treatment of mental health care, chemical dependency and serious mental illness; and
- The following outpatient treatment of mental health care, chemical dependency and serious mental illness:
 - Psychological testing
 - Neuropsychological testing
 - Electroconvulsive therapy, and
 - Intensive outpatient program

Intensive outpatient program means a freestanding or hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or specializes in the treatment of co-occurring mental illness with drug addiction, substance abuse or alcoholism. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that the [participants](#) will benefit from programs that focus solely on mental illness conditions.

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

Note: Non-Network providers are not covered under the ActiveCare Select Plan unless an [emergency](#) or if a Transition of Care Approval was previously authorized. In a true medical emergency, you should seek care at the nearest emergency room.

What happens if services are not preauthorized?

Aetna will review the medical necessity of your treatment prior to the final benefit determination. If the treatment or service is not [medically necessary](#), benefits will be denied. There is a \$250 penalty for failure to preauthorize a medically necessary admission to a non-network [hospital](#). The penalty will be deducted from any benefit payment that may be due for the admission. The penalty is in addition to the deductible or out-of-pocket maximum.

How to Preauthorize

Medical: Network providers will preauthorize services for you. *If you do not use a network provider for your medical care, you are responsible for preauthorization by calling Aetna at 1-800-222-9205.* (The preauthorization telephone number also appears on your TRS-ActiveCare ID card.) This phone call is important. There is a \$250 penalty for failure to preauthorize a [medically necessary](#) admission to a non-network [hospital](#). You, your provider, or a family member may call. The call should be made between 8 a.m. and 6 p.m. (Central Time) Monday through Friday. Calls made after working hours, on weekends, or holidays will be recorded and returned the next working day.

Mental health care, chemical dependency and serious mental illness: Preauthorization for all inpatient and certain outpatient mental health care, chemical dependency and serious mental illness – network and non-network – should be obtained by calling 1-800- 424-4047 between 8 a.m. and 5 p.m. (Central Time).

Is there a time limit for preauthorizing hospital admissions?

All inpatient admissions should be preauthorized at least two working days before admission. However, in the case of an [emergency](#), hospital admissions may be authorized within two working days after admission, or as soon thereafter as reasonably possible.

How to Request or Replace an ID Card

Plan [participants](#) will receive two [ID cards](#) – one from Aetna for the medical benefits and a separate card from Caremark for the pharmacy/prescription drug benefits. To request additional cards or to replace lost or damaged cards, call Customer Service at 1-800-222-9205, or log on to www.trsactivecare.aetna.com. Members can go through the TRS-ActiveCare website to order medical ID cards online, or the Caremark website at www.caremark.com to order cards for your prescription drug benefits. There is no charge for ID cards.

Note: You will receive ID cards when you first enroll in a plan and only upon any plan changes thereafter.



Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

- The unauthorized, fraudulent, improper, or abusive use of Identification Cards ([ID cards](#)) issued to you and your covered dependents will include, but not be limited to, the following actions, when intentional:
 - Use of the identification card prior to your effective date;
 - Use of the identification card after your date of termination of coverage under the plan;
 - Obtaining prescription drugs or other benefits for persons not covered under the plan;
 - Obtaining prescription drugs or other benefits that are not covered under the plan;
 - Obtaining covered drugs for resale or for use by any person other than the person for whom the prescription order is written, even though the person is otherwise covered under the plan;
 - Obtaining covered drugs without a prescription order or through the use of a forged or altered prescription order;
 - Obtaining quantities of prescription drugs in excess of medically necessary or prudent standards of use or in circumvention of the quantity limitations of the Plan;
 - Obtaining prescription drugs using prescription orders for the same drugs from multiple providers;
 - Obtaining prescription drugs from multiple pharmacies through use of the same prescription order.
- The fraudulent or intentionally unauthorized, abusive, or other improper use of identification cards by any participant can result in, but is not limited to, the following sanctions being applied to all participants covered under your coverage:

- Denial of benefits;
- Cancellation of coverage under the plan for all participants under your coverage;
- Limitation on the use of the identification card to one designated physician, other provider, or participating pharmacy of your choice;
- Recoupment from you or any of your covered dependents of any benefit payments made;
- Pre-approval of drug purchases and medical services for all participants receiving benefits under your coverage;
- Notice to proper authorities of potential violations of law or professional ethics.

Sample ID Cards

ActiveCare 1-HD

 	
TRACTIVECARE 1-HD GRP: 866325-010-00001 Issuer (80840) 9140860054 ID W1234 56789 NAME 01 JOHN Q SAMPLE 02 DEPENDENT A SAMPLE 03 DEPENDENT B SAMPLE 04 DEPENDENT C SAMPLE 05 DEPENDENT D SAMPLE	
Choice POS II PCP: NO ELECTION REQUIRED PCP: NO ELECTION REQUIRED PCP: NO ELECTION REQUIRED PCP: NO ELECTION REQUIRED PCP: NO ELECTION REQUIRED	WWW.TRSACTIVECAREAETNA.COM PAYER NUMBER 80054 0753 24-hour Nurse Information Line: 1-800-556-1555 Mental Health/Substance Abuse: 1-800-424-4047 Teladoc (Member cost sharing may apply): 1-855-835-2362 While coverage remains inforce, covered participants are entitled to benefits as provided under the terms and conditions for TRS-ActiveCare. You do not have to choose a primary care doctor. Referrals are not required. However, some services may also require precertification. Without pre-approval, you may pay more or even full price. See your plan documents for information on your plan requirements. In an emergency call 911 or go to the nearest emergency room. Note: This card does not guarantee coverage. Teladoc is not administered by Aetna Life Insurance Company. Aetna Life Insurance Company EL PASO P.O. BOX 981106 TX 79998-1106 TRACTIVECARE CUSTOMER SVC 1-800-222-9205 PROVIDERS CALL 1-888-632-3862

ActiveCare Select

 	
TRACTIVECARE SELECT ER COPAY +20% AFTER DEDUCTIBLE GRP: 866345-010-00001 Issuer (80840) 9140860054 ID W1234 56789 NAME 01 JOHN Q SAMPLE 02 DEPENDENT A SAMPLE 03 DEPENDENT B SAMPLE 04 DEPENDENT C SAMPLE 05 DEPENDENT D SAMPLE	
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Aetna Whole Health/ActiveCare Select Baylor Scott & White Quality Alliance

 	
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Aetna Whole Health/ActiveCare Select Memorial Hermann Accountable Care Network

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WWW.TRSACTIVECAREAETNA.COM PAYER NUMBER 60054 0753

24-hour Nurse Information Line: 1-800-556-1555
Mental Health/Substance Abuse: 1-800-424-4047
Teladoc: 1-855-835-2362

While coverage remains inforce, covered participants are entitled to benefits as provided under the terms and conditions for TRS-ActiveCare. You do not have to choose a primary care doctor. Referrals are not required. However, some services may also require precertification. Without pre-approval, you may pay more or even full price. See your plan documents for information on your plan requirements. In an emergency call 911 or go to the nearest emergency room. Note: This card does not guarantee coverage. Teladoc is not administered by Aetna Life Insurance Company.

Aetna Life Insurance Company
P.O. BOX 981106
EL PASO TX 79998-1106

TRS-ACTIVECARE CUSTOMER SVC 1-800-222-9205
PROVIDERS CALL 1-888-632-3862

Aetna Whole Health/ActiveCare Select Baptist Health System & HealthTexas Medical Group

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WWW.TRSACTIVECAREAETNA.COM PAYER NUMBER 60054 0753

24-hour Nurse Information Line: 1-800-556-1555
Mental Health/Substance Abuse: 1-800-424-4047
Teladoc: 1-855-835-2362

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Aetna Life Insurance Company
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TRS-ACTIVECARE CUSTOMER SVC 1-800-222-9205
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Aetna Whole Health/ActiveCare Select Seton Health Alliance

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24-hour Nurse Information Line: 1-800-556-1555
Mental Health/Substance Abuse: 1-800-424-4047
Teladoc: 1-855-835-2362

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TRS-ACTIVECARE CUSTOMER SVC 1-800-222-9205
PROVIDERS CALL 1-888-632-3862

ActiveCare 2

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Aetna Life Insurance Company
P.O. BOX 981106
EL PASO TX 79998-1106

TRS-ACTIVECARE CUSTOMER SVC 1-800-222-9205
PROVIDERS CALL 1-888-632-3862

Coverage Outside of the United States

The TRS-ActiveCare plans provide benefits for medical services outside the United States.

ActiveCare 1-HD and ActiveCare 2

Overseas / International / Foreign claims will be covered the same as US Domestic claims subject to confirmation of covered medical necessity. Claims will be translated if needed, currency exchange calculated based on the date of service (if inpatient services the date of discharge is used). All claims are reviewed for medical necessity. If covered under the plan provisions the submitted billed charges will be paid as follows:

- [Emergency](#) or urgent care will be paid at the preferred benefit level
- Elective services including Preventive care will be paid at the [out-of-network](#) benefit level

ActiveCare Select

Overseas / International / Foreign claims will be covered the same as US Domestic claims subject to confirmation of covered medical necessity. Claims will be translated if needed, currency exchange calculated based on the date of service (if inpatient services, the date of discharge is used). All claims are reviewed for medical necessity. If covered under the plan provisions the submitted billed charges will be paid as follows:

- Emergency or urgent care will be paid at the preferred benefit level
- Elective services including Preventive care - No Coverage

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 Aetna Claim Form completely and attach your bills from the foreign provider. Missing information will delay or prevent claims processing. (Claim form is available on the www.trsactivecare.aetna.com website or call customer service at 1-800-222-9205 for assistance.)

Note: Some foreign providers may want payment upfront from the member. It would then be the member's responsibility to seek reimbursement from Aetna. Aetna will pay claims according to the TRS/Aetna out-of-network allowable rate. You may still be responsible for any amounts that exceed the plan allowable rate in addition to your deductible, copay and co-insurance rates.

Transitional Care

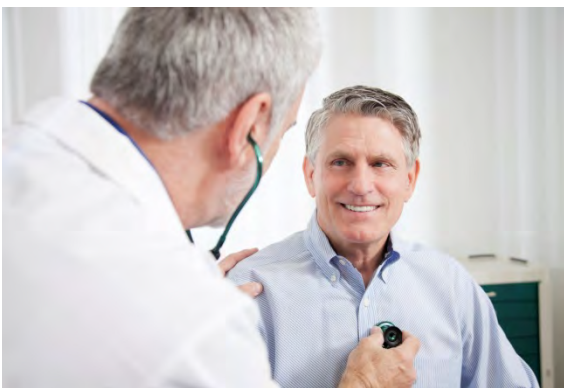
Transitional care applies only to initial enrollees as of the date the district/entity begins participating in TRS-ActiveCare; to new hires, new dependents entering the plan upon a qualifying event.

If you or a covered dependent are undergoing a course of medical treatment at the time of enrolling in ActiveCare 1-HD, the ActiveCare Select Plan, or ActiveCare 2 and your doctor is not in the PPO/Select network, ongoing care with the current doctor may be requested for a period of time, usually 90 days but not to exceed six months from the initial date of TRS-ActiveCare coverage. Transitional care benefits may be available if being treated for any of the following conditions by a non-network doctor:

- Examples of an active course of treatment include, but are not limited to:
 - 3rd trimester pregnancy
 - Ongoing treatment plan such as chemotherapy or radiation therapy
 - Terminal illness
 - Conditions requiring multiple surgeries
 - Recent surgery
 - Outpatient treatment for mental illness or substance abuse
 - Ongoing or disabling condition that worsens
 - Organ or bone marrow transplant

Transitional care benefits are subject to approval. To request transitional care benefits, complete a *Transitional Benefits/Release of Patient Information Form* available from your [Benefits Administrator](#) or on the www.tractivecareareaetna.com website. Instructions for submitting the request to Aetna 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 you enroll in the ActiveCare 1-HD or ActiveCare 2 Plan. Benefits will be denied if you are enrolled in the ActiveCare Select Plan.

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



What the Medical Plan 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. **In the absence of any benefit not specifically listed in this booklet**, TRS-ActiveCare defaults to the standard processing guidelines and policies of Aetna for claims administration.

Refer to the specific Benefits Summary for the TRS-ActiveCare plan you selected on pages 4-16 of this booklet for more detailed information, including the applicable [copay](#), [deductible](#) and [coinsurance](#).

Acquired Brain Injury

Benefits for [medically necessary](#) treatment of an acquired brain injury will be determined on the same basis as treatment for any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neuro-feedback therapy, remediation, post-acute transition services and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an acquired brain injury.

To ensure that appropriate post-acute care treatment is provided, TRS-ActiveCare includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

- Has incurred an acquired brain injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

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

Allergy Care

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

Ambulance Services/Air Ambulance

TRS-ActiveCare provides coverage for professional local ground ambulance or air ambulance transportation services received at the time of an [emergency](#) and when determined to be **medically necessary** by Aetna. There are no benefits available for [ambulance services](#) unless a patient is transported to the nearest hospital equipped and staffed to treat the condition. Payment for non-network ambulance services will be limited to the plan out-of-network [allowable amount](#).

What does medically necessary mean?

Supplies and services are covered only if they are [medically necessary](#). This means that the services and supplies must be:

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

Medically necessary charges do not include charges for:

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

Medical necessity is determined by Aetna. A determination of medical necessity does not guarantee payment unless the service is covered by the TRS-ActiveCare plan.

Decisions regarding medical necessity are guided by current medical policies that may be viewed at www.aetna.com.

Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder (ASD) by the [participant's](#) physician in a treatment plan recommended by that physician are available.

An individual providing services prescribed under the physician's treatment plan must be a [health care practitioner](#):

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

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

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

Bariatric Surgery (Institutes of Quality) (preauthorization required)

- [Bariatric surgery](#), also known as weight loss surgery, refers to the various surgical procedures performed to treat people living with morbid or extreme obesity. It is an effective treatment for weight loss for those who have not experienced long-term weight loss success through other means. Studies show that bariatric surgery is effective in treating obesity and reducing many of the health complications associated with obesity. Bariatric surgery, however, has associated risks and can result in significant and costly complications and readmissions. Facilities and providers also vary significantly in cost and quality of care.
- Bariatric IOQ facilities provide the following services:
 - Lap bands
 - Bypass
 - Sleeve gastrectomy

Bariatric Surgery may be covered under ActiveCare 1-HD and ActiveCare 2 when all criteria have been met and performed at an IOQ (Institute of Quality) facility. Contact Aetna for a list of IOQ facilities for Bariatric. The [copay](#) does not apply to the out-of-pocket maximum for ActiveCare 2. Bariatric surgery is not covered under the Select plans.

Breastfeeding Support, Services, and Supplies

Benefits will be provided for breastfeeding counseling and support services when rendered by a provider, during pregnancy and/or in the post-partum period. Benefits include the purchase or rental of manual, electric, or [hospital](#)-grade breast pumps, accessories, and supplies as follows:

Pump Type	Coverage Level	Qualifying Source	Limit/Restriction
Manual Breast Pump	Plan pays 100% (no cost-share)	Network or non-network provider, retail	N/A
Electric Breast Pump	Plan pays 100% (no cost-share)	Network provider or contracted durable medical equipment (DME) supplier only	Two per calendar year
Hospital Grade Breast Pump	Plan pays 100% (no cost-share; rental only)	Network or contracted DME supplier only	Rental cost up to the purchase price (\$125-\$150)

You may be required to pay the full amount and submit a claim form to Aetna with an itemized receipt for the breast pump, accessories and supplies. Visit the www.tractivecareetna.com website to obtain a claim form.

Care Advocate Team

A dedicated care advocate nurse team supports everything from clinical [precertification](#) and concurrent review - to acute care management. Through our predictive modeling tools, expanded triggers, and monitoring of inpatient admissions on a daily basis, we find the individuals who need our help and support them through a single-nurse approach. We help employees and their families take advantage of the benefits available to them. This team also includes a social worker to ensure we can help members with all of their needs.

Chemical Dependency Treatment (preauthorization required for all inpatient and certain outpatient treatment; see page 23)

Chemical dependency is the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

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

Chiropractic Care

TRS-ActiveCare pays benefits for services (including occupational therapy) and supplies provided by or under the direction of a Doctor of Chiropractic. The plan provides up to a maximum of 35 visits per person, per [plan year](#).

Clinical Trials

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

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

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

Condition Management/Disease Management

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

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

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

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

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

- Coverage for targeted preventive screenings
- Seasonal mailings with educational materials related to your condition
- Annual contact calls to encourage medication compliance
- Tools to help you better self-manage your condition

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

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

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

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

To enroll or ask questions about condition/disease management programs, call 1-800-222-9205.

Cosmetic, Reconstructive, or Plastic Surgery

For cosmetic, reconstructive or plastic surgery, TRS-ActiveCare covers only the following services if [medically necessary](#):

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

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

Dental Services and Covered Oral Surgery

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

When [medically necessary](#) as determined Aetna and prescribed by your doctor, covered oral surgery is limited to:

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

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

Diabetic Management Services

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

Diabetic Equipment

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

Diabetic Supplies

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

Note: All diabetic supplies listed above, along with blood glucose monitors (including noninvasive glucose monitors and monitors for the blind), will be covered under the prescription drug program, administered by Caremark. Test strips, lancets and syringes will be covered subject to [deductible](#) and [coinsurance](#) for ActiveCare 1-HD and covered 100% for ActiveCare 2 and ActiveCare Select. Must be a 90 day prescription and filled only through Mail Order Delivery or at a participating Retail-Plus pharmacy.

Diabetic Management Services/Diabetes Self-Management Training Programs

Includes initial and follow-up instruction concerning:

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

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

Durable Medical Equipment

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

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

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. All emergency room care, whether provided by a network provider or a non-network provider, will be eligible for the in network level of benefits. If you continue to be treated by a non-network provider after you receive emergency care and you can safely be transferred to the care of an in network provider, only non-network benefits will be available if the plan has [out-of-network](#) benefits.

Note: [Non-network providers](#) may bill you for any charges exceeding the non-network [allowable amount](#).

- **Inpatient care:** If you are admitted to a network [hospital](#), network providers will preauthorize your hospital admission. If you are admitted to a non-network hospital, the hospital admission must be preauthorized within 48 hours by calling 1-800-222-9205. If the non-network hospital admission is not preauthorized, there is a \$250 penalty. **Note:** If you are treated by a non-network provider in a network hospital during the first 48 hours of your emergency, benefits will be paid at the in network level based on [reasonable and customary](#). Payment for [ambulance services](#) will be limited to the allowable amount.
- **Outpatient care:** Network level of benefits are available for treatment following an accident or medical emergency (even in a non-network emergency room facility).

What is an Emergency?

[Emergency](#) care means health care services provided in a hospital emergency facility (emergency room), freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent 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.

24 Hour Nurseline

800-556-1555

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

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

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

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

Care Option	Relative Cost*	Description
Doctor's Office Office hours vary	Lower out-of-pocket cost to you than an urgent care visit	Your doctor's office is generally the best place to go for non-emergency care such as health exams, colds, flu, sore throats, minor injuries, aches, and pains.
Teladoc 24 hours, 7 days a week	Lower out-of-pocket cost to you than an office visit	Telephonic consultation by a board certified physician. Copays waived for ActiveCare 2 and Select plans. \$40 for 1-HD members (applied to deductible and co-insurance). Call 855-835-2362, and tell them you are covered through TRS-ActiveCare.
Retail Health Clinic Example: MinuteClinic (CVS); similar to retail store hours	Lower out-of-pocket cost to you than an urgent care visit	Walk-in clinics are often located in stores and pharmacies to provide convenient, low-cost treatment for minor medical problems like ear infections, athlete's foot, bronchitis, and some vaccinations.
Urgent Care Provider Hours generally include evenings, weekends, and holidays	Lower cost than an ER visit	Urgent care centers provide care when your doctor is not available, and you don't have a true emergency. For example, they can treat sprained ankles, fevers, and minor cuts and injuries.
Emergency Room (ER) 24 hours, seven days a week	Highest out-of-pocket cost to you	An emergency means you could die, lose the use of a limb or organ, or otherwise place your health in serious jeopardy if you don't get care quickly. For serious, life-threatening conditions, you need emergency care. For medical emergencies, call 911 or your local emergency services first.

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

Family Planning

Covered services include:

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

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

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 Aetna 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 (60 visits per plan year maximum)

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

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

Home health care benefits are not provided for food or home-delivered meals, social casework or homemaker services, transportation, or services provided primarily for [custodial care](#). Private Duty Nursing is not a covered benefit.

Home Infusion Therapy (preauthorization required)

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

- Drugs and IV solutions
- Pharmacy compounding and dispensing services
- All equipment and ancillary supplies necessitated by the defined therapy
- Delivery services
- Patient and family education,
- Nursing services
- Some home infusion drugs may be considered under your Specialty pharmacy benefit. These drugs must be pre-certified by Caremark. Please contact Caremark to obtain additional information and assistance.

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

Hospice Care/Compassionate Care Program (preauthorization required for out-of-network providers)

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

The following services are covered for home [hospice care](#):

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

Covered facility hospice care includes:

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

Compassionate Care and Hospice (notification required for in-network providers)

The Aetna [Compassionate Care Program](#) is an enhanced hospice benefit package available to TRS [participants](#).

The program provides a full spectrum of support and services to terminally ill participants and their families, including nurse case management support, online tools and information.

This benefit includes coverage for the following:

- The option to continue to seek curative and palliative care while in hospice.
- The ability to enroll in a hospice program with a 12 month terminal prognosis.
- Nurses who are specially trained to coordinate care, help manage your benefits, identify helpful resources and more.
- A website that can give you information about living wills, tips for discussing care and treatment options with loved ones, and more.
- Respite and bereavement services

More information can be found on www.aetnacompassionatecare.com or by calling TRS Customer Service at 1-800-222-9205.

Hospital Admission (preauthorization required)

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

Note: Any charge for room and board in a private room over the semiprivate room rate is not covered unless [medically necessary](#), as determined by Aetna.

Infertility Services

Testing for problems of infertility is covered.

Note: Services or supplies provided for, in preparation for, or in conjunction with in vitro fertilization and artificial insemination are not covered. See page 54 for additional exclusions.

Lab and X-Ray Services

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

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

If care is not available from a network provider as determined by Aetna and Aetna preauthorizes your visit to a non-network provider prior to the visit, network benefits will be paid. Otherwise, non-network benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate. If a non-network provider is used, the [participant](#) will be responsible for any expenses exceeding the [allowable amount](#).

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

Added Savings and Value with Quest Diagnostics

You can take advantage of extra savings when you need a lab test. Quest Diagnostics has agreed to lower rates for TRS-ActiveCare participants. That helps you save on out-of-pocket costs. In fact, the ActiveCare 2 and ActiveCare Select plans cover lab services at 100% if you use a Quest Diagnostics facility.

In addition to savings, Quest Diagnostics also gives you access to:

- Thousands of locations near where you live and work
- Appointment scheduling online or by phone
- Email reminders to help you keep track of your appointments
- Saturday hours as well as extended hours at many locations
- Free courier service to pick up lab work from most doctor's offices

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

ActiveCare 1-HD: If the lab and X-ray services performed outside the doctor's office are for preventive care, they will be paid at 100% when network providers are used (and subject to [deductible](#) and [coinsurance](#) when non-network providers are used). Lab and X-ray services due to non-preventive diagnoses will be subject to deductible and coinsurance.

ActiveCare Select 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% when network providers are used (and subject to deductible and coinsurance when non-network providers are used). Lab and X-ray services due to non-preventive diagnoses will be subject to deductible and coinsurance except for [high-tech radiology](#) (such as CT scans, MRIs and nuclear medicine), which will be subject to an additional \$100 [copay](#) per service. *(Copay waived if performed in an emergency room or if admitted.)*

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

These services will be paid at the network benefits level. **However**, payment for non-network services is limited to the [allowable amount](#), and you are responsible for any charges billed by the provider which exceed the allowable amount, except for inpatient admissions from the [emergency](#) care services.

Maternity Care

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

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

How are doctor's charges for maternity care covered?

All TRS-ActiveCare Plans: Pre-natal Care is covered at 100%. Additional expenses during your pregnancy will be subject to your plan's [deductible](#) and [coinsurance](#).

How is a newborn child covered under TRS-ActiveCare?

To add coverage for the newborn, you must sign, date and submit an Enrollment Application and Change Form to your [Benefits Administrator](#) within 31 days after the date of birth. **Note:** This new timeframe applies to all plans regardless of whether you already had family coverage. If the application is submitted after the enrollment period for the newborn child, the request to add coverage will be denied—even if there would be no change in premium.

You do not have to wait for the newborn's Social Security number to be issued before you submit an Enrollment Application and Change Form. Enroll the newborn and re-submit another form after the Social Security number has been issued.

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

Important note about how your deductible could change when you have a baby on the 1-HD plan: If you are covered by the 1-HD Plan for single coverage and have a baby, you are automatically moved to the family plan and your deductible increases to \$5,000. If you do not plan to add the baby to your plan, please call member services to adjust your deductible accumulators.

Newborn grandchildren are not automatically covered by TRS-ActiveCare for the first 31 days; however, a covered employee may enroll eligible newborn grandchildren within 31 days after the newborn's date of birth. An eligible grandchild must primarily reside in the employee's household and must be a dependent of the employee for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.

Note: TRS-ActiveCare includes a free voluntary comprehensive prenatal program, **Beginning Right Maternity Program**—that helps mothers take better care of themselves and their babies. The program assesses pregnancy risk level and provides close monitoring through a series of calls from an experienced obstetrical nurse from pregnancy through six weeks after delivery. To enroll or ask questions about the program, call toll-free: 1-800-272-3531.

Medical-Surgical Expenses

TRS-ActiveCare provides coverage for [medically necessary](#) medical-surgical expenses for you and your covered dependents.

These include:

- Services of physicians and professional other providers
- Services of a certified registered nurse-anesthetist (CRNA)
- Diagnostic X-ray and laboratory procedures except for C-Reactive Protein testing
- Radiation therapy
- Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. For information on coverage for amino acid-based elemental formulas, refer to the prescription drug program on page 57.
- Medically necessary treatment for symptoms of Autism Spectrum Disorder
- Anesthetics and its administration, when performed by someone other than the operating physician or professional other provider
- Oxygen and its administration provided the oxygen is actually used
- Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the [participant](#)
- Prosthetic appliances, required for the alleviation or correction of conditions arising out of accidental injury occurring or illness commencing after the participant's effective date of coverage under TRS-ActiveCare, excluding all replacements of such devices other than those necessitated by growth to maturity of the participant
- Services or supplies used by the participant during an outpatient visit to a [hospital](#), a therapeutic center, or a [chemical dependency treatment center](#), or scheduled services in the outpatient treatment room of a hospital
- Certain diagnostic procedures, including, but not limited to bone scan, cardiac stress test, CT scan, MRI, myelogram, PET scan
- Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes
- Injectable drugs, administered by or under the direction or supervision of a physician or professional other provider. **Note:** Certain specialty medications are covered under the pharmacy benefit administered by Caremark. Please call Caremark for more information.
- [Telemedicine](#) services other than by telephone or facsimile (other than services provided by Teladoc)
- Outpatient contraceptive services and prescription contraceptive devices to women with reproductive capacity with a written prescription by a [health care practitioner](#) as shown in Preventive Care.
Note: Prescription contraceptives for women are covered under the pharmacy benefits administered by Caremark.

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

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

Mental Health Care (preauthorization required for all inpatient and certain outpatient treatment; see page 23)

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

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

Refer to the Benefits Summary of the TRS-ActiveCare plan you selected for day or visit limitations that apply.

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

National Medical Excellence (NME)

Facing a transplant or other complex medical procedure can be a difficult challenge. While most people will never need these unique and highly specialized procedures, they are becoming more common place as medical science progresses.

But should the need arise, Aetna's National Medical Excellence (NME) Program helps eligible members access covered treatment for solid organ transplants, bone marrow transplants, and certain other rare or complicated conditions at participating facilities experienced in performing these services.

Aetna's criteria for selection of these providers are based in part on well-established research, which shows that quality care and successful outcomes are often directly linked to the volume of procedures performed.

Program Components

The National Medical Excellence Program has three components:

- National Medical Excellence Program, designed to help arrange covered care for organ and tissue transplants, including heart, lung, liver, kidney, pancreas, kidney/pancreas, peripheral stem cell and bone marrow transplants.
- National Special Case Program developed to provide referral management for preauthorized services for Aetna members with very complex conditions that are not commonly encountered in routine patient management activities. Some examples of diagnoses/procedures qualifying as NME special cases:
 - Acrocephalosyndactylia
 - Desmoid Tumors
 - Epidermolysis Bullosa
 - Merkel Cell Cancer
 - Laryngotracheal Reconstruction
 - Brachial Plexus Neuropathies
 - Dysautonomia Familial
 - Fragile X Syndrome
 - Moyamoya Disease
- [Emergency](#) Out of Country Care, for members who need emergency inpatient medical care while temporarily traveling outside of the United States.

Features of the National Medical Excellence Program

The National Medical Excellence Program provides:

- Access to Covered Care, when precertified through the NME unit, through a nationwide network of health care providers and [hospitals](#) demonstrating continual achievement in complex care.
- Specialized Case Management by nurses experienced in coordinating complicated care. Working with the patient, physician, facility and family members, our case managers coordinate all phases of the procedure-from initial assessment and treatment to follow-up.
- Coordination of follow-up care that permits members to get after-care services close to home, when possible. Our case managers take a personalized approach to each case.

Organ and Tissue Transplants (preauthorization required)

Organ and tissue transplants (bone marrow, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, and lung) and related services and supplies are covered at an Aetna Institute of Excellence (IOE) if the:

- Transplant is not [experimental/investigational](#) in nature
- Donated human organs or tissue or an FDA-approved artificial device are used
- Recipient or donor is a [participant](#) under TRS-ActiveCare (Benefits are also available to the donor who is not a participant under TRS-ActiveCare)
- Transplant procedure is preauthorized with [National Medical Excellence \(NME\)](#) team
- Recipient meets all of the criteria established by Aetna in its written medical policy guidelines, and
- Recipient meets all of the protocols established by the [hospital](#) in which the transplant is performed

Covered services and supplies include:

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

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

Services and supplies not covered by TRS-ActiveCare include:

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

Orthotics

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

Foot orthotic devices (such as orthopedic shoes, inserts, arch supports, footwear, lifts, wedges, heels, and miscellaneous shoe additions) may be considered eligible for benefits if they are [medically necessary](#) (therapeutic support, protection, restoration or function) and prescribed by physician, chiropractor and/or other qualified provider. Accommodative foot orthotics are considered not medically necessary as they do not address structural or functional abnormalities, they are primarily for comfort, and/or they are over-the-counter items (with or without a prescription).

Non-covered items include, but are not limited to, an orthodontic or other dental appliance (except as allowed for accidental injury under covered oral surgery on page 36); splints or bandages provided by a physician in a non-[hospital](#) setting or purchased over-the-counter for support of strains and sprains; elastic stockings and garter belts.

Maintenance and repairs to orthotics resulting from accident, misuse or abuse are the [participant's](#) responsibility.

Outpatient Facility Services

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

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

Preventive Care

TRS-ActiveCare encourages preventive care and maintenance of good health. Covered services under this benefit must be billed by the provider as "preventive care." Preventive care benefits will be provided for the following covered services and when using network providers, the services will not be subject to [copayment](#), [deductible](#), [coinsurance](#) or dollar maximums:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
- Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
- Additional preventive care and screenings for women, not described above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. Examples of covered services included are routine annual physicals; immunizations; well-child care; well-woman exam and pap smear; breastfeeding support, services and supplies; cancer screening mammograms; bone density test; screening for prostate cancer and colorectal cancer (including routine colonoscopies); smoking cessation counseling services and healthy diet counseling; and obesity screening/counseling. Examples of covered services for women with reproductive capacity are female sterilization procedures and specified FDA-approved contraception methods with a written prescription by a [health care practitioner](#).

including cervical caps, diaphragms, implantable contraceptives, intra-uterine devices, injectables, transdermal contraceptives and vaginal contraceptive devices. Prescription contraceptives for women are covered under the pharmacy benefits administered by Caremark. To determine if a specific contraceptive drug or device is included in this benefit, contact Customer Service at the toll-free number on your [identification card](#). The list may change as FDA guidelines are modified.

<http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations>

Covered preventive care services not included in the description above will be subject to applicable [copayment](#), [deductible](#), and [coinsurance](#). Examples include ear and eye exams (one per [plan year](#)) and early detection tests for cardiovascular disease.

You may find more information about covered preventive care services by visiting healthcare.gov or by contacting Customer Service at the toll-free number on your identification card. Please be aware that you may incur some cost if the preventive service is not the primary purpose of the visit or if your doctor bills for services that are not preventive.

Benefits for the Prevention and Detection of Osteoporosis

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

Qualified individual means a participant who is:

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

Benefits for Screening Tests for Hearing Impairment

Benefits are available for a covered dependent child for a screening test for hearing loss from birth through the date the child is 30 days old and for necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

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

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

Immunizations

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

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

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

Professional Services

Covered services must be [medically necessary](#) as determined by Aetna and provided by a licensed doctor or by other covered health providers. 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.

Who are covered health providers?

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

- Advanced Practice Nurse (APN)
- Doctor of Chiropractic
- Doctor of Dentistry
- Doctor of Medicine
- Doctor of Optometry
- Doctor of Osteopathy
- Doctor of Podiatry
- Doctor in Psychology
- Licensed Audiologist
- Licensed Chemical Dependency Counselor
- Licensed Dietician
- Licensed Hearing Instrument Fitter and Dispenser
- Licensed Marriage and Family Therapist
- Licensed Clinical Social Worker
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Licensed Professional Counselor
- Licensed Speech-Language Pathologist

- Licensed Surgical Assistant
- Nurse First Assistant (NFA)
- Physician Assistant (PA)
- Psychological Associates who work under the supervision of a Doctor in Psychology

Prosthetic Devices

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

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

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

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

Rehabilitation Services (Physical, Speech and Occupational Therapies)

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



Serious Mental Illness

(preauthorization required for all inpatient and certain outpatient treatment; see page 23)

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

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

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

Skilled Nursing Facility (preauthorization required)

TRS-ActiveCare covers up to 25 days per benefit year of care in a skilled nursing facility and pays benefits for:

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

Teladoc



Teladoc is an affordable alternative to emergency room and urgent care. Many common medical issues can be resolved through the convenience of just a phone call at 855-835-2362 – 24/7/365. **Note: Be sure to mention you are covered through “TRS-ActiveCare”.**

Highlights include:

- Copays waived for ActiveCare 2 and ActiveCare Select plans; only \$40 for ActiveCare 1-HD plan.
- Board certified providers specializing in family practice, internal medicine, emergency medicine and pediatrics.
- Common diagnosis and treatment of sinusitis, upper respiratory infection, urinary tract infection, bronchitis, otitis media, influenza and the common cold.
- Consults available wherever the patient is - at home, at work, or traveling within the United States.
- Guaranteed member call back within 60 minutes! The average call back time is 20-30 minutes.
- Diagnosis, recommended treatment and prescriptions ordered when appropriate.
- A copy of the consult record will be sent to the member's PCP upon request.

Limitations and Exclusions

In addition to the limitations and exclusions set out in the description of What the Medical Plan Covers, beginning on page 30, TRS-ActiveCare does not cover medical expenses for the following:

- As determined by Aetna, services or supplies that are not [medically necessary](#) or any [experimental/investigational](#) and/or unproven services or supplies
- Charges resulting from the failure to keep a scheduled visit with a physician or other professional provider, for the completion of any forms, or for the acquisition of medical records
- Vision services or supplies, including but not limited to, orthoptics, vision training, vision therapy, radial keratotomy, contact lenses or the fitting of contact lenses, eyeglasses, photorefractive keratotomy, INTACS and LASIK
- Cosmetic, reconstructive, or plastic surgery except as allowed on page 35
- General dental services, including dental appliances (except for appliances as allowed for accidental injury under covered oral surgery on page 36)
- Any items of medical/surgical expense incurred for dental surgery except as allowed on page 36
- Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease (unless covered by the Texas Diabetic Mandate)
- Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain
- Services or supplies provided for obesity or weight reduction, except for medically necessary treatment of morbid obesity as determined by Aetna, except for obesity counseling that may be allowed under preventive services.
- Services or supplies provided for [bariatric surgery](#) except for medically necessary bariatric procedures performed at designated an Aetna Institute of Quality (IOQ)
- 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 Aetna
- Private duty nursing
- Any charge for room and board in a private room over the semiprivate room rate is not covered unless medically necessary, as determined by Aetna
- Dietary and nutritional services and supplies except for: an inpatient nutritional assessment program provided in and by a [hospital](#) and approved by Aetna, diabetic management services that are provided by a physician and approved by Aetna, medically necessary dietary supplements required for the treatment of Phenylketonuria (PKU) or other heritable diseases, medically necessary treatment for symptoms of Autism Spectrum Disorder, or amino acid-based elemental formulas (a prescription order is required)
- Services or supplies provided before the [participant's](#) effective date of coverage or after the expiration date of coverage

- Charges that would not be made if you did not have health coverage or charges that you are not legally required to pay
- Services or supplies provided by a person, entity, facility or [hospital](#) that has not been approved as a network or non-network provider by Aetna
- Room and board charges during a [hospital](#) admission for diagnostic or evaluative procedures, unless Aetna 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 Aetna considers [experimental](#) and/or [investigational](#) in nature
- Medical social services, bereavement counseling (except as part of a preauthorized hospice treatment plan), or vocational counseling
- Environmental sensitivity, clinical ecology, or inpatient allergy testing or treatment
- Chelation therapy except for treatment of acute metal poisoning
- Prescription drugs or medicines that are covered under a separate prescription drug program with its own limitations and exclusions
- Any outpatient prescription or nonprescription drugs (except for contraceptive drugs with a written prescription by a [health care practitioner](#) provided under the medical portion of this plan as shown in Preventive Care)
- Acupuncture, intersegmental traction, surface EMGs, spinal manipulation under anesthesia, and muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph, and Dynatron
- Any occupational therapy services which do not consist of traditional physical therapy modalities and are not part of a rehabilitation program designed to restore lost or impaired body functions
- Any portion of a charge for a service or supply that is in excess of the [allowable amount](#) as determined by Aetna
- Any services or supplies not specifically defined as eligible expenses, unless pre-approved through case management by Aetna
- Services or supplies for [custodial care](#) as determined by Aetna
- Services or supplies provided by a person who is related to the [participant](#) by blood or marriage, such as, but not limited to spouse, child, sibling or self
- Over-the-counter products, which do not require a prescription
- Over-the-counter contraceptives for male use
- Any services or supplies provided for treatment of adolescent (up to age 18) behavior disorders, including conduct disorders and opposition disorders.

- Services for smoking cessation or nicotine addiction except for smoking cessation counseling that may be allowed under preventive services. (Supplies may be covered through the prescription drug benefit)
- Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the [participant](#) for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Travel and lodging are not a covered benefit.

What does “non-covered” mean?

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

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

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

Aetna medical policies are subject to change without notice at any time. Participants and providers should verify the status of any relevant medical policy immediately before services are provided.

Current medical policies are available on the TRS-ActiveCare or Aetna websites, or by calling Customer Service.

How Your Prescription Drug Plan Works

About Caremark

Caremark is one of the largest pharmacy health care providers in the United States. Caremark's network includes more than 64,000 pharmacies nationwide, including chain pharmacies and 20,000 independent pharmacies.

Through Caremark pharmacy services, you can order maintenance and specialty medications online or by phone, and have them delivered directly to you. The Caremark website offers these and other services, including Ask-a-Pharmacist, for answers and information about your medications. To start using these and other features and services, register at www.caremark.com




Caremark ID Cards

Your prescription benefit plan is designed to bring you quality pharmacy care that will help you save money. If you enroll in one of the TRS-ActiveCare plan options, you will receive a new Caremark prescription drug [ID card](#) in the mail. Included with the ID card will be Caremark Welcome Kit reflecting your elected prescription benefit plan. If you need to obtain a temporary ID card or order additional cards, you can call 1-800-222-9205 and select Option 2 to speak to a Caremark representative, or you can go online at www.caremark.com


Be sure to take your prescription ID card to your pharmacy when you get a prescription filled for the first time. Your TRS-ActiveCare member number is the same on both your Aetna medical card and your Caremark prescription benefit card, so you may present either card to your pharmacy when you fill a prescription for medications.



Sample ID Cards

ActiveCare 1-HD

CAREMARK		Prescription Card	
RxBIN	004336	 TRS ACTIVECARE <small>TRS-ActiveCare</small> Retail/Mail Copay 31-day/90-day supply 20%/20% Generic 20%/20% Brand (Preferred) 20%/20% Brand (Non-Preferred) 20%/20% Specialty	Present this Prescription Card to fill your prescription at any participating retail pharmacy or retail-plus pharmacy. For more information, visit www.caremark.com/trsactivecare or call TRS-ActiveCare Customer Service and speak to a Customer Care representative toll-free at 1-800-222-9205. Pharmacy Help Desk for Pharmacists: 1-800-364-6331 Submit paper claims to: Caremark Claims Department P.O. Box 52136, Phoenix, AZ 85072-2136 <small>1296-ID_ActiveCare_custom-0714</small>
RxPCN	ADV		
RxGRP	RX1296		
Issuer (80840)	9151014609		
 ID	123456789		
 NAME	JOHN Q SAMPLE		

ActiveCare Select

**Prescription Card**

RxBIN	004336	 <small>TRIS-ActiveCare Retail/Mail Copay 31-day/90-day supply \$20/\$45 Generic \$40/\$105 Brand (Preferred) 50%/50% Coinsurance Brand (Non-Preferred) 20% Coinsurance Specialty</small>
RxPCN	ADV	
RxGRP	RX1296	
Issuer (80840)	9151014609	
ID	123456789	
 NAME	JOHN Q SAMPLE	

00001

Present this Prescription Card to fill your prescription at any participating retail pharmacy or retail-plus pharmacy.


For more information, visit www.caremark.com/trsactivecare or call TRS-ActiveCare Customer Service and speak to a Customer Care representative toll-free at 1-800-222-9205.


Pharmacy Help Desk for Pharmacists: 1-800-364-6331

Submit paper claims to:
Caremark Claims Department
P.O. Box 52136, Phoenix, AZ 85072-2136

1296-ID_ActiveCare_custom-0714

ActiveCare 2

**Prescription Card**

RxBIN	004336	 <small>TRIS-ActiveCare Retail/Mail Copay 31-day/90-day supply \$20/\$45 Generic \$40/\$105 Brand (Preferred) \$65/\$180 Brand (Non-Preferred) \$200 per fill (up to 31 DS) Specialty \$450 per fill (32-90 DS) Specialty</small>
RxPCN	ADV	
RxGRP	RX1296	
Issuer (80840)	9151014609	
ID	123456789	
 NAME	JOHN Q SAMPLE	

00001

Present this Prescription Card to fill your prescription at any participating retail pharmacy or retail-plus pharmacy.

For more information, visit www.caremark.com/trsactivecare or call TRS-ActiveCare Customer Service and speak to a Customer Care representative toll-free at 1-800-222-9205.

Pharmacy Help Desk for Pharmacists: 1-800-364-6331

Submit paper claims to:
Caremark Claims Department
P.O. Box 52136, Phoenix, AZ 85072-2136

1296-ID_ActiveCare_custom-0714

Drug Exclusions

Caremark and TRS regularly review formulary options to look for ways to control costs while preserving individual choice and access to clinically effective drugs. Updates to the tier status of individual medications happen on an ongoing basis.

Drug exclusions from the formulary will occur once per year and will typically go into effect on January 1st. Patients utilizing drugs that are to be excluded on January 1st during the four months preceding January 1st will receive notification prior to the change, and Caremark is available to provide support in identifying potential substitute therapies. For a complete list of this year's formulary exclusions, visit Caremark's website.

Caremark Preferred Drug list

Standard TRS-ActiveCare plans 1, 2, and Select include a formulary, which is a list of drugs indicating preferred and non-preferred status. Each covered drug is Food and Drug Administration (FDA) approved and is also reviewed by an independent group of doctors and pharmacists for safety and efficacy. TRS-ActiveCare encourages the use of the preferred drugs on this list to help control rising prescription drug costs. You will usually pay a lower [copayment](#) for generic drugs (Tier 1) and brand-name medications that are on the formulary (Tier 2).

Save Money on Prescriptions

You will pay:

- The lowest [copayment](#) for Tier 1 generic drugs;
- A higher copayment for Tier 2 preferred brand-name drugs; and
- The highest copayment for Tier 3 non-preferred brand-name drugs.

Your doctor may be able to help you save money by prescribing Tier 1 and Tier 2 drugs if appropriate. Visit Caremark's website to check the price and coverage of medications under your plan.

Generic Medications

FDA approved generics are safe and effective. Generic drugs may have unfamiliar names, but they are safe and effective. 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 U.S. Food and Drug Administration requires that the active ingredients have the same strength, purity, and quality as the brand-name alternatives. Prescriptions filled with generic drugs have lower copayments under TRS-ActiveCare's prescription drug program. For more information about your plan's formulary, visit www.caremark.com or contact TRS-ActiveCare Customer Service at 1-800-222-9205.

New this plan year: Drugs on the Generics Only Preventive Drug Therapy List maintained by the IRS are covered at no cost to participants on the ActiveCare-1HD plan. The list of eligible generic drugs is posted on the Aetna member website and Caremark website.

Education and Safety

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



How Your Prescription Drug Plan Works

State and federal laws limit the length of time a prescription is valid, regardless of the number of refills remaining. Please verify the expiration date on your refill slip before refilling your medicine.

Type of Service	ActiveCare 1-HD Network	ActiveCare Select Network	ActiveCare 2 Network	Non-Network
Drug Deductible (per plan year)	Subject to plan year deductible	\$0 for generic drugs \$200 per individual for brand-name drugs	\$0 for generic drugs \$200 per individual for brand-name drugs	Same as Network
Maximum Out-of-pocket Per plan year , includes medical and pharmacy deductible , applicable copay , and coinsurance	\$6,550 Individual \$13,100 Family	\$6,850 Individual \$13,700 Family	\$6,850 Individual \$13,700 Family	Same as Network
Retail Short Term (up to 31-day supply) Generic Preferred Brand Non-preferred Brand	20% after deductible	\$20 \$40 50% coinsurance	\$20 \$40 \$65	AC 1-HD: You will be reimbursed the amount that would have been charged by a network pharmacy less the required deductible and coinsurance AC Select: You will be reimbursed the amount that would have been charged by a network pharmacy less the required deductible and coinsurance AC 2: You will be reimbursed the amount that would have been charged by a network pharmacy less the required deductible and coinsurance
Retail Maintenance (after first fill; up to 31-day supply) Generic Preferred Brand Non-preferred Brand	20% after deductible	\$35 \$60 50% coinsurance	\$35 \$60 \$90	
Mail Order and Retail-Plus Network (up to 90-day supply) Generic Preferred Brand Non-preferred Brand	20% after deductible	\$45 \$105 50% coinsurance	\$45 \$105 \$180	
Specialty Medications	20% after deductible	20% coinsurance per fill	\$200 per fill (up to 31-day supply) \$450 per fill (32-day to 90-day supply)	

Network Retail Pharmacy Program

Participating network retail pharmacies will accept your TRS-ActiveCare [ID card](#) and charge you the lesser of the negotiated Caremark price or the usual and customary cost for up to a 31-day supply of your prescription at a traditional retail network pharmacy, or a 60-day to 90-day supply at a Retail-*Plus* network pharmacy. For the ActiveCare 1-HD Plan, after your [plan year deductible](#) is met, you will pay the applicable [coinsurance](#) percentage based on the cost of the prescription until your out-of-pocket maximum is satisfied. For the ActiveCare Select and ActiveCare 2 Plans, after your prescription brand-name drug deductible is met, you will pay any applicable [copay](#) or coinsurance percentage based on the cost of the prescription.

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

Mail order through the Caremark Pharmacy

By using the Caremark Pharmacy, you can receive up to a 90-day supply of covered medications. For the ActiveCare 1-HD Plan, after your plan year deductible is met, you will pay the applicable coinsurance percentage based on the cost of the prescription until your out-of-pocket maximum is satisfied. For the ActiveCare Select and ActiveCare 2 Plans, after your prescription brand-name drug deductible is met, you will pay any applicable copay or coinsurance percentage based on the cost of the prescription.

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

How to Fill a Mail Order Prescription

For new long-term or maintenance medications, ask your doctor to write two prescriptions:

- The first for up to a 90-day supply, plus any appropriate refills, to fill through the Caremark Mail-Service Pharmacy.
- The second for up to a 31-day supply, which you can fill at a participating retail network pharmacy for use until your mail-service prescription arrives.

Complete a Mail-Service Order Form and send it to Caremark, along with your original prescription(s) and the appropriate copayment for each prescription. Be sure to include your original prescription. Photocopies are not accepted.

Please note: You must mail in a Caremark Mail-Service Order Form the first time you request a new prescription through mail service. Caremark's automated refill service is only available after your first prescription order has been processed. You can download a Mail-Service Order Form by visiting www.caremark.com

A credit card is the preferred payment method, but you can also pay by check or money order. For credit card payments, include your VISA®, Discover®, MasterCard® or American Express® number and expiration date in the space provided on the order form.

You can expect to get your mail order prescription 7 to 10 days from the time your order is placed.

Retail-Plus Pharmacy Network

Retail pharmacies that choose to participate in the Retail-Plus network are able to dispense a 60-day to 90-day supply of medication. You may visit www.caremark.com/trsactivecare or contact TRS-ActiveCare Customer Service for more information on which pharmacies have chosen to participate in the Retail-Plus network.

At a Non-Participating Pharmacy

If you utilize a non-participating pharmacy or a network pharmacy that will not file the electronic claim, you must file a direct claim with Caremark. You will be responsible for any cost differences between the pharmacy charge and the plan reimbursement.

If you obtain a prescription outside of the United States, mail a copy of your prescription and purchase receipts along with the claim form. The mailing address is on the back of the form.

Clinical programs — Dispense as Written Prescriptions, Prior Authorization, Step Therapy, and Quantity limits

Dispense-as-Written Prescriptions

If you fill a prescription for a brand-name drug that has a generic version (or equivalent) available, the pharmacist can substitute the generic version unless you or your doctor have indicated on the prescription that you should only receive the brand-name drug.

For instance, the doctor may indicate “Brand Medically Necessary” on the prescription.

Generic equivalents approved by the U.S. Food and Drug Administration (FDA) contain the same active ingredients—and are the same in safety, strength, performance, quality, and dosage form—as their brand counterparts. Generally, generics cost much less than brand-name drugs, for both you and TRS-ActiveCare.

Step Therapy

Under the Step Therapy program, you may be required to try a prerequisite or “first-line” drug before a step therapy or “second-line” drug is approved. Prerequisite drugs and their corresponding step-therapy drugs are FDA approved and are used to treat the same conditions.

If it is Medically Necessary, you can obtain coverage for a step-therapy drug without trying a prerequisite drug first. In this case, your doctor must request coverage for a step-therapy drug as a medical exception. If coverage is approved, your physician will be notified. Your doctor can request a coverage review by calling Caremark at 1-800-222-9205.

Supply Limits

Some prescription drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a prescription drug has been assigned a maximum quantity level for dispensing, call TRS-ActiveCare Customer Service at 1-800-222-9205.

Drugs Requiring Prior Authorization

Under TRS-ActiveCare, Caremark may review prescriptions for certain medications with your doctor before they can be covered. This is done under a coverage management program. A prior authorization review follows clinical guidelines that are reviewed and approved by an independent group of doctors and pharmacists.

Coverage Management Programs

Below is a list of each of the three coverage management programs. To find out more information about coverage reviews and prior authorization, please call TRS-ActiveCare Customer Service at 1-800-222-9205.

Prior Authorization

For some medications, you must obtain approval through a coverage review before the medication can be covered under your plan. The coverage review process will allow Caremark to obtain more information about your specific course of treatment (information that is not available on your original prescription) in determining whether a given medication qualifies for coverage under TRS-ActiveCare.

Qualification by History

Certain medications may also require a coverage review based on:

- Whether certain criteria are met, such as age, sex, or condition; and/or
- Whether an alternate therapy or course of treatment has failed or is not appropriate.

In either of these instances, pharmacists will review the prescription to ensure that all criteria required for a certain medication are met. If the criteria are not met, a coverage review will be required.

Quantity Management

To promote safe and effective drug therapy, certain covered medications may have quantity restrictions. These quantity restrictions are based on manufacturer or clinically approved guidelines and are subject to periodic review and change.

Coverage Review Process

You can check to see if your medication requires prior authorization (coverage review) by calling TRS-ActiveCare Customer Service at 1-800-222-9205.

If your medication requires a coverage review, you or your doctor may start the process by calling Caremark.

At a Retail Pharmacy in Your Plan's Network

- If you are filling a prescription at a retail pharmacy and a coverage review is necessary, Caremark will automatically notify the pharmacist, who in turn will tell you that the prescription needs to be reviewed for prior authorization.
- You or your doctor may start the process by calling Caremark.
- Caremark will contact your doctor to request more information than appears on the prescription. After receiving the necessary information, Caremark will notify you and your doctor to confirm whether or not coverage has been authorized.
- If coverage is authorized, you simply pay your normal [copayment](#) for the medication. If coverage is not authorized, you may be responsible for the full cost. If appropriate, you can talk to your doctor about alternatives that may be covered.

Through the Caremark Pharmacy

- If you are filling a prescription through the Caremark Pharmacy and a coverage review is required, Caremark will contact your doctor to request more information than appears on the prescription. After receiving the necessary information, Caremark will notify you and your doctor to confirm whether or not coverage has been authorized.
- If coverage is authorized, you will receive your medication and simply pay your normal copayment for it. If coverage is not authorized, Caremark will send you a notification in the mail, along with your original prescription if it was mailed to the Caremark Pharmacy.

Specialty Pharmacy Program

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

CVS Caremark Specialty Pharmacy, (a Designated Dispensing Entity), is the preferred specialty pharmacy provider for TRS- ActiveCare. A list of medications that must be dispensed by CVS Caremark Specialty Pharmacy can be obtained by calling CVS Caremark Specialty Pharmacy at 888-265-7790. You may also speak to your Aetna Member Services or your Aetna Care Advocate nurse for the most up to date Specialty medication list. Specialty medications on this list are subject to change.

In general, the drugs on this list will not be covered by any pharmacy except for CVS Caremark Specialty Pharmacy, regardless of their medical necessity, their approval, or if the member has a prescription by a physician or other provider. In limited circumstances, however, coverage may be allowed through an alternate provider. Those circumstances include:

- Specialty Medications billed by a facility as part of an inpatient hospital stay.*
- Specialty Medications billed as part of an emergency room visit.*
- Situations where Medicare is the primary carrier.*
- Limited distribution Specialty Medications where CVS Caremark does not have access to the drug.*
- Circumstances where homecare is not clinically appropriate (either due to the member's clinical history or due to characteristics of the drug which require special handling) and an alternative infusion site

(that is qualified to administer the drug) is not available for coordination of services within a reasonable proximity (30 miles or less).**

- The treating physician has provided written documentation outlining the clinical rationale for the requirement that the member be treated at the designated facility and confirming that the designated facility is unable to accept drug dispensed by CVS Caremark. The written documentation will be reviewed and approved by appropriate CVS Caremark clinical personnel *before* allowing coverage for the requesting provider under the medical benefit.**

*Prior approval by CVS Caremark is not required.

**Situation will be evaluated by CVS Caremark clinical staff.

Certain [Specialty Medications](#) will be covered only under the *pharmacy* benefit through CVS Caremark Specialty Pharmacy. As part of this policy, these Specialty Medications will be excluded from coverage under the *medical* plan.

Prior authorization and specialty preferred drug plan design management may be required regardless of the benefit under which the drug is covered or the identity of the provider who is administering the drug.

In addition, for designated Specialty Medications where coverage is still allowed under the medical benefit, the drug, drug dosage(s) and site(s) of care for infusion therapy may require prior authorization for medical necessity, appropriateness of therapy and patient safety.

Caremark Infusion Nursing and Site of Care Management for Specialty Medications

Infusion nursing services for select Specialty Medications that are administered in the home and/or in an ambulatory infusion center are covered through the pharmacy benefit and are coordinated through and dispensed by the CVS Caremark Specialty Pharmacy. For non-oncology infused Specialty Medications that require administration by a medical professional, a Caremark CareTeam nurse will work with you and your provider to assess your clinical history and determine clinically appropriate options (location for your infusion) for clinician-infused Specialty Medications. Options may include homecare, an ambulatory infusion center, physician office, etc. Caremark CareTeam nurses will contact all impacted members to provide assistance and guidance. Whether they're administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service. By ordering your specialty medications through Caremark, you can receive:

- Toll-free access to specialty-trained pharmacists and nurses 24 hours a day, seven days a week;
- Delivery of your medications within the United States, on a scheduled day, Monday through Friday, at no additional charge;
- Most supplies, such as needles and syringes, provided with your medications;
- Safety checks to help prevent potential drug interactions;
- Refill reminders;
- Health and safety monitoring; and
- Up to a 90-day supply of your specialty medication subject to applicable copay/deductible/coinsurance.

Coordination of Benefits (COB)

TRS-ActiveCare/Caremark offers Coordination of Benefits (COB) as part of your plan. There are two options for payment of claims.

Paper Claim Submission

Under this program, you may submit a paper claim to Caremark along with an [Explanation of Benefits](#) (EOB) from the primary payer or a receipt for out-of-pocket costs. Caremark then reimburses you up to the amount that TRS-ActiveCare would have paid if there were no other coverage.

Electronic Claim Submission (Retail Only)

At the time of purchase, the pharmacy submits a secondary claim electronically to Caremark's real-time claims processing system for the balance unpaid by the primary payer. Caremark then reimburses the pharmacy up to the amount that TRS-ActiveCare would have paid if there were no other coverage. You are then responsible for payment of the unpaid balance.

The secondary benefit will not be more than your benefit under TRS-ActiveCare if there were no other coverage. For example: If you paid \$30 under the primary plan, but your TRS-ActiveCare [copayment](#) (copay) would have been \$20, Caremark will reimburse you \$10 as the secondary benefit. If your primary copayment (copay) is \$15, Caremark would not pay any secondary benefit because you would have paid \$20 in the absence of any other coverage. Claims are either paid or rejected based on plan rules.

Prescription Drug Plan Exclusions

Expenses Not Covered

If any expense not covered is contrary to a law to which the plan is subject, the provision is hereby automatically changed to meet the law's minimum requirement. No payment will be made under any portion of the plan for:

- A drug that can be purchased without a prescription order; these are commonly called over-the-counter (OTC) drugs (contact Caremark for a list of exceptions);
- Therapeutic devices or appliances, support garments, and other non-medical devices;
- Medication that is to be taken by or administered to a plan [participant](#), in whole or in part, while the plan participant is a patient in a [hospital](#), rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution that operates on its premises a facility for dispensing pharmaceuticals;
- [Investigational](#) or [experimental](#) drugs; including compounded medications for non-FDA approved use;
- Prescriptions that a plan participant is entitled to receive without charge under any workers' compensation law or any municipal, state, or federal program;
- Hair growth stimulants;
- Drugs prescribed to remove or reduce wrinkles in the skin;
- Fertility medications;
- Ostomy supplies;
- Topical fluoride products;
- Growth hormones, unless pre-authorized;

- Injectibles (contact Caremark for a list of exceptions);
- Charges for the administration or injection of any drug; some vaccine exceptions
- Plasma/blood products (except hemophilia factors);
- Any prescription filled in excess of the number specified by the doctor or any refill dispensed after one year from the doctor's original order; and
- Drugs with cosmetic implications.

Claim Denials and Appeals

Under TRS-ActiveCare, you have the option of appealing adverse coverage determinations.

Initial Review

Non-urgent Claims (Pre-service and Post-service)

If you submit a prescription for a drug that is subject to any limitations—such as prior authorization, preferred drug step therapy, or quantity limitations— your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use the Caremark Pharmacy, your doctor will be contacted directly. Caremark will need the following information:

- Patient name;
- Employee ID;
- Phone number;
- The prescription drug for which benefit coverage has been denied;
- The diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes); and
- Any additional information that may be relevant to your appeal.

You will be notified of the decision no later than 15 days after receipt of a pre-service claim that is not an urgent care claim if Caremark has sufficient information to decide your claim. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim. If you receive an adverse determination on your claim, you will be provided with a written statement that explains the denial and includes instructions on how to appeal that decision.

If Caremark does not have the necessary information needed to complete the review, we will notify you to request the missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information.

If all the needed information is received within the 45-day time frame, you will be notified of the decision no later than 15 days after the receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45-day period, your claim is considered denied and you have the right to appeal as described below.

Urgent Claims (Expedited Reviews)

In the case of an urgent care claim, Caremark will notify you of its decision as soon as possible, but no later than 72 hours after receipt of the claim, unless there is insufficient information to decide the claim. If further

information is needed, Caremark will notify you within 24 hours of receipt of your claim that further information is needed and that you have 48 hours to submit the additional information. Additional information must be submitted within 48 hours of the request. Caremark will then notify you of its decision within 48 hours of receipt of the information. If the missing information is not received within that 48 hours, the claim is deemed denied and you have the right to appeal the claim.

An urgent care claim is defined as a request for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, or health, or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

Appeal of Adverse Benefit Determination

Non-urgent Appeal

If you are not satisfied with the decision regarding your benefit coverage or if you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered denied because missing information was not promptly submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing:

- Your name;
- Caremark ID number;
- Phone number;
- The prescription drug for which benefit coverage has been denied;
- The diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes); and
- Any additional information that may be relevant to your appeal.

This information should be mailed to:

Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-443-1172

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by Caremark in relation to your appeal; the plan provisions on which the decision is based; a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman, if any, that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to

review your file; the right to receive, upon request and at no charge, the information used to review your second level appeal, and to present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you, together with an opportunity to respond prior to issuance to any final adverse determination of this appeal.

The decision made on your second-level appeal is final and binding.

If your second-level appeal is denied and you are not satisfied with the decision of the second-level appeal (i.e., your “final adverse benefit determination”), you can initiate an external review. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

Urgent Appeal (Expedited Review)

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not promptly submitted) if your situation is urgent. An urgent situation is one in which the time period for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your appeal. Urgent appeal requests may be oral or written. You or your physician may call 1-800-222-9205, option 2 or send a written request to:

Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-443-1172

Physicians may submit urgent appeals requests by calling the physician-only toll-free number at 1-866-443-1183.

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination no later than 72 hours after receipt of your appeal request. The notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by Caremark in relation to your appeal; the plan provisions on which the decision is based; a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman, if any, that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your appeal. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you, together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

In addition, in urgent situations, you also have the right to immediately request an urgent (expedited) external review, rather than wait until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time that you request the independent external review. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

Independent External Review

External Appeals Review

Generally, to be eligible for an independent external review, you must exhaust the internal claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal to both Caremark and request an independent external review at the same time, or alternatively you can submit your urgent appeal for the independent external review after you have completed the internal appeal process.

To file for an independent external review, Caremark must receive your external review request within 4 months of the date of the adverse benefit determination (if the date that is 4 months from that date is a Saturday, Sunday, or holiday, the deadline is the next business day) at:

Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-443-1172

Non-urgent External Review

Once you have submitted your external review request, Caremark will review, within 5 business days, your claim to determine if you are eligible for external review, and within 1 business day of its decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, Caremark will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to Caremark for reconsideration.

The IRO will review your claim within 45 calendar days and send you and Caremark written notice of its decision. If you are not satisfied with or you do not agree with the decision, your determination letter will contain contact information for the applicable office of health insurance consumer assistance or an ombudsman.

Generic alternative vs. Generic equivalent drugs

Generic Drug

A medication that is generally sold under the name of its active ingredients—the chemicals that make it work—rather than under a brand name. A generic is typically much less expensive than its brand-name counterpart. There are two classifications of generic drugs: Generic equivalent drugs are approved by the U.S. Food and Drug Administration and contain the same active ingredients—and are the same in safety, strength, performance, quality, and dosage form—as their brand-name counterparts. Generic alternative drugs are U.S. Food and Drug Administration (FDA)–approved generic medications whose active ingredients are different from those in another brand-name drug.

You may be taking a brand-name drug that does not have a generic equivalent. However, there may be a different generic that can sometimes be used to treat the same condition as your current brand-name drug. Generic alternatives are not the same as generic equivalents.

Preventive Medications

The plan covers the following preventive medications – both prescription and some over-the-counter (OTC) – at a \$0 [copayment/coinsurance](#). To receive these medications at a \$0 copayment/coinsurance, you must have an authorized prescription for the product and it must be dispensed by a retail network pharmacy or by mail through the Caremark Pharmacy.

- Aspirin: an OTC product for men and women age 45 to 79 for cardiovascular protection;
- Folic acid: OTC doses of 400 to 800 mcg/day for women who are pregnant or who are planning to become pregnant;
- Fluoride: a prescription product to prevent dental cavities;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Any charge related to the administration of a vaccine in a doctor's office is covered under your medical option. See the summary for your medical plan option for more details;
- Iron supplements: an OTC product to treat/prevent anemia;
- Smoking cessation products: OTC and prescription products;
- Nicotrol NS;
- Nicotrol Inhaler;
- Zyban;
- Chantix;
- Nicorette Gum/Lozenge;
- Nicotine Transdermal System;
- Female contraceptives;
- Prescription FDA-approved contraceptive agents (includes prescription IUDs—Mirena, Depo-Provera, patches, and oral agents);
- [Emergency](#) contraceptives (Plan B and Ella); and
- Medications that are prescribed for use in cleansing the bowel as a preparation for colonoscopy screening.

For more specific information regarding coverage options and limitations, please contact Caremark customer service.

Employee Eligibility

Who can enroll in TRS-ActiveCare?

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

- Receiving health care coverage as an employee or retiree under the State University Employees Uniform Insurance Benefits Act. *Example:* A school employee who has UT SELECT coverage as an employee with The University of Texas System.
- Receiving health care coverage as an employee or retiree under the Texas Employees Group Benefits Act. *Example:* A school employee who has HealthSelect coverage as an employee with ERS.
- A TRS retiree receiving, or who declined coverage, under TRS-Care, including a retiree who has returned to work.*

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

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

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

Who is eligible for TRS-ActiveCare coverage?

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

Independent contractors and volunteers are not employees and are therefore not eligible for TRS-ActiveCare coverage.

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

Eligible Dependents

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

- A spouse (including same sex marriage or a common law spouse); A child under the age of 26, who is one of the following:
 - A natural child;
 - An adopted child or child who is lawfully placed for legal adoption;
 - A foster child;
 - A stepchild, or
 - A child under the legal guardianship of the employee;
- “Any other child: (other than those listed above) under the age of 26 in a regular parent-child relationship with the employee, meeting all four of the following requirements:
 - 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 under age 26 whose primary residence is the household of the employee and who is a dependent of the employee for federal income tax purposes; and
- An unmarried child of a covered employee, age 26 or over may be eligible for dependent coverage if the child is either mentally or physically incapacitated to such an extent as to be dependent on the employee on a regular basis as determined by TRS and the child meets other requirements as determined by TRS.

Note: A dependent does not include a brother or sister of an employee unless the brother or sister is an unmarried individual under 26 years of age who is either: (1) under the legal guardianship of the employee, or (2) in a regular parent-child relationship with an employee as defined in the “any other child” category above. Parents and grandparents of the covered employee do not meet the definition of an eligible dependent. **It is against the law to elect coverage for an ineligible person. Violations may result in prosecution and/or expulsion from the TRS-ActiveCare program for up to five years.**

If an employee and spouse both work for a participating district/entity, the spouse may be covered as an employee or as a dependent of an eligible employee. Only one parent may enroll dependent children for coverage. A child (under age 26) who is employed by a participating district/entity and is a contributing TRS member cannot be covered as a dependent on his or her parent's TRS-ActiveCare coverage.

Making Changes/Special Enrollment Events

Subject to the qualifications noted below, you may be able to enroll for coverage, change plan options, or change the dependents you cover during a [plan year](#) if you or your dependent has a [special enrollment event](#) under applicable law. Changes in employee and/or dependent coverage must be requested within 31 days after the special enrollment event. (Special rules apply to newborns; see box on page 80 for more information.) If you do not request the appropriate changes during the applicable special enrollment period, the changes cannot be made until the next plan enrollment period or if applicable, until another special enrollment event occurs.

Refer to the Effective Date of Coverage chart on page 83 for more information on special enrollment events, when coverage begins and when premium is due.

What is a special enrollment event?

An event, as defined by the Health Insurance Portability and Accountability Act (HIPAA), provides a special enrollment period for individuals and dependents when there is a loss of other coverage or a gain of additional dependents.

New Dependent

You may have a special enrollment event when a new dependent is added to your family as a result of marriage, birth, adoption or placement for adoption. A common law marriage is not considered a special enrollment event unless there is a Declaration of Common Law Marriage filed with an authorized government agency. All applications to add a dependent or change plans due to a legal marriage must be accompanied with official documentation indicating the actual date of marriage in accordance with existing plan rules for special enrollment events.

Note: The COBRA election period is separate from the TRS-ActiveCare enrollment period(s), including special enrollment periods. For example, you have 60 days to elect COBRA coverage with a prior employer, but you must make a request for TRS-ActiveCare coverage within 31 days of the loss of coverage or the addition of a new dependent.

Can dependents be added throughout the plan year?

An employee may be able to add eligible dependents during a plan year if the employee has a qualified status change or special enrollment event. Such events may include marriage, birth, adoption or placement of 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. The cost of coverage may change based on the selected coverage category.

Loss of Coverage

Loss of coverage qualifies as a [special enrollment event](#) if:

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

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

- Medicare;
- Medicaid;
- CHIP;
- HIPP; and
- 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

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

- An increase in the premium cost;
- A reduction in the employer's contribution to the premium;
- Any other voluntary termination of coverage, including failure to pay your premium;
- Any additional surcharge or benefit reduction for spouse coverage;
- Any reduction of benefits such as an increase in [deductible](#) or change in the coordination of benefits; and
- A doctor or other health care provider no longer participates in the plan's network

In order to have a special enrollment event, when you or your dependent loses other health coverage, you or your dependent must have had other health coverage when coverage under TRS-ActiveCare was previously declined in writing. If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA continuation coverage is exhausted. If the other coverage was not COBRA continuation coverage, special enrollment can be requested when you or your dependent loses eligibility for the other coverage. Refer to page 79 for additional information on loss of other coverage.

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

Dropping Coverage

TRS-ActiveCare [participants](#) may drop TRS-ActiveCare coverage during a [plan year](#), unless restricted from doing so by their district/entity's Section 125 cafeteria plan's rules.

An employee cannot change plans when dropping a dependent from TRS-ActiveCare coverage, unless a [special enrollment event](#) has also occurred.

Court-Ordered Dependent Children

If the participating district/entity receives a court order or national medical support notice that directs an employee to provide health coverage for a dependent child, the court-ordered dependent child will be automatically enrolled from the date the participating district/ entity receives the court order or national medical support notice. A court order or national medical support notice that directs anyone other than the employee to provide health coverage for a dependent child does not require TRS-ActiveCare to provide dependent coverage for the dependent child and is not a [special enrollment event](#) for the employee or any of the employee's eligible dependents.

A court order or national medical support notice that is directed to the employee is a special enrollment event for the employee and the employee's spouse and other eligible dependents. Therefore, if an eligible employee is not covered by TRS-ActiveCare at the time the participating district/entity receives the court order or national medical support notice, the employee, the employee's spouse, and the employee's dependent child(ren) may be enrolled for coverage in TRS-ActiveCare.

With regard to any individuals who are not the subject of the court order or national medical support notice, normal eligibility and special enrollment event rules apply (for example, a request to enroll such individuals must be received within 31 days of the receipt by the participating district/entity of the court order or national medical support notice).

If the participating district/entity receives a 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 already enrolled in TRS-ActiveCare; you may select a different plan at this time. If you are not covered and you decide not to enroll in TRS-ActiveCare, you may select a plan for the dependent child(ren). If only one child is being added to coverage, the child will be set up with a single ID number and the employee-only premium rate will be charged. If you are adding more than one child, the youngest child will be set up with an ID number. The other child(ren) will be listed as dependents, and the employee and child(ren) premium rate will be charged.

Other Court-Ordered Dependents

Notwithstanding anything to the contrary above, a court order or national medical support notice that directs an employee to provide health coverage for a spouse, for an ex-spouse, or for other dependents that are not eligible children under TRS-ActiveCare eligibility standards does not require TRS-ActiveCare to provide dependent coverage as a result of the court order or national medical support notice; additionally, a special enrollment event does not arise from such court order or national medical support notice. An ex-spouse is not eligible for TRS-ActiveCare coverage unless the ex-spouse is already covered as a COBRA continuation [participant](#).

Effective Date of Coverage

The effective date is the date TRS-ActiveCare begins for a [participant](#). See the chart below to help determine the effective date of coverage. Pre-existing condition waiting periods and [creditable coverage](#) no longer apply.

If...	Your effective date is...	Your eligible dependent's effective date is...
Start date		
The district/entity first begins participation in TRS-ActiveCare on September 1, 2016, and the employee enrolls for coverage during summer enrollment...	September 1, 2016	September 1, 2016
The district/entity begins participation in TRS-ActiveCare after September 1, 2016, and the employee enrolls for coverage...	The date the district/entity first begins participation in TRS-ActiveCare	The same date as the employee's effective date of coverage <i>In no event will the dependent's coverage become effective prior to the employee's effective date</i>
Declines		
The employee enrolls for coverage during the 2016-2017 enrollment period and had originally declined coverage under TRS-ActiveCare...	September 1, 2016	September 1, 2016
New Hires		
A new hire in a TRS-covered position who is a TRS member on his or her actively-at-work date enrolls for coverage within 31 days after the actively-at-work date...	The employee's choice of: (1) his or her actively-at-work date, or (2) the first of the month following the employee's actively-at-work date <i>Premium is billed for the full month in which coverage begins. New hires must choose the effective date of coverage within 31 days after the actively-at-work date</i>	The same date as the employee's effective date of coverage <i>In no event will the dependent's coverage become effective prior to the employee's effective date</i>
A new hire in a non-TRS covered position who is regularly scheduled to work 10 or more hours per week on his or her actively-at-work date enrolls for coverage within 31 days after the actively-at-work date...	The employee's choice of: (1) his or her actively-at-work date, or (2) the first of the month following the employee's actively-at-work date <i>Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the actively-at-work date</i>	The same date as the employee's effective date of coverage <i>In no event will the dependent's coverage become effective prior to the employee's effective date</i>

If...	Your effective date is...	Your eligible dependent's effective date is...
Non-TRS Covered Positions		
<p>An employee in a non-TRS covered position who works less than 10 regularly scheduled hours per week and becomes employed in a TRS-covered position and enrolls for coverage within 31 days after the date he or she becomes an eligible employee...</p> <p>Note: <i>If an employee who meets eligibility requirements as regularly scheduled to work 10 or more hours per week declines coverage, he or she may not elect coverage later during that plan year if changing status to a TRS member. (Changing TRS membership status is not an enrollment event.)</i></p>	<p>The employee's choice of: (1) his or her eligibility date, or (2) the first of the month following <i>the employee's</i> eligibility date <i>Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the eligibility date.</i></p>	<p>The same date as your effective date of coverage. <i>In no event will the dependent's coverage become effective prior to the employee's effective date.</i></p>
<p>An employee in a non-TRS covered position that works less than 10 hours per week and begins to work 10 or more regularly scheduled hours per week and enrolls for coverage within 31 days after the date he or she becomes an eligible employee...</p>	<p><i>The employee's choice of: (1) his or her eligibility date, or (2) the first of the month following the employee's eligibility date Premium is billed for the full month in which coverage begins The employee must choose the effective date of coverage within 31 days after the eligibility date</i></p>	<p>The same date as your effective date of coverage <i>In no event will the dependent's coverage become effective prior to the employee's effective date</i></p>
Loss of Eligibility		
<p>The employee is enrolled in an approved HMO and loses eligibility because he or she no longer lives, works or resides in that HMO service area, the employee may enroll in another approved HMO (if applicable) or ActiveCare 1-HD, ActiveCare Select, or ActiveCare 2 within 31 days after losing eligibility.</p> <p>Please note: <i>If an employee enrolled in an ActiveCare Select (Aetna Whole Health) network moves out of the Aetna Whole Health network area, he or she will remain in the ActiveCare Select plan and may choose providers in the ActiveCare Select (Open Access) network. A new ID card will be sent indicating the network change.</i></p>	<p>The first of the month following the event date</p>	<p>The same date as the employee's effective date of coverage <i>In no event will the dependent's coverage become effective prior to your the employee's effective date</i></p>

If...	Your effective date is...	Your eligible dependent's effective date is...
Military		
<p>The employee returns from military service and enrolls (or re-enrolls) in TRS-ActiveCare within 31 days after his or her actively-at-work date...</p> <p><i>If the employee returns to active employment within the same plan year and chooses to re-enroll in TRS-ActiveCare, the employee must select the same plan option in which he or she was previously enrolled.</i></p>	<p><i>The employee's choice of:</i> (1) his or her actively-at-work date, or (2) the first of the month following the employee's actively-at-work date <i>Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the actively-at-work date</i></p>	<p>The same date as the employee's effective date of coverage <i>In no event will the dependent's coverage become effective prior to the employee's effective date</i></p>
Leaving before 31 days after active work date		
<p>The employee returns from leave-without-pay status and enrolls (or reenrolls) for coverage within 31 days after his or her actively-at-work date...</p> <p><i>If the employee returns to active employment within the same plan year and choose to reenroll in TRS-ActiveCare, the employee must select the same plan option in which he or she was previously enrolled.</i></p>	<p><i>The employee's choice of:</i> (1) His or her actively-at-work date, or (2) the first of the month following the employee's actively-at-work date <i>Premium is billed for the full month in which coverage begins. The employee must choose the effective date of coverage within 31 days after the actively-at-work date</i></p>	<p>The same date as the employee's effective date of coverage <i>In no event will the dependent's coverage become effective prior to the employee's effective date</i></p>
Newborn/Adoption/Legal Guardian		
<p>An eligible, but not covered employee adopts a child and chooses to enroll within 31 days after the date of adoption or date on which the child to be adopted is placed with the employee, the employee may enroll:</p> <p>(1) employee only, or (2) employee and spouse or (3) employee and adopted child, or (4) employee, spouse and adopted child <i>Other eligible dependents can also be added at this time</i></p>	<p><i>The date of adoption or date on which the child to be adopted is placed with the employee</i></p> <p><i>Premium is billed for the full month in which coverage begins</i></p>	<p>The date of adoption or the date on which the child to be adopted is placed with the employee</p> <p><i>Premium is billed for the full month in which coverage begins</i></p>

If...	Your effective date is...	Your eligible dependent's effective date is...
<p>An eligible, but not covered employee, has a newborn child, the employee may enroll:</p> <p>(1) employee only, or (2) employee and spouse, or (3) employee and newborn, or (4) employee, spouse and newborn</p> <p><i>The employee has 31 days after the newborn's date of birth to enroll the newborn for coverage</i> <i>The employee, spouse and other eligible dependents can only be added within 31 days after the newborn's date of birth</i></p>	<p>The newborn's date of birth</p> <p><i>Premium is billed for the full month in which coverage begins</i></p>	<p>The newborn's date of birth</p> <p><i>Premium is billed for the full month in which coverage begins</i></p>
<p>A covered employee adopts a child and chooses to enroll within 31 days after the date of adoption or date on which the child to be adopted is placed with the employee, the employee may enroll:</p> <p>(1) adopted child only, or (2) spouse only, or (3) spouse and or adopted child</p> <p><i>Other eligible dependents can also be added at this time</i></p>		<p>The date of adoption or the date on which the child to be adopted is placed with the employee</p> <p><i>If only enrolling the adopted child, premium is waived for the first calendar month if the date of birth is other than the first of the month. If enrolling any other eligible dependent, premium is billed for the full month in which coverage begins</i></p>
<p>A covered employee, you become a legal guardian of an eligible dependent child and choose to enroll the dependent within 31 days after the date the legal guardianship is granted...</p> <p><i>Other eligible dependents can also be added at this time</i></p> <p><i>An award of legal guardianship is not a special enrollment event if for a non-covered employee or his or her dependents</i></p>		<p>The date the guardianship is granted</p> <p><i>Premium is waived for the first calendar month if the date of notification is other than the first of the month</i></p>
<p>A covered employee adds a court-ordered eligible dependent child after the participating district/entity receives notice of the court order or national medical support notice ...</p> <p><i>Other eligible dependents can also be added at this time</i></p> <p><i>A court order on the spouse (or ex-spouse) of a covered employee does not require TRS-ActiveCare to provide dependent coverage</i></p>		<p>The date the participating district/entity receives notification of the court order or national medical support notice</p> <p><i>Premium is waived for the first calendar month if the date of notification is other than the first of the month</i></p>

If...	Your effective date is...	Your eligible dependent's effective date is...
<p>An eligible, but not covered employee adds a court-ordered eligible dependent child after the participating district/entity receives notice of the court order or national medical support notice...</p> <p><i>Other eligible dependents can also be added at this time. A court order is a special enrollment event for the employee. If the employee chooses to enroll himself and other eligible dependents, he or she has 31 days after the date the participating district/entity receives the court order or national medical support notice to enroll</i></p>	<p>The date the participating district/entity receives notification of the court order or national medical support notice</p> <p><i>Premium is billed for the full month in which coverage begins</i></p>	<p>The date the participating district/entity receives notification of the court order or national medical support notice</p> <p><i>Premium is billed for the full month in which coverage begins</i></p>
<p>A covered employee adds an eligible newborn grandchild or another newborn child who is in a regular parent-child relationship with the employee within 31 days after the date of birth...</p>		<p>The newborn's date of birth</p> <p><i>Premium is waived for the first calendar month if the date of birth is other than the first of the month</i></p>
<p>A covered employee adds an eligible grandchild or another child who is in a regular parent-child relationship with the employee within 31 days after the child qualifies as a dependent...</p> <p><i>Adding a grandchild or another child who is in a regular parent-child relationship with the employee is not a special enrollment event for a non-covered employee or his or her dependents</i></p>		<p>First of the month following the date the child qualifies as a dependent</p>
Marriage/Name Change		
<p>A covered employee gets married and chooses to enroll within 31 days after the date of marriage, you may enroll:</p> <p>(1) spouse only (2) spouse's eligible children, or (3) spouse and spouse's eligible children</p> <p><i>Other eligible dependents can also be added at this time</i></p>		<p>The first of the month following the date of marriage</p>

If...	Your effective date is...	Your eligible dependent's effective date is...
An eligible, but not covered employee gets married and chooses to enroll within 31 days after the date of marriage, the employee may enroll: (1) employee only, or (2) employee and spouse, or (3) employee and spouse's eligible children, or (4) employee, spouse and spouse's eligible children <i>Other eligible dependents can also be added at this time</i>	The first of the month following the date of marriage	The first of the month following the date of marriage
Special enrollment situations		
An employee receives an Insurance Enrollment Notification letter from the Texas Health and Human Services agency, regarding eligibility for HIPP	The first of the month following the date of the notification letter	The first of the month following the date of the notification letter
The employee makes 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

Promptly notify your [Benefits Administrator](#) to:

- Terminate TRS-ActiveCare coverage for a spouse upon a divorce
- Terminate TRS-ActiveCare coverage when a child reaches age 26 unless the child meets the eligibility requirements of either mentally or physically incapacitated
- Terminate TRS-ActiveCare coverage when a child, age 26 or over, that is either mentally or physically incapacitated marries

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

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

When Coverage Ends

Your TRS-ActiveCare employee coverage will end:

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

A dependent's coverage will end:

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

Notice of Creditable Coverage

You may request a Certificate of [Creditable Coverage](#) within 24 months of termination of your or your dependent's coverage under TRS-ActiveCare. If a certificate is required after December 31, 2014, you will need to contact Aetna at 1-800-222-9205 to request.

Can coverage be dropped throughout the plan year?

Unless restricted due to participation in an Internal Revenue Code Section 125 cafeteria plan, an employee can drop all coverage or drop dependent coverage. If coverage is dropped during the [plan year](#), the individual will not be eligible to re-enroll in TRS-ActiveCare until the next plan enrollment period unless a [special enrollment event](#) occurs. **Note:** You cannot elect to drop coverage retroactively; a future cancellation date is required.

When is a dependent child no longer eligible for coverage?

Coverage for a dependent child terminates at the end of the month in which the child turns 26, or enters into active, full-time military service, whichever occurs first, unless eligible as a disabled dependent. If a child becomes an employee and is a contributing TRS member, the child's coverage will also terminate. A child under age 26 who is employed by a district/entity and is a contributing TRS member can be covered as a dependent on his or her parent's TRS-ActiveCare coverage.

Refer to page 86 of this booklet for information on how to apply for COBRA continuation coverage for the dependent.

If you have a disabled dependent child age 26 or over, your child may be eligible for dependent coverage if the child is either mentally or physically incapacitated to such an extent as to be dependent on you on a regular basis and the child meets other requirements as determined by TRS. You (and your dependent's attending physician) must complete a Dependent Child's Statement of Disability form to provide satisfactory proof of the disability and dependency. The form must be submitted within 31 days after the date the child turns 26. To avoid any gap in coverage, the form must be submitted and approved prior to the end of the month in which the child turns 26.

Continuation of TRS-ActiveCare Coverage (COBRA)

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

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

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

An individual who elected coverage on or before December 9, 2004, may elect under the Uniformed Services Employment and Reemployment Rights Act (USERRA) to continue health coverage with his or her employer's plan for a maximum coverage period of 18 months. An individual who elected coverage on or after December 10, 2004, may elect under USERRA to continue health coverage with his or her employer's plan for a maximum coverage period of 24 months. Under most circumstances, the coverage period under COBRA and USERRA runs concurrently during the first 24 months. Coverage may be elected from USERRA or COBRA, but not both. Once you return to active employment and meet eligibility requirements, you can re-enroll for TRS-ActiveCare coverage within 31 days. If you return to active employment within the same [plan year](#) and choose to re-enroll in TRS-ActiveCare, you must select the same plan option in which you were previously enrolled.

Events Qualifying for 18-Month Continuation	Events Qualifying for 29-Month Continuation	Events Qualifying for 36-Month Continuation
<ul style="list-style-type: none"> • Loss of eligibility due to reduction of employee work hours • Voluntary employee termination including retirement (early or disability) • Employee layoff for economic reasons • Employee discharge, except for discharge for gross misconduct, or • Failure of a participating district/entity to pay all premiums for at least 90 days 	<ul style="list-style-type: none"> • 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 <p><i>To receive the additional 11 months of COBRA continuation coverage, you must notify your plan administrator of the Social Security Administration's (SSA) determination before the end of the 18-month period of COBRA continuation coverage.</i></p>	<ul style="list-style-type: none"> • 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.

Note: Employees may not make plan changes during a [plan year](#) unless there is a [special enrollment event](#) – even if changing from active to COBRA status.

How to Apply for COBRA

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

When COBRA Coverage Ends

COBRA/continuation coverage ends if:

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

Who administers COBRA coverage?

Billing and eligibility processing for COBRA coverage will be administered by WellSystems. Please contact WellSystems at 1-844-752-5146 if you have any questions regarding COBRA/continuation coverage.

COBRA Mailing Address for Correspondence/Administration	Phone: 844-752-5146 Fax: 855-284-0574
	Wellsystems TRS Unit P.O. Box 1390 Brandon, FL 33509-1390

What is the cost for COBRA coverage?

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

How to File a Medical Claim

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

Network providers, other than hospitals, must submit and Aetna must receive claims for in-network care as determined by their network contract. Network hospitals must submit and Aetna must receive claims for in-network care as determined by their network contract. Claims not submitted and received by Aetna within the period stated in the provider contract will not be considered for payment of benefits.

Who files claims?

When you receive treatment or care from a network provider, you will not be required to file claims. The provider will submit the claims directly to Aetna for you. You may be required to file your own claims when you receive treatment or care from a non-network 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 Aetna. Written agreements between Aetna and other providers may require payment directly to them. However, if the benefit payments are for claims from providers with no written agreement with Aetna, Aetna may choose to pay either you or your provider. If you receive payment from Aetna, 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:

- **Get a claim form**
Claim forms are available online. You can download a claim form from the website by logging onto www.tractivecareareaetna.com or by calling Customer Service at 1-800-222-9205. Use a separate claim form for each individual; do not combine expenses for family members on one claim form.
- **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 W# (number)
 - 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
- **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
- **Mail the claim form and itemized bills**
Keep a copy of the claim form and itemized bills for your records. Send the claim form and itemized bills to: Aetna, P.O. Box 981106, El Paso, TX 79998-1106. (The address also appears on the form.) Do not send the claim form to TRS. This will only delay processing. **Note: Foreign claims must be translated. If no translation is attached, processing may be delayed.**
You must file and Aetna must receive claims for non-network expenses within 12 months after the date of service.

- **Review your Explanation of Benefits (EOB) statement 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.

Note: EOBs are available online through Aetna Navigator for Members at www.trsactivecare.aetna.com; you must log in and elect to receive paper copies by mail. **To assist providers in filing your claims, you should always carry your TRS-ActiveCare ID card with you.**

Receipt of Claims

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

Review of Claim Determination

Claim Determinations

When Aetna receives a properly submitted claim, it has authority and discretion to interpret and determine benefits in accordance with TRS-ActiveCare program provisions. Aetna will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between Aetna and TRS.

You have the right to seek and obtain a full and fair review by Aetna of any determination of a claim, any determination of a request for preauthorization, or any other determination made by Aetna in accordance with the benefits and procedures detailed in your TRS-ActiveCare health benefit program.

If a Claim Is Denied or Not Paid in Full

On occasion, Aetna may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the [Explanation of Benefits](#) summary prepared by Aetna; then review this Benefits Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to Aetna and request a review of the decision as described in the **Medical Claim Appeal Procedures** below.

If the claim is denied in whole or in part, you will receive a notice from Aetna with the following information, if applicable:

- The reason for the determination;
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;
- An explanation of how you may have the claim reviewed by Aetna if you do not agree with the denial;
- A description of additional information which may be necessary to complete an appeal and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable) and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of Aetna's internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- In certain situations, a statement in non-English language(s) that the written notice of claim denial and certain other benefit information may be available upon request in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Aetna;
- The right to request reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, [experimental](#) treatment or similar exclusion, or a statement that such explanation will be provided upon request;
- In the case of a denial of an urgent care/clinical claim, a description of the expedited review procedure applicable to such claim. An urgent care/clinical claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Claims, Appeals and External Review

Filing Health Claims under the Plan

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to “you” in this Claims, Appeals and External Review section includes you and your Authorized Representative. An “Authorized Representative” is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company (Aetna). The notice will explain the reason for the denial and the appeal procedures available under the Plan.

Note: TRS-ActiveCare is **not** subject to the Employee Retirement Income Security Act (ERISA), a federal law that sets minimum standards for most voluntarily established health plans in private industry.

Urgent Care Claims

An “Urgent Care Claim” is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health Claims – Standard Appeals

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is experimental or investigational; or
- A decision that the service or supply is not medically necessary.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

- A rule violation was minor and is not likely to influence a decision or harm you; and
- It was for a good cause or was beyond Aetna's or the Plan's or its designee's control; and it was part of an ongoing good faith exchange between you and Aetna or the Plan.

This exception is not available if the rule violation is part of a pattern or practice of violations by Aetna or the Plan.

You may request a written explanation of the violation from the Plan or Aetna, and the Plan or Aetna must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

Full and Fair Review of Claim Determinations and Appeals

Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call the dedicated Aetna's Member Services Unit at 1-800-222-9205. Your request should include the group name (TRS-ActiveCare), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

Health Claims – Voluntary Appeals

External Review

“External Review” is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A “Final External Review Decision” is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the claim decision involves medical judgment and the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review

Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for external review.

Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444- EBSA (3272). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO

Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- (i) Your medical records;
- (ii) The attending health care professional's recommendation;
- (iii) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- (iv) The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- (v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

- (vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- (vii) The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan must allow you to request an expedited External Review at the time you receive:

- (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- (b) A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

Member Appeals:

Aetna
Attn: National Accounts CRT
PO Box 14463
Lexington, KY 40512

Physicians and facilities providing medical services to TRS-ActiveCare [participants](#) may also request an appeal in writing. They should forward the request and additional documentation to:

Aetna
Attn: Provider Resolution Team
PO Box 14020
Lexington, KY 40512

If you have any questions about the claims procedures or the review procedure write to Aetna or call 1-800-222-9205.

Subrogation, Reimbursement and Third Party Recovery Provision

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

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

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

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

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

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

Coordination of Benefits

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

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

How Are COB Benefits Paid?

TRS-ActiveCare will pay the difference between the [allowable amount](#) and the benefit paid by the primary plan, not to exceed the amount TRS-ActiveCare would have paid in the absence of any other coverage. You or your provider may submit and Aetna 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 Aetna within this 12-month period will not be considered for payment of benefits.

How to Determine Which Plan is Primary

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

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

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

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

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

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

For all TRS-ActiveCare [participants](#) without [ESRD](#):

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

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

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

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

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

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

A newborn child is automatically covered for the first 31 days after the date of birth. The plan of the parent whose birth date is earlier in the calendar year is primary. See page 81 for information on enrolling newborns.

You can access helpful information and administrative forms from the Aetna and Caremark websites through the TRS-ActiveCare website, www.trsactivecare.aetna.com. The ActiveCare 1 – HD, ActiveCare Select, and the ActiveCare 2 plans offer online services where members can check the status of claims, view benefit information, and find a network doctor or facility.

Your Secure Member Website

Aetna Navigator is where you will find information and tools to make the most of your plan benefits and better manage your health care and health dollars. It is easy to register and use the site.

To register:

Visit www.trsactivecare.aetna.com and click “Log In/Register” on Aetna Navigator. Follow the simple prompts.

Need help? Use the “Ask Ann” link to register retrieve a password, and find your way around the site.

Once you are registered, you can:

- Check benefits and claims
- Search for doctors who participate in the [Aetna network](#)
- Find hours and locations of urgent care centers
- Confirm family members covered under your plan
- Request a new or replacement Aetna [ID card](#) or print a temporary card
- Get cost estimates for medical procedures and treatments
- Take the Health Assessment
- View your Personal Health Record
- Get started with Aetna discounts on hearing and vision care, fitness memberships, and much more
- Link to reliable health information with Aetna IntelliHealth[®] and Aetna SmartSourceSM and much more...



Personal Health Record

Aetna Navigator is where you will find your Personal Health Record (PHR), and online record of care you have received, gathered from your claims information. You can view medical procedure and services received, and preventive and routine care provided – by home and when. You can also enter your own information, such as medications prescribed, over-the-counter drugs, and nutritional supplements you use.

The PHR also features:

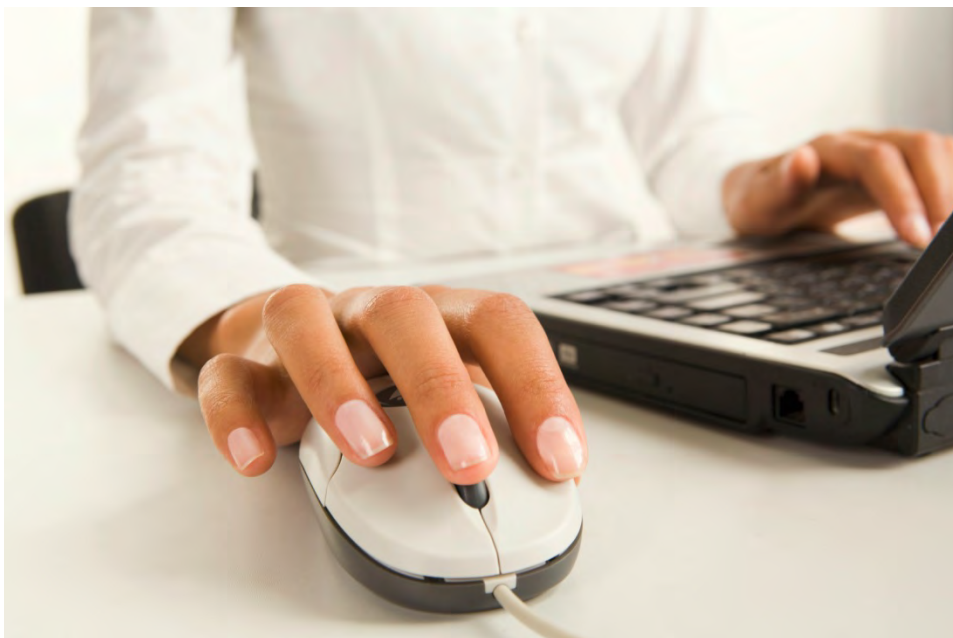
- MedQuery[®], an advanced program that can identify opportunities for better care and better health. MedQuery works for you by sending personal health recommendations and alerts that appear on your PHR.
- Health and physical activity trackers that let you record important information and measures such as blood pressure, blood glucose, strength training, and other daily fitness activities.

To view your PHR, go to www.tractivecare.aetna.com and log in to Aetna Navigator. In the “I want to ...” menu on the left side of your Aetna Navigator home page, select “View Personal Health Record.”

Mobile apps and tools

- Access Aetna Navigator on the go with **Aetna Mobile**. Pull up your secure member website to find network doctors, view and show your [ID card](#), check on claims, contact Member Services, and more. The Aetna Mobile app works with Apple[®] mobile digital devices and Android[™]-powered phones.
* **Get it:** Text “Apps” to 23862 ** OR visit www.aetna.com/mobile.

- **iTriage** helps you make sense of your health care options. Check a symptom, look up conditions and procedures, find the right doctor or facility, look up ER wait times, and much more. **Get it:** The app is free on Google Play or the App Store;* you can also visit www.itriagehealth.com.



Caremark Online Resources and Tools

Your Secure Caremark Member Website

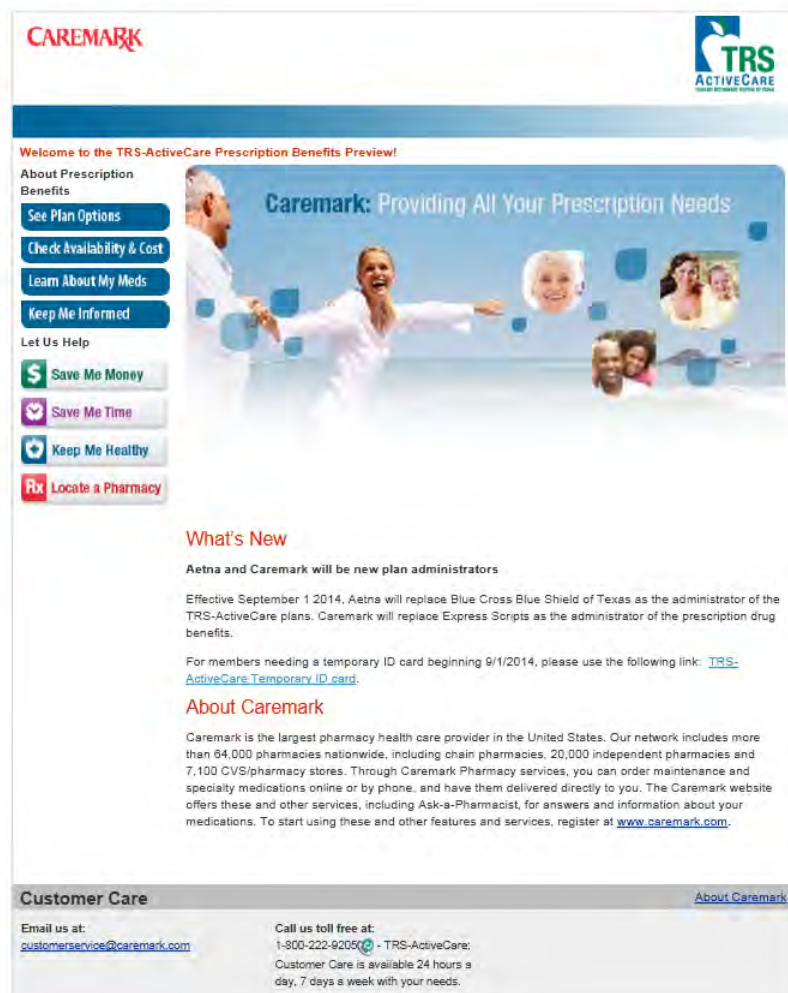
The main Caremark website is available at www.caremark.com. You can get:

- Refill reminders
- View and print temporary ID card
- Rx information
- Cost information
- Prescription history
- Track your Rx spend

Caremark also hosts a website specifically for TRS-ActiveCare plans:

www.caremark.com/trsactivecare

From this site, you can check drug costs for the different ActiveCare plan options, access the Generics Only Preventive Therapy Drug List for ActiveCare 1-HD, and see if a pharmacy is in the Retail-Plus Pharmacy Network.



Caremark Mobile Apps

The Caremark app gives you real-time, secure access to your prescriptions and pharmacy information. Look up pharmacies near you. Order prescriptions using the mail service, then check on the status of your order. Check your prescription history. You can use the app on your iPhone or Android phone. To get the app, visit www.caremark.com/trsactivecare. On the home page, look for the More Mobile Choices link to “get your App now.”

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.

Activities of Daily Living: The need for assistance with bathing, toileting, feeding, personal grooming, dressing, or getting in and out of a bed or chair.

Aetna Network: A series of providers who have contracted with Aetna in all 50 states for the benefit of TRS-ActiveCare participants.

Alcoholism or Drug Abuse Treatment Facility: A licensed institution, or a distinct part of an institution, mainly providing a program for diagnosis, evaluation, and effective treatment of Alcoholism or Drug Abuse.

Allowable Amount:

Medical – The allowable amount is the maximum amount determined by Aetna to be eligible for consideration of payment by TRS-ActiveCare for a particular service, supply, or procedure.

Prescription Drug – The allowable amount means the lesser of:

- (1) usual and customary;
- (2) maximum allowable cost plus a contractually determined dispensing fee; or
- (3) the average wholesale price less a contractually determined discount amount plus dispensing fee.

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

Ambulance Service: A vehicle that is medically staffed and equipped to transport ill or injured persons from the place where they are injured or stricken by disease to the nearest [hospital](#) that can provide the necessary care. The vehicle must be licensed under applicable local, county or state laws or regulations, and have attendants who are fully trained in [emergency](#) care, such as Emergency Medical Technicians (EMT) or paramedics. Benefits are not payable for transfer of a patient solely for convenience.

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

Balance Billing: A non-network provider's practice of billing the patient directly for the provider's charges that remain unpaid after the plan pays the [allowable amount](#) for covered services.

Bariatric Surgery: Bariatric surgery, also known as weight loss surgery, refers to the various surgical procedures performed to treat people living with morbid or extreme obesity. Bariatric surgery, however, has associated risks and can result in significant and costly complications and readmissions. Aetna has a national network of bariatric facilities that are deemed Institutes of Quality and have proven optimal clinical outcomes and value for members. Bariatric IOQ facilities provide the following services:

- Lap bands
- Bypass
- Sleeve gastrectomy

For ActiveCare 1 – HD and ActiveCare 2, all [medically necessary](#) bariatric surgical procedures, will be covered only if performed by a network provider at an Institute of quality s IOQ. There are no Bariatric surgery benefits for ActiveCare Select plans.

Chemical Dependency Treatment Center: A facility that provides a program for the treatment of chemical dependency. This program follows a written treatment plan approved and monitored by a physician who is affiliated with a [hospital](#) that has 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 or the Commission on Accreditation of Rehabilitation Facilities.

Coinsurance: This is the percentage of the participant's share for covered expenses for services and supplies, after the [deductible](#) has been met. 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.

Coinsurance Limit: Is the maximum out-of-pocket amount you will pay per [plan year](#). The deductibles, office visit [copays](#), and coinsurance all apply to your maximum out-of-pocket expense. 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.

Copayment (Copay): A predetermined amount the participant must pay for medical services during an office visit at the time the services are provided or a prescription is filled. Copays do not apply to the deductible.

Compassionate Care Program: The Aetna Compassionate Care Program is available for TRS-ActiveCare participants who are facing difficult decisions associated with life-limiting diseases and have a life expectancy of a year or less. Benefits include the assignment of a specially trained nurse case manager who offers benefits guidance and helps coordinate care with your health care team.

Creditable Coverage: Prior health coverage under various plans such as group health plans, individual health policies, Medicare, and Medicaid. Any prior coverage that ended more than 63 or more consecutive days from the start of new coverage is not considered to be creditable coverage.

Crisis Stabilization Unit: An institution licensed or certified by the Texas Department of Mental Health and Mental Retardation or other appropriate licensing agency. It provides a residential program on a 24-hour basis, usually short-term, and provides intensive instruction and highly structured activities for persons with acute demonstrable psychiatric crisis of moderate to severe

Custodial Care: Services and supplies furnished to a person mainly to assist him or her in the [activities of daily living](#), such as bathing, toileting, feeding, personal grooming, dressing, or getting in or out of bed or a chair. This includes room and board and other institutional care. Custodial care is not a covered service regardless of the provider or prescriber.

Day Care Treatment: A partial confinement treatment program for a mental health disorder given to a person during the day. There is no room charge made by the [hospital](#) or treatment facility. A day care program must be available for at least four hours but not more than eight hours in any one 24-hour period.

Deductible: Plan deductible is the amount of Covered Medical Expenses that you pay out-of-pocket each Plan year before TRS-ActiveCare begins payment for eligible covered medical and pharmacy expenses. The office visit [copays](#), [precertification](#) penalties, charges for services not covered and any payment for charges greater than the Plan's allowable reimbursement do not apply to the deductible.

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

Designated Dispensing Entity: A Designated Dispensing Entity is a pharmacy or other provider that has entered into an agreement with us or with an organization contracting on our behalf, to provide Specialty Medications for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity. If you are directed to a Designated Dispensing Entity and you choose not to obtain your specialty medication from a Designated Dispensing Entity, you will be subject to the non-network benefit terms for that specialty medication.

Durable Medical Equipment (DME): Equipment or supplies prescribed for the therapeutic treatment of an active disease or injury.

Eligibility Date: The date an individual and/or dependents become eligible for benefits under the Plan or also known as your effective date of coverage.

Emergency: This means the sudden and unexpected onset of a change in a person's physical or mental condition which, if the procedure or treatment was not performed immediately, could, as determined by Aetna, reasonably be expected to result in:

- Placing the person's health in serious jeopardy;
- Serious impairment to bodily function;
- Serious dysfunction of a body part or organ;
- Serious disfigurement; or
- Serious jeopardy to the health of a fetus.

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

Experimental or Investigational: A drug, device, procedure, or treatment will be determined to be experimental if:

1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
2. required FDA approval has not been granted for marketing; or
3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
5. it is not of proven benefit for the specific diagnosis or treatment of a Member's particular condition; or
6. it is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of a Member's particular condition; or
7. it is provided or performed in special settings for research purposes.

Although a physician or other health care provider may have prescribed such treatment, services or supplies, Aetna may consider that treatment to be experimental/ investigational within this definition.

ESRD (End Stage Renal Disease): Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

Explanation of Benefits: A description sent to an employee, spouse or dependent child by a health plan that includes the charges for services provided, the benefits considered, and the amount paid.

Health Care Practitioner: Means an advanced practice nurse, doctor of medicine, doctor of dentistry, physician assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

High-tech Radiology: High-tech radiology (CT scan, MRI, nuclear medicine; copay waived if performed during ER visit or inpatient admission)

Home Health Care: A service provided by a licensed agency or organization that provides skilled nursing and other therapeutic services

Hospice Care: Medical care and support services provided to a terminally ill person and his or her family under arrangements with a Hospice Care Agency as a part of a Hospice Care Program.

Hospital: A short-term acute care facility which:

- Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Health Care Organizations or is certified as a hospital provider under Medicare
- Provides 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

Identification (ID) Cards: These cards are issued to provide a participant's physician, [hospital](#), and any other provider with the necessary information to verify benefits, file claims properly, and allow participants to obtain prescriptions at a retail pharmacy. TRS-ActiveCare employees, spouses, and dependent children will receive two cards, one from Aetna for medical expense and one from Caremark for pharmacy expenses.

Both the Aetna and Caremark ID cards are issued using a "unique identification" number for the employee/spouse/dependent children. Due to concerns for privacy, the Social Security number is not used.

Long Term Acute Care (LTAC): Specialty hospitals for patients who require long acute stays for such diagnosis as ventilator weaning, critical care issues, medically complex care, and extensive wound management.

Medical Rehabilitation Hospital: A hospital licensed to provide facilities for the diagnosis and inpatient rehabilitative treatment of disease or injury with the objective of restoring physical function to the fullest extent possible.

Maximum Out-of-Pocket Limit: This is the maximum out-of-pocket amount you are responsible to pay for covered expenses per plan year. The deductibles, office visit copays, and coinsurance all apply to your maximum out-of-pocket expense. 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](#).

Medically Necessary Service or Supply: A service or supply determined by Aetna to be necessary for the diagnosis, care, or treatment of the physical or mental condition involved. The service or supply must be widely accepted professionally in the United States as effective, appropriate, and essential, based upon recognized standards of the health care specialty involved. To be appropriate and essential the services or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- Be a diagnostic procedure indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- As to diagnosis, care, and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- Information provided on the affected person's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized specialty involved; and
- Any other relevant information brought to Aetna's attention.

Examples that are not considered to be [medically necessary](#):

- Services provided by a unlicensed provider;
- Those services and supplies furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, or any person who is part of his/her family;
- Those services and supplies furnished to a person solely because he or she is an inpatient on any day on which the person's physical or mental condition could safely and adequately be diagnosed or treated while not confined;
- That part of the cost that exceeds the cost of any other service or supply that would have been sufficient to safely and adequately diagnose or treat the person's physical or mental condition.

Non-Network: A non-network provider is one which has not contracted with your insurance company for reimbursement at a negotiated rate. This means that as the patient, you would be responsible for the amount charged by your doctor that exceeds the plan's allowable amount. This term is used interchangeably with "out-of-network" and "non-participating."

Non-Network Allowable: Health care services and supplies that are provided by a Non-Network provider or are not contracted with Aetna to provide services. There may be reduced reimbursement or no coverage depending on your plan type. You will be responsible for all charges remaining after Aetna has paid the allowed amounts.

Non-Network Fee Schedule: The [non-network allowable](#) amount is developed from base Medicare rates. This is the maximum allowable rate for services provided by a non-network provider.

Non-participating: A non-participating provider is one which has not contracted with your insurance company for reimbursement at a negotiated rate. This means that as the patient, you would be responsible for the amount charged by your doctor that exceeds the plan's allowable amount. This term is used interchangeably with "non-network" and "out-of-network".

Out-of-Network: An out-of-network provider is one which has not contracted with your insurance company for reimbursement at a negotiated rate. This means that as the patient, you would be responsible for the amount charged by your doctor that exceeds the plan's allowable amount. This term is used interchangeably with "non-network" and "non-participating."

Other Plan: This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level required by the law will be counted.

Participant: An employee, spouse, and dependent child who is enrolled in TRS-ActiveCare.

Plan: Texas Public School Employees Group Benefit Program known as TRS-ActiveCare and as more fully described in this Booklet.

Plan Sponsor: The Plan Sponsor is the Teacher Retirement System of Texas as trustee of the Texas Public School Employees Group Benefits Program.

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

Precertification: The process of determining medical necessity for specific medical services as determined by Aetna. It begins with a telephone call to the TRS-ActiveCare/Aetna Service Center before the procedure and/or service is performed. A precertification penalty may apply if precertification is not obtained.

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

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

Reasonable and Customary: The average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the amount of money they will approve for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference.

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 Aetna as a residential treatment center for certain mental health care services for emotionally disturbed children and adolescents under the age of 18. Services provided to an individual age 18 or older by a Residential Treatment Center for Children and Adolescents will not be covered by TRS-ActiveCare.

Routine Physical: A physical exam or any diagnostic testing performed without any signs, symptoms, or diagnosis. Physicals to diagnose or evaluate a medical condition are not routine physicals.

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

Specialty Medications: Specialty Medications are defined as certain pharmaceutical and/or biotech or biological drugs (including “bio-similars” or “follow-on biologics”) which are used in the management of chronic or genetic disease, including but not limited to, injectables, infused, inhaled or oral medications, or otherwise require special handling.

Surgery Center: A freestanding, licensed ambulatory surgical facility that meets specific standards of care and medical criteria and:

- Is equipped and staffed to provide general surgery;
- Is directed by a staff of physicians, at least one of whom must be at the site when surgery is performed and during the recovery period;
- Has at least one certified anesthesiologist at the site when surgery, requiring general, or spinal anesthesia is performed and during the recovery period;
- Extends surgical staff privileges to physicians who practice surgery in an area and to [hospital](#) and dentists who perform oral surgery;
- Has at least two operating rooms and at least one recovery room;
- Provides or arranges with a medical facility in the area for diagnostic X-ray and lab services needed in connection with surgery;
- Provides, in the operating and recovery rooms, full-time Skilled Nursing services under the direction of an R.N.; must have a written agreement with a hospital in the area for immediate [emergency](#) transfer of patients;
- Provides an ongoing quality assurance program with reviews by physicians who do not own or direct the facility; and
- Does not have a place for patients to stay overnight.

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.



Initial Notice about Special Enrollment Rights

The federal law called Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you about very important provisions in the plan. The first is your right to enroll in the plan under its “special enrollment provision” if you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

A. SPECIAL ENROLLMENT PROVISIONS

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

If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other available health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if you move out of an HMO service area, or the employer stops all contributions towards other coverage for you and your dependents). However, you must request enrollment, and Aetna must receive your request, within 31 days after coverage ends for you or your dependents (or you move out of the prior plan’s HMO service area, or after the employer stops all contributions toward the other coverage, including employer paid COBRA paid premiums).

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

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

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

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

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

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment, and Aetna must receive your request, within 60 days after the determination is made concerning eligibility for such assistance for you or your dependents'.

Additional Information

To request special enrollment or obtain more information, call Customer Service at the phone number on the back of your TRS-ActiveCare ID card.

Notice of Privacy Practices

The Teacher Retirement System of Texas (TRS) administers your health benefits plan and your pension plan pursuant to federal and Texas law. This notice is required by the Privacy Regulations adopted pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH).

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully. This notice also sets out TRS' legal obligations concerning your health information. Additionally, this notice describes your rights to control your health information.

Please contact in writing the Privacy Officer, at the following address, if you have questions or want additional information about the privacy practices described in this notice:

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

Federal law requires TRS to maintain and protect the privacy of your health information. Your protected health information is individually identifiable health information, including genetic information and demographic information, collected from you or created or received by TRS that relates to:

- your past, present or future physical or mental health or condition;
- the health care you receive; or
- the past, present, or future payment for the provision of health care for you.

Unsecured protected health information is protected health information that is not secured through the use of a technology or methodology that renders the protected health information unusable, unreadable or indecipherable.

The effective date of this notice was April 14, 2003 and has been revised effective April 1, 2013. Texas law already makes your member information, including your protected health information, confidential. Therefore, following the original implementation of this notice and the implementation of this notice as revised, TRS did not and is not changing the way that it protects your information. On April 14, 2003, the new rights and other terms in this notice, as originally drafted, automatically applied. Likewise, as subsequently revised, the rights and other terms of this notice continue to automatically apply. You do not need to do anything to get privacy protection for your health information.

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

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

How TRS May Use and Disclose Your Protected Health Information

Certain Uses and Disclosures Do Not Require Your Written Permission. For any use or disclosure of your protected health information that is described immediately below, TRS and/or Medical Board members, auditors, actuarial consultants, lawyers, health plan administrators or pharmacy benefit managers acting on behalf of TRS, TRS-Care or TRS-ActiveCare may use and disclose your protected health information without your written permission (an authorization).

For all activities that are included within the definitions of “payment,” “treatment” and “health care operations” as set out in 45 C.F.R. Section 164.501, including the following noted below. This notice does not contain all of the activities found within these definitions; refer to 45 C.F.R. Section 164.501 for a complete list. When “TRS” is used below in describing these reasons, the auditors, actuarial consultants, lawyers, health plan administrators and pharmacy benefit managers acting on behalf of TRS, TRS-Care or TRS-ActiveCare are intended to be included.

- **For treatment.** TRS is not a medical provider and does not directly participate in decisions about what kind of health treatment you should receive. TRS also does not maintain your current medical records. However, TRS may disclose your protected health information for treatment purposes. For example, TRS may disclose your protected health information if your doctor asks that TRS disclose the information to another doctor to help in your treatment.
- **For payment.** Here are two examples of how TRS might use or disclose your protected health information for payment. TRS may use or disclose your information to prepare a bill for medical services to you or another person or company responsible for paying the bill. The bill may include information that identifies you, the health services you received, and why you received those services. The second example is that TRS could use or disclose your protected health information to collect your premium payments.

- **For health care operations.** TRS may use or disclose your protected health information to support health plan administration functions. TRS may provide your protected health information to its accountants, attorneys, consultants, and others in order to make sure TRS is complying with the laws that affect it. For example, your protected health information may be given to people looking at the quality of the health care you received. Another example of health care operations is TRS using and sharing this information to manage its business and perform its administrative activities.
- **When federal, state or local law, judicial or administrative proceedings, or law enforcement requires a use or disclosure.** For example, upon receipt of your request for disability retirement benefits, TRS and members of the Medical Board may use your protected health information to determine if you are entitled to a disability retirement. TRS may disclose your protected health information:
 - To a federal or state criminal law enforcement agency that asks for the information for a law enforcement purpose;
 - To the Texas Attorney General to collect child support or to ensure health care coverage for your child;
 - In response to a subpoena if the TRS Executive Director determines that you will have a reasonable opportunity to contest the subpoena;
 - To a governmental entity, an employer, or a person acting on behalf of the employer, to the extent that TRS needs to share the information to perform TRS' business;
 - To the Texas Legislature or agencies of the state or federal government, including, but not limited to health oversight agencies for activities authorized by law, such as audits; investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system, (ii) government benefit programs, (ii) other government regulatory programs, and (iv) compliance with civil rights laws;
 - To a public health authority for the purpose of preventing or controlling disease; and
 - If required by other federal, state, or local law.
- **For specific government functions.** TRS may disclose protected health information of military personnel and veterans in certain situations. TRS may also disclose protected health information to authorized federal officials for conducting national security, such as protecting the President of the United States, or conducting intelligence activities, or to the Texas Legislature or agencies of the state or federal government, including, but not limited to health oversight agencies, for activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, civil, administrative, or criminal proceedings or actions, or other activities. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system, (ii) government benefit programs, (ii) other government regulatory programs, and (iv) compliance with civil rights laws.

- **Business associates.** TRS has contracts with individuals and companies (business associates) that help TRS in its business of providing health care coverage and in making disability retirement benefit decisions. For example, several companies assist TRS with the TRS-Care and TRS-ActiveCare programs: Aetna and Caremark. . Some of the functions these companies provide are: performing audits; performing actuarial analysis; adjudication and payment of claims; customer service support; utilization review and management; coordination of benefits; subrogation; pharmacy benefit management; and technological functions. TRS may disclose your protected health information to its business associates so that they can perform the services that TRS has asked them to do. To protect your health information, however, TRS requires that these companies follow the same rules that are set out in this notice and to notify TRS in the event of a breach of your unsecured protected health information.
- **Executor or administrator.** TRS may disclose your protected health information to the executor or administrator of your estate.
- **Health-related benefits.** TRS or one of its business associates may contact you to provide appointment reminders. They may also contact you to give you information about treatment alternatives or other health benefits or services that may be of interest to you.
- **Legal Proceedings.** TRS may disclose your protected health information: (1) in the course of any judicial or administrative proceeding, including, but not limited to, an appeal of denial of coverage or benefits; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized by law); and (3) because it is necessary to provide evidence of a crime that occurred on our premises.
- **Coroners, Medical Examiners, Funeral Directors, and Organ Donation.** TRS may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. TRS also may disclose, as authorized by law, protected health information to funeral directors so that they may carry out their duties. Further, TRS may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.
- **Research.** TRS may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.
- **To Prevent a Serious Threat to Health or Safety.** Consistent with applicable federal and state laws, TRS may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Inmates.** If you are an inmate of a correctional institution, TRS may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.
- **Workers' Compensation.** TRS may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.
- **To your personal representative.** TRS may provide your protected health information to a person representing or authorized by you, or any person that you tell TRS in writing is acting on your behalf. For this purpose, a person acts on your behalf by being involved in your health care or in the payment for your health care.

- **To an entity assisting in disaster relief.** TRS may also disclose your protected health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then TRS may, using our professional judgment, determine whether the disclosure is in your best interest. TRS will attempt to gain your personal authorization when possible before making such disclosures.

Certain Disclosures that TRS is Required to Make

The following is a description of disclosures that TRS is required by law to make:

- **Disclosures to the Secretary of the U.S. Department of Health and Human Services.** TRS is required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Regulations.
- **Disclosures to you.** TRS is required to disclose to you most of your protected health information in a “designated record set” when you request access to this information, including information maintained electronically. Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. TRS is also required to provide, upon your request, an accounting of the disclosures of your protected health information. In many cases, your protected health information will be in the possession of a plan administrator or pharmacy benefits manager. If you request protected health information, TRS will work with the administrator or pharmacy benefits manager to provide your protected health information to you.
- **Certain Uses and Disclosures of Genetic Information that Cannot Be Made.** TRS and Medical Board members, auditors, actuarial consultants, lawyers, health plan administrators or pharmacy benefit managers acting on behalf of TRS, TRS-Care or TRS-ActiveCare are prohibited from using or disclosing genetic information for underwriting purposes.
- **Certain Uses and Disclosures of Protected Health Information that Will Not Be Made.** The following uses and disclosures of protected health information will not be made by TRS and Medical Board members, auditors, actuarial consultants, lawyers, health plan administrators, or pharmacy benefit managers acting on behalf of TRS, TRS-Care or TRS-ActiveCare:
 - Uses and disclosures that constitute marketing purposes;
 - Uses and disclosures that constitute the sale of your protected health information; and
 - Uses and disclosures that constitute fundraising purposes.

All Other Uses And Disclosures Require Your Prior Written Authorization. The following uses and disclosures will be made by TRS and Medical Board members, auditors, actuarial consultants, lawyers, health plan administrators or pharmacy benefit managers acting on behalf of TRS, TRS-Care, or TRS-ActiveCare only with a written permission (an authorization) from you:

- Most uses and disclosures of psychotherapy notes; and
- For any other use or disclosure of your protected health information that is not described in this notice.

If you provide TRS with such an authorization, you may cancel (revoke) the authorization in writing at any time, and this revocation will be effective for future uses and disclosures of your protected health information.

Revoking your written permission will not affect a use or disclosure of your protected health information that TRS and Medical Board members, auditors, actuarial consultants, lawyers, health plan administrators or pharmacy benefit managers acting on behalf of TRS, TRS-Care, or TRS-ActiveCare already made, based on your written authorization.

Your Rights

The following is a description of your rights with respect to your protected health information:

- **The Right to Request Limits on Uses and Disclosures of Your Protected Health Information.** You can ask that TRS limit how it uses and discloses your protected health information. TRS will consider your request but is not required to agree to it. If TRS agrees to your request, TRS will put the agreement in writing and will follow the agreement unless you need emergency treatment, and the information that you asked to be limited is needed for your emergency treatment. You cannot limit the uses and disclosures that TRS is legally required to make.

If you are enrolled in TRS-ActiveCare, you may request a restriction by writing to: Aetna Legal Support Services, 152 Farmington Avenue, W121, Hartford, CT 06156-9998. In your request, state: (1) the information whose disclosure you want to limit, and (2) how you want to limit our use and/or disclosure of the information. You have the right to request that your protected health information not be disclosed to TRS if you have paid for the service received in full.

- **The Right to Choose How TRS Sends Protected Health Information to You.** You can ask that TRS send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, courier service instead of U.S. mail) only if not changing the address or the way TRS communicates with you could put you in physical danger. You must make this request in writing. You must be specific about where and how to contact you. TRS must agree to your request only if:
 - You clearly tell TRS that sending the information to your usual address or in the usual way could put you in physical danger; and
 - You tell TRS a specific alternative address or specific alternative means of sending protected health information to you. If you ask TRS to contact you via an email address, TRS will not send protected health information by email unless it is possible for the protected health information to be encrypted.

- **The Right to See and Get Copies of Your Protected Health Information.** You can look at or get copies of your protected health information that TRS has or that a business associate maintains on TRS' behalf. You must make this request in writing. If your protected health information is not on file at TRS and TRS knows where the information is maintained, TRS will tell you where you can ask to see and get copies of your information. You may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set that is in the possession of TRS or a business associate of TRS. If you request copies of your protected health information, TRS can charge you a fee for each page copied, for the labor involved in compiling and copying the information, and for postage if you request that the copies be mailed to you. Instead of providing the protected health information you request, TRS may provide you with a summary or explanation of the information, but only if you agree in advance to:
 - Receive a summary or explanation instead of the detailed protected health information; and
 - Pay the cost of preparing the summary or explanation.

The fee for the summary or explanation will be in addition to any copying, labor, and postage fees that TRS may require. If the total fees will exceed \$40, TRS will tell you in advance. You can withdraw or change your request at any time. TRS may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your protected health information, you may request that the denial be reviewed. TRS will choose a licensed health care professional to review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, the denial will not be reviewable. If this event occurs, TRS will inform you in our denial that the decision is not reviewable.

- **The Right to Get a List of TRS' Uses and Disclosures of Your Protected Health Information.** You have the right to get a list of TRS' uses and disclosures of your protected health information. By law, TRS is not required to create a list that includes any uses or disclosures:
 - To carry out treatment, payment, or healthcare operations;
 - To you or your personal representative;
 - Because you gave your permission;
 - For national security or intelligence purposes;
 - To corrections or law enforcement personnel; or
 - Made prior to three (3) years before the date of your request, but in no event made before April 14, 2003.

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

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

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

- **The Right to Correct or Update Your Protected Health Information.** If you believe that there is a mistake in your protected health information or that a piece of important health information is missing, you can ask TRS to correct or add the information. You must request the correction or addition in writing. Your letter must tell TRS what you think is wrong and why you think it is wrong. TRS will respond to your request within 60 days of receiving it. TRS can extend this deadline one time by an additional 30 days. If TRS extends its response time, it must tell you in writing the reasons for the delay and the date by which TRS will respond. Because of the technology used to store information and laws requiring TRS to retain information in its original text, TRS may not be able to change or delete information, even if it is incorrect. If TRS decides that it should correct or add information, it will add the correct or additional information to your records and note that the new information takes the place of the old information. The old information may remain in your record. TRS will tell you that the information has been added or corrected. TRS will also tell its business associates that need to know about the change to your protected health information. TRS will deny your request if your request is not in writing or does not have a reason why the information is wrong or incomplete. TRS will also deny your request if the protected health information is:
 - Correct and complete;
 - Not created by TRS; or
 - Not part of TRS' records.

TRS will send you the denial in writing. The denial will say why your request was denied and explain your right to send TRS a written statement of why you disagree with TRS' denial. TRS' denial will also tell you how to complain to TRS or the Secretary of the Department of Health and Human Services. If you send TRS a written statement of why you disagree with the denial, TRS can file a written reply to your statement. TRS will give you a copy of any reply. If you file a written statement disagreeing with the denial, TRS must include your request for an amendment, the denial, your written statement of disagreement, and any reply when TRS discloses the protected health information that you asked to be changed; or TRS can choose to give out a summary of that information with a disclosure of the protected health information that you asked to be changed. Even if you do not send TRS a written statement explaining why you disagree with the denial, you can ask that your request and TRS' denial be attached to all future disclosures of the protected health information that you wanted changed.

- **Right to be Notified of a Breach of Unsecured Protected Health Information.** You have the right to be notified, and TRS has the duty to notify you, of a breach of your unsecured protected health information. A breach means the acquisition, access, use or disclosure of your unsecured protected health information in a manner not permitted under HIPAA that compromises the security or privacy of your protected health information. If this occurs, you will promptly be provided information about the breach and how you can mitigate any harm as a result of the breach.
- **The Right to Get This Notice.** You can get a paper copy of this notice on request.
- **The Right to File a Complaint.** If you think that TRS has violated your privacy rights concerning your protected health information, you can file a written complaint with the TRS Privacy Officer by mailing your complaint to:

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

All complaints must be in writing.

You may also send a written complaint to:

Region VI, Office for Civil Rights
Secretary of the U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202
FAX (214) 767-0432, and e-mail at OCRComplaint@hhs.gov

Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

Finally, you may send a written complaint to:

Texas Office of the Attorney General
P.O. Box 12548
Austin, Texas, 78711-2548
(800) 806-2092

TRS will not penalize or in any other way retaliate against you if you file a complaint.

More Information

If you want more information about this notice, how to exercise your rights, or how to file a complaint, please contact the TRS Telephone Counseling Center at 1-800-223-8778. TDD users should call (800) 841-4497.

Notice of Continuation Coverage Rights under COBRA

Introduction

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When Is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How Is COBRA Coverage Provided?

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

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

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

Disability Extension of 18-Month Period of Continuation Coverage

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

If the SSA determines a qualified beneficiary is disabled, the SSA will send that individual a "Social Security Administration Retirement, Survivors and Disability Insurance Notice of Award" letter. You must send a copy of this letter before the end of the first 18 months of COBRA coverage to WellSystems PO Box 732513 Dallas, TX 75373-2513.

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

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

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

When is COBRA Coverage Not Available?

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

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

If You Have Questions

Questions concerning your eligibility or premium payments should be addressed to WellSystems: 844-752-5146. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) Questions concerning Cobra administration or claims payment should be addressed to Aetna: 1-800-222-9205.

Keep Your Plan Informed of Address Changes

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

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

Keep Your COBRA Administrator Informed of Changes

In order to protect your family’s rights, you should keep WellSystems informed of any changes that could affect your policy; these changes would include contact information (address, phone number, email address) for you and your family members, as well as any changes in employment or a dependent status. You should also keep a copy, for your records, of any notices you send to WellSystems. All changes can be submitted online on the WellSystems Enrollment Portal or the Enrollment Application and Change form.

Wellsystems TRS Unit
PO Box 1390
Brandon, FL 33509-1390

Direct Phone Number	Fax Number	E-Mail Address
844-752-5146 Monday through Friday 7:00 am – 4:00 pm CST	877-283-9176	Cobra@wellsystems.com

Women's Health and Cancer Notice

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for [plan year](#) anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage. In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

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

Notice Regarding Network Facilities and Non-Network Providers

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

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

As indicated below, Texas provides premium assistance for State Medicaid, but not for CHIP. If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 8, 2016. You should contact your State for further information on eligibility.

ALABAMA – Medicaid

Website: <http://www.medicaid.alabama.gov>
Phone: 1-855-692-5447

ALASKA – Medicaid

Website:
<https://dhss.alaska.gov/dpa/pages/medicaid/default.aspx>
Phone (Outside of Anchorage): 1-800-770-5650
Phone (Anchorage): 1-907-465-3347

ARIZONA – CHIP

Website: <http://www.azahcccs.gov>
(Outside of Maricopa County): 1-800-528-0142
Phone (Maricopa County): 1-602-417-5010

COLORADO – Medicaid

Medicaid Website: <http://www.colorado.gov/>
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid

Website: <https://www.myflorida.com/accessflorida>
Phone: 1-866-762-2237

GEORGIA – Medicaid

Website: <http://dch.georgia.gov/>
Click on Programs, then Medicaid
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP

Medicaid Website:
www.healthandwelfare.idaho.gov/
Medicaid Phone: 1-800-926-2588

1-800-222-9205

INDIANA – Medicaid

Website: <http://www.in.gov/fssa>
Phone: 1-800-889-9949

IOWA – Medicaid

Website:
www.dhs.iowa.gov/ime/members/member-resources
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <http://www.kancare.ks.gov>
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Website: <http://chfs.ky.gov/dms/default.htm>
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: <http://www.louisiana.gov>
Phone: 1-888-342-6207

MAINE – Medicaid

Website: <http://www.maine.gov/dhhs/oms/>
Phone: 1-800-977-6740
TTY: 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP

Website: <http://www.mass.gov/MassHealth>
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: <http://www.mn.gov/dhs/partners-and-providers/health-care/>

Phone: 1-800-657-3629

MISSOURI – Medicaid

Website:

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 1-573-751-2005

MONTANA – Medicaid

Website: <http://medicaidprovider.mt.gov/>

Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633

NEVADA – Medicaid

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

Medicaid Phone: 1-800-992-0900 #1

NEW HAMPSHIRE – Medicaid

Website: www.dhhs.nh.gov/ombp/medicaid/

Phone: 603-271-5218 or 4344

NEW JERSEY – Medicaid and CHIP

Medicaid Website:

<http://www.state.nj.us/humanservices/dmahs/client/medicaid/>

Medicaid Phone: 1-800-356-1561

NEW YORK – Medicaid

Website:

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

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid and CHIP

Website: <http://www.ncdhhs.gov/dma>

Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid

Website:

<http://www.nd.gov/dhs/services/medicalserv/medicaid/>

Phone: 1-800-597-1603

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website:

<http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid

Website: <http://www.dhs.pa.gov/hipp>

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.eohhs.ri.gov

Phone: 1-855-840-4774

SOUTH CAROLINA – Medicaid

Website: <http://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <http://www.gethipptexas.com/>

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Website: <http://health.utah.gov/upp>

Phone: 1-866-435-7414

VERMONT – Medicaid

Website: <http://www.greenmountaincare.org/>

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website:

http://www.coverva.org/programs_premium_assistance.cfm

Medicaid Phone: 1-800-242-8282

WASHINGTON – Medicaid

Website: <http://hca.wa.gov/medicaid>

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: www.dhhr.wv.gov/bms/

Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid

Website: <http://www.badgercareplus.org/pubs/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <http://health.wyo.gov/healthcarefin/>

Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

TRS-ActiveCare Benefits Booklet

ActiveCare 1-HD, Select, and 2 Health Plans

Effective September 1, 2016