



2019 TRS-Care Standard Plan Guide for Non-Medicare-Eligible Participants

January 1 – December 31

Teacher Retirement System of Texas
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www.trs.texas.gov

Eligibility/Enrollment 1-888-237-6762
Medical Coverage 1-800-367-3636
Prescription Coverage 1-844-345-4577





About Your 2019 TRS-Care Standard Plan Guide

This guide provides an overview of the TRS-Care Standard plan eligibility requirements, enrollment, and the program benefits for non-Medicare-eligible participants.

For a detailed description of your plan, please refer to the *TRS-Care Benefits Booklet*.

The TRS-Care program may be changed in the future to provide coverage levels that are different from what is described in your plan materials (including this guide), or the TRS-Care program may be discontinued. The cost to participants in the TRS-Care program may be changed with the approval of the TRS Board of Trustees.

To the extent that any information in your guide is not consistent with or contradicts TRS laws and rules, the TRS laws and rules control. The *TRS-Care Benefits Booklet* will always control over information in other health plan materials.

TRS-Care 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.

This guide applies to the 2019 plan and supersedes any prior versions.



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TRS-Care Standard Quickstart Guide

Get the most out of your health care benefits:

Enroll – Make sure to submit your TRS 700A form within the initial enrollment period, which is three consecutive months or 90 days after your retirement date.

Understand your TRS-Care Standard Plan – Review your plan to learn how to make the most of your health benefits. You'll find more details and helpful resources on the TRS Health Benefits page at www.trs.texas.gov.

Know your out-of-pocket costs – Understand what you will pay and what your TRS-Care plan will pay.

Find an in-network doctor you trust – Use our provider search tool to find a doctor who fits best with your lifestyle and budgetary needs. Visit Aetna's DocFind® at www.aetna.com/docfind/custom/trscare to find and confirm an in-network doctor.

Know which labs and diagnostic centers are in-network – Talk to your doctor about using only in-network labs and facilities for your care. Visit Aetna's DocFind® at www.aetna.com/docfind/custom/trscare to find and confirm an in-network lab.

Plan ahead in the event of an emergency – Locate the in-network urgent care and emergency room near you in case the unexpected happens. Avoid freestanding ERs in strip malls, as costs can far exceed what you would pay for treatment at a hospital-based ER.

Schedule your annual wellness visit – Your annual exam can help you prevent health issues or catch health issues early. Keep in mind that if you talk about a health problem at your wellness visit, remember that it's no longer just a checkup and you will have to pay out of pocket for the visit.

Switch to generic medications – Talk to your doctor about switching your medications to generic brands to save you money on prescription drug costs. Ask your doctor and visit info.caremark.com/trscarestandard for details and a generic drug list.

Stay informed – Use your *TRS-Care Standard Plan Guide* and benefits booklet to be a knowledgeable health care shopper.

Understanding Your TRS-Care Standard Plan Benefits

Rising health care costs are a challenge across the country and Texas is no exception. For the past several years, TRS-Care health plan costs have consistently outpaced funding – and despite additional financial support from the Texas Legislature, premiums and benefits may change from year to year in order to ensure the health plan's sustainability for current and future retirees. Here's how the 2019 TRS-Care Standard plan works:

HEALTH PLAN

You and any dependents not eligible for Medicare will be covered by the TRS-Care Standard plan, which offers you comprehensive health care coverage, as well as access to significant discounts on medical services and prescription drugs when you use in-network providers.

PLAN YEAR

Your plan year runs from Jan. 1 to Dec. 31. Your deductibles and out-of-pocket maximums reset each year on Jan. 1.

MEDICAL BENEFITS ADMINISTERED BY AETNA

You have freedom to choose any doctor in Aetna's large network without a referral, as well as discounts for the in-network care you receive through Aetna's negotiated rates. You also have coverage for in-network preventive services such as cancer screenings, immunizations and annual wellness checkups at no cost.

PHARMACY BENEFITS ADMINISTERED BY CVS CAREMARK

Your prescription drug benefits are administered by CVS Caremark, meaning you can pick up your medications at your local neighborhood pharmacy or retail stores like CVS, Walgreens, HEB, Kroger and Randalls. You can also get prescriptions by mail order, including 90-day supplies of certain generic preventive maintenance medications at no cost to you.



This is your guide to making the most of your health care benefits. It equips you with the information you need to use your health plan and ensure you get the most value out of the health care dollars you spend. Let's get started!

The Basics

Your TRS-Care Standard plan offers you and any covered dependents valuable protection from the high cost of health care, as well as access to significant discounts on medical services and prescription drugs when you use in-network providers.

In addition, you can expect:

- No-cost preventive services.
- The freedom to choose any doctor in the health plan's network, with no referral required.
- Prescription drug benefits through CVS Caremark, available at local retail pharmacies and by mail order, including no cost for certain generic medications classified as "preventive." See page 12 for more information.
- A telemedicine service called Teladoc that offers low-cost and convenient doctor visits by phone or computer, 24/7.

How the Plan Works

- You pay an annual in-network individual deductible of \$1,500 (or \$3,000 if you cover dependents in a family plan) for medical care and prescription drug costs (including mental health, skilled home care and chemical dependency) before the plan begins to pay its share of your health care expenses.
- If you use in-network doctors and hospitals for your health care, you benefit from lower costs for the care you receive and the convenience of having your claims filed automatically on your behalf.
- Once you meet your annual in-network deductible, the plan pays 80 percent of your eligible in-network medical and prescription expenses; this is called coinsurance.
- Once you have met your plan's maximum out of pocket for the year (\$5,650 for individual coverage or no more than \$11,300 for a family when you use in-network providers), the plan pays 100 percent of all your eligible medical and prescription drug expenses.
- You have a separate deductible for care you receive from doctors and hospitals that are not in the network. So think carefully before you choose an out-of-network provider. It will take longer to meet your deductible, and you will not benefit from the plan's lower rates for health care services.

	In-Network	Out-of-Network
Deductible for medical & prescription expenses	\$1,500 individual; \$3,000 family	\$3,000 individual; \$6,000 family
Maximum out-of-pocket for medical & prescription expenses	\$5,650 individual; \$11,300 family	\$11,300 individual; \$22,600 family
Coinsurance for medical & prescription expenses	You pay 20% after meeting your deductible	You pay 40% after meeting your deductible
Teladoc – Board-certified doctors who diagnose, treat and write prescriptions via phone or video, available 24/7	\$40 consultation (counts toward the deductible and maximum out-of-pocket)	

Out-of-Pocket Costs

Your out-of-pocket costs are the dollars you pay for health care services, including deductibles and coinsurance.

Here's an example:

- You visit a specialist (a dermatologist) for rosacea.
- You walk up to the receptionist counter and office staff tell you that today's dermatology visit is \$100.
- If you haven't met your deductible, you pay that \$100 directly to your doctor. (The full amount you paid is applied toward your annual deductible.) That \$100 is an out-of-pocket cost for you.
- If your deductible is met, you might be required to pay 20 percent coinsurance or \$20, and your health plan will pay the balance. The \$20 is your out-of-pocket cost.

Out-of-Pocket Maximum

There is a limit on the amount you pay in a single year for health care costs; it's called your out-of-pocket maximum. After it has been met, the health plan pays 100 percent of your eligible medical and prescription drug costs and continues to pay 100 percent for the remainder of the calendar year.

Your out-of-pocket maximum amount resets annually on Jan. 1, just like your deductible.

Your Health Plan in Action

DEDUCTIBLE	COINSURANCE	OUT-OF-POCKET MAXIMUM
<p>\$1,500 for individual coverage (in-network)</p> <p>When you go to an in-network doctor or get a prescription drug, you pay the full cost of the service or prescription drug until your covered medical costs reach \$1,500 (or \$3,000 if you have a family plan).</p> <p>Example: <i>You visit an allergist and the negotiated rate is \$150. You pay in full and that amount is subtracted from your deductible.</i></p> <p>Visit cost: \$150</p> <p>You pay: \$150</p> <p>Your remaining deductible: \$1,350</p>	<p>You pay 20 percent (in-network)</p> <p>Once you've paid \$1,500 (or \$3,000 if you cover family) for in-network medical and pharmacy costs, your health plan begins to pay 80 percent of the costs. You pay only 20 percent of your expenses.</p> <p>Example: <i>You go in for that same allergist visit and have met your deductible. You pay 20 percent of that cost, or \$30. Your TRS-Care plan pays the rest.</i></p> <p>Visit cost: \$150</p> <p>You pay: \$30</p> <p>This amount goes toward meeting your out-of-pocket maximum.</p>	<p>\$5,650 for individual coverage or \$11,300 for family coverage (in-network)</p> <p>Once you've paid \$5,650 (or \$11,300 if you cover family) toward deductibles and coinsurance out of your pocket, the plan pays 100 percent of your costs for the rest of the calendar year.</p> <p>Example: <i>The allergist says you need outpatient sinus surgery, which costs \$30,000. You've already met your \$1,500 individual deductible, which counts toward your out-of-pocket maximum. At this point, you'd have to pay the remaining \$4,150 in order to meet your out-of-pocket maximum of \$5,650, at which point your plan begins to pay 100 percent.</i></p> <p>Surgery cost: \$30,000</p> <p>You pay: \$4,150 to meet your out-of-pocket maximum.</p> <p>The plan pays the rest.</p>

There are three categories of common out-of-pocket costs:

1. Premiums

This is the set amount you pay each month for your health insurance. Your premium costs do not apply toward your deductible or out-of-pocket maximum. The following chart lists your monthly premium costs.

2. Deductibles

This is the amount of money you have to spend out of pocket before your health plan begins to pay its share of your health care costs. A few things to remember:

- Any eligible medical or prescription drug expense applies toward your deductible.
- You have separate deductibles for in- and out-of-network expenses. This means you cannot apply out-of-network care toward your in-network deductible.
- Your deductible starts over each year on Jan. 1.

3. Coinsurance

When you have paid or met your deductible, your health plan begins to pay a percentage of your medical expenses and you pay a percentage as well. The percentage you pay is called "coinsurance."

It pays to stay in-network

If you go out-of-network, your individual deductible increases to \$3,000, and your coinsurance doubles to 40 percent. Not only that, but out-of-network expenses are not applied to your in-network costs. You also may be required to pay the difference between the plan's allowable rate for the service and the amount the out-of-network hospital or doctor bills. That's why it pays to comparison shop for your health care services. Log into Aetna Navigator® by visiting www.trscarestandardaetna.com and clicking the "Non-Medicare retiree" button.

2019 Monthly Premiums

Most Non-Medicare retirees	Non-Medicare retirees with disabled children (of any age)*
Retiree only \$200	
Retiree + Spouse \$689	
Retiree + Child(ren) \$408	Retiree + Child(ren) \$208
Retiree + Family \$999	Retiree + Family \$799
Surviving Child(ren) \$208	

*Monthly premiums for non-Medicare retirees with disabled children will be reduced by \$200 in tiers that cover children. It is the participant's responsibility to notify TRS should a child become disabled.

Premiums are determined by the TRS retiree or surviving spouse's Medicare eligibility, regardless of the Medicare status of their dependents. For example, if you are the TRS retiree and you're not yet eligible for Medicare and you cover your spouse who is eligible for Medicare, you would pay \$689 per month because you, the retiree, are not yet eligible for Medicare.

Planning to retire due to a disability?

If you're planning to retire due to a disability, you will pay the premiums listed on this page, depending on whether you cover yourself only or any dependents.

Already retired due to a disability?

Premiums are determined by the TRS retiree or surviving spouse's Medicare eligibility, regardless of the Medicare status of their dependents. For example, if you are the TRS retiree and you're not yet eligible for Medicare and you cover your spouse who is eligible for Medicare, you would pay \$689 per month because you, the retiree, are not yet eligible for Medicare.

If you retired prior to Jan. 1, 2017, receive TRS disability benefits, and are not eligible for Medicare, you still won't pay a premium for retiree-only coverage in the 2019 plan year (Jan. 1 – Dec. 31, 2019). Monthly premiums that cover a spouse or dependent are reduced by \$200. Refer to Disability Retirees on page 16 for more information.

Retiree only	\$0
Retiree + Spouse	\$489
Retiree + Child(ren)	\$208
Retiree + Family	\$799



QUICK TIP

Make every health care dollar you spend go further.

Use in-network doctors and hospitals that will file your medical claim with Aetna so every eligible expense will be applied toward your deductible. Aetna's in-network doctors have lower, contracted rates, which translate to less money out of your pocket.

Use DocFind at www.trscarestandardaetna.com to learn if your doctor is in Aetna's network, or to find other in-network providers.



QUICK TIP

Take advantage of no-cost prescription drugs.

If you take certain generic medications classified as “preventive,” such as a prescription drug used for hypertension, a heart condition or depression, you may receive your medication at no cost to you. It’s an important way that TRS is investing in the health of retirees. See page 13 for details.

POP ? QUIZ

Q: You go to your doctor, who is in the Aetna network, because you can’t get rid of a cough. The doctor determines you’ve got bronchitis. The full cost of the visit is \$100, but you’ve reached your deductible.

So your cost would be?

- A. It’s at no cost to you, because it’s preventive care.*
- B. It’s still \$100.*
- C. It’s \$20 (20% of the full cost).*

A: C is the right answer. It’s not preventive care, because you went in for a specific condition. It’s not \$100, because you’ve met your deductible. The cost of this in-network visit, or your share of the coinsurance would be \$20.

Remember, we’re talking about in network. If you go out of network and you’ll pay 40 percent of the plan’s allowable rate and the full difference of the allowable rate and whatever that doctor charges (assuming you’ve met your out-of-network deductible).



Using Your Health Plan

Choosing Your Doctor

With the thousands of doctors and hospitals in Aetna's network, chances are you can find one you like.

Locating an in-network doctor couldn't be easier. Here's how:

- Visit the TRS-Care Standard Plan website at www.trscarestandardaetna.com.
- Select TRS-Care for Non-Medicare Retirees and then click on the DocFind TRS-Care Provider Directory.
- Call TRS-Care Customer Service at 1-800-367-3636 Monday through Friday, 7 a.m. – 6 p.m. CST.

Know your network

One of the most valuable features of your health plan is the network of doctors and hospitals you have access to for your health care. When a doctor is “in-network,” it means that he or she has worked with our health plan on a mutually agreed upon rate for the services they deliver. In contrast, doctors who are not in-network have not. That's why going out of the network can be like driving a car without brakes — you have little control over the amount of money you spend for your care:

- You don't have the benefit of prenegotiated rates for your health care.
- Out-of-network doctors and hospitals can charge market price, which means you may have to pay the difference between your plan's allowable rate and the rate the doctor or hospital bills in full. Be aware: Costs above the plan's allowable rate and the billed amount do not apply toward your maximum out-of-pocket cost.
- You don't get to count out-of-network charges against your in-network deductible.
- You may also have to deal with extra paperwork because doctors outside of Aetna's network may require you to file your own health care claims.

The bottom line: If you use an out-of-network provider, regardless of the circumstances, you will most likely have to pay more — maybe much more than the usual deductible and coinsurance amounts.

Going to the Doctor

Regularly seeing a primary care physician or family doctor leads to lower costs and better health.

An annual wellness visit — provided to you at no cost under your preventive benefits — is a big part of that. This is the

yearly opportunity for your doctor to see the big picture of how you're doing and ensure you're symptom free. If you get a clean bill of health, great. You can then maintain, manage and even improve your health with regular checkups, following your doctor's advice and taking advantage of complimentary tools and programs available through your health plan.

When you make your appointment for your annual wellness visit, be sure to let the scheduler know that your visit should be coded as preventive care when you check in. If you discuss an ongoing condition or receive any diagnostic care, the visit will no longer qualify as preventive care services and you'll be responsible for out-of-pocket costs.

Your annual wellness visit will also make your doctor aware of any early or worsening signs of illness or disease — because when it comes to your health and your wallet, the sooner you know, the better. Keep in mind that there are serious conditions with no signs or symptoms that can put you at risk. Your annual wellness visit is your first line of defense.

Services covered and those considered preventive care

If you go to an in-network doctor symptom-free, for any kind of preventive exams or screenings (including certain cancer screenings), there's no charge to you. But not all visits to the doctor are considered preventive care; some are considered diagnostic care.

A diagnostic visit is when you go to the doctor for a specific complaint, initial treatment or health condition, or for on-going treatment of a medical condition, lab work or other tests necessary to address a known problem. Sometimes the difference between preventive and diagnostic care can get a little tricky.



QUICK TIP

Not all doctors are created equal.

So when you're looking for one, take advantage of Aetna's DocFind tool. From cost and quality information for in-network providers to candid reviews from real patients, DocFind is a valuable online tool to help you find the right health care solutions.

You can get there from the TRS website or from Aetna's website at www.trscarestandardaetna.com.



Consider, for example, if you go to your in-network doctor for a preventive care visit that you planned on being at no cost to you – let's say your annual physical. But during the course of the exam you complain about your shoulder hurting. Your doctor looks at it, discovers you have arthritis and prescribes a medication. In this case, your original preventive visit has now turned into an office visit for a specific illness or injury – and now you'll be charged for the visit as diagnostic care.

Visit www.trs.texas.gov
for a full list of preventive services
covered by your health care plan.

Take advantage of health services that are provided typically at no cost to you:

- Blood pressure screening
- Cholesterol screening
- Annual preventive wellness visit
- Diabetes (Type 2) screening
- Depression screening
- Lung cancer screening
- Routine screening mammograms
- Certain vaccinations like an annual flu or shingles shot

Be sure to visit an in-network primary care provider for these services so that they are 100 percent covered and at no cost. You'll find a full list of preventive services covered by your health care plan at www.trs.texas.gov.

POP QUIZ

Q: *A woman who takes medicine for high cholesterol has an annual wellness exam and receives a blood test to measure her cholesterol level.*

The same woman makes quarterly visits to her in-network doctor for blood tests to check her cholesterol level and to confirm the medication dosage level is appropriate. Which scenario is preventive and at no cost?

A: The first statement; the office visit and blood test are considered preventive because they're part of an overall wellness exam. The blood tests in option number two are not considered preventative because they are treatment for an existing condition.

Getting Care When You're Sick or Injured

When you are not feeling well or are injured and it's not an emergency, your first call should be to your primary care doctor. He or she knows your health history and can provide you with the most informed care. It's also the most cost-effective place to begin if you're not sure if you require a specialist.

But if your doctor's office is closed and you can't get an appointment, or you don't have an established relationship with a primary care physician (we can help you with that, too) — the good news is that you have options.

Getting care from home

- Connect with a doctor by phone, iPad, or computer 24/7 via Teladoc.
- Call 1-855-Teladoc (1-855-835-2362).
- Teladoc doctors diagnose non-emergency medical problems, recommend treatment, call in a prescription to your pharmacy of choice, and more.
- Pay a \$40 consultation fee (which counts toward your deductible and out-of-pocket maximum).

Retail clinics

Retail or “walk-in” clinics, located in Walgreens, CVS and HEB stores across the state, are a good alternative if you have an uncomplicated illness like a sore throat or earache and can't get an appointment with your primary care doctor. The cost is typically lower than an urgent care clinic, but be aware that retail clinics are not equipped to handle urgent health needs, such as a broken bone.

Urgent care or acute care clinics

Urgent care or acute care clinics are designed for after-hours care when your doctor's office is closed or when an urgent health need doesn't require a hospital ER visit. Typical services at an urgent care clinic include treatment for broken bones, cuts and burns, as well as for asthma and bronchitis. The cost for an urgent care clinic is typically more than for a retail clinic, but considerably less than an emergency room.

Emergency room

Life-threatening emergencies require immediate attention. If you suspect you have one, call 911 or go to the nearest ER and your plan will pay as in-network.

Finding urgent and emergency care near you

Visit the TRS-Care Standard Plan website to access the DocFind® tool or use the Aetna mobile app to find an in-network urgent care center or emergency room near you before you need one.

- Go to www.aetna.com or download the Aetna mobile app on your mobile phone. Just text Apps to 23862 (data and messaging rates may apply).
- Click on Find a Doctor.
- Select Urgent Care Facilities or Walk-In Clinics.

Get familiar with the urgent care and walk-in clinic closest to your neighborhood, and locate the hospital-based ER that is in your network before you need one. Visit the TRS-Care Standard website to access the DocFind® tool to find out the clinics that are in your network.

QUICK TIP

Beware of the freestanding ER that appears to be an urgent care facility.

Understanding the difference can have a big impact on your out-of-pocket costs for care. How do you spot one? Freestanding ERs are not physically attached to hospitals. You're more likely to see one next to your grocery store. They are required to have the word “emergency” in their name.

Lab, X-Ray or Other Diagnostic Tests

Just because your doctor is in the network doesn't mean that the labs or diagnostic testing and screening facilities they use are in-network as well. The unexpected cost of an out-of-network lab, x-ray, or test can be an unpleasant health care "gotcha," so know before you go to make sure the service is covered at an in-network rate.

Be a good health care shopper: MRI tests

Most of us take pride in being savvy shoppers — finding the best deal on the purchases we make, from groceries to cars. Health care shouldn't be any different. The cost of many common medical procedures can vary widely, with no correlation to the quality of the care you receive.

Just one example: Magnetic Resonance Imaging (MRI) tests. An MRI is used when you need a high-resolution look at what's happening inside your body. But it's important for you to know that the cost of having one can greatly vary depending on where you get it done. MRI and Computed Tomography (CT) scans have the highest variability in costs of any other types of medical imaging. Sometimes, the price can vary by 10 times between locations, and that's without any difference in quality.

From claims to comparison shopping, Aetna Navigator has you covered

The Aetna Navigator tool allows you to manage every aspect of your health online, 24 hours a day.

- Get a new ID card, by mail or electronically.
- Compare actual costs for common procedures and treatments before you receive care with the Member Payment Estimator.
- Use your Personal Health Record to understand the care you've received and sign up for customized alerts.
- Sign in to Teladoc.

Go to www.trscarestandardaetna.com and click on **Register on Aetna Navigator** to get started.

Staying in the Hospital

When it comes to a hospital stay, how much you have to pay depends on how much money you have already spent toward your deductible and coinsurance. Even a short hospital stay is costly, so you very quickly meet your deductible and out-of-pocket maximum when in-patient care is required.

Hospital prices vary significantly, even when they are in-network. The cost that one hospital charges for a knee replacement may be 50 percent more than another hospital charges — with no difference in the quality of the care you receive. If your doctor practices at more than one hospital,

use the Member Payment Estimator tool on Aetna Navigator to check prices first before agreeing on a facility.

Filling a Prescription

Caremark offers a broad choice of pharmacies, so you're likely to find a convenient location in your neighborhood. Find a pharmacy near you at info.caremark.com/trscarestandard.

When you need to fill a prescription

As with medical benefits, you must first meet a deductible before the plan starts paying its share of prescription drug expenses. Once you've met your deductible, you'll pay just 20 percent of your medication costs as long as the medications are part of the formulary.

You have a choice of ways to fill prescriptions and save on the medications you use.

- A. For short-term prescriptions (up to a 31-day supply),** you can visit any pharmacy in the Caremark retail network (which includes non-CVS pharmacies). To find a network pharmacy, visit info.caremark.com/trscarestandard.
- B. You may also use out-of-network pharmacies,** but you may pay more out of your own pocket for your medication. And remember, the cost of your drugs will not apply toward your in-network deductible.

If you need to fill an ongoing or "maintenance" medication, save time and energy with these convenient options:

- **Use the mail-order service, Caremark Pharmacy.** You can order up to a 90-day supply of your medication and have it delivered to any address you provide. You can pay via credit card, check or money order. Visit info.caremark.com/trscarestandard to learn more about the service. If you use this option, you can also break up your costs for a 90-day supply into three monthly installments, which may help you manage costs.
- **Visit a Caremark Retail-Plus pharmacy.** Retail pharmacies that participate in the Retail-Plus network can dispense a 60- to 90-day supply of medication. To find Retail-Plus pharmacies near you, visit info.caremark.com/trscarestandard or call CVS Caremark Customer Service at 1-844-345-4577 (TTY: 711).

If you need to fill a specialty medication

Specialty medications are drugs used to manage a chronic or genetic condition. They may be injected, infused, inhaled or taken orally, and may require special handling.

For speciality medications, you must use the CVS Caremark Specialty Pharmacy. To use this service, call CaremarkConnect® toll-free at 1-800-237-2767 or visit www.cvsspecialty.com.

Take advantage of no-cost prescription drugs to protect your health

Your TRS-Care health plan includes full coverage for certain generic drugs classified as “preventive medications,” or drugs that are used to prevent a condition, not treat an existing one.

If you are prescribed a medication in one of the classes on this page, your medication may be preventive, and you may be eligible to receive the drug at no cost to you.

Be sure and check the list of drugs classified as “preventive” at info.caremark.com/trscarestandard to see if your drug is on the list and make the most of this valuable benefit.

Top Four Prescription Drugs from CVS Caremark

- Generic Crestor (rosuvastatin)
- Generic Benicar (olmesartan)
- Generic Zetia (ezetimibe)
- Generic Vytorin (ezetimibe/simvastatin)



Types of Generic Preventive Medications That May Be Offered to You at No Cost

<p>CARDIOVASCULAR Antiarrhythmic agents Antianginal agents Coronary artery disease Antihyperlipidemics & combinations</p> <p>DIABETES Antidiabetics Diabetic diagnostic products & supplies Hematologic agents Coagulation factors</p> <p>HYPERTENSION ACE inhibitors, ARBs, CCBs Beta blockers Diuretics Antihypertensives & combinations</p>	<p>IMMUNIZING AGENTS Vaccines Toxoids Passive immunizing agents & biologicals</p> <p>MENTAL HEALTH Antidepressants Antipsychotics Osteoporosis Calcium regulators Hormone receptor modulators</p> <p>PREVENTIVE CARE Antiobesity agents Smoking deterrents Agents for chemical dependency Bowel preparations</p>	<p>RESPIRATORY DISORDERS Antiasthmatics Seizure Disorders Anticonvulsants</p> <p>STROKE Anticoagulants Platelet aggregation inhibitors</p> <p>WOMEN'S HEALTH Aromatase inhibitors & antiestrogens Contraceptives Prenatal vitamins</p> <p>VARIOUS CONDITIONS Antimalarial agents Dental caries prevention Hereditary angioedema (HAE) agents Immunosuppressive MS agents Antiretroviral agents</p>
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Avoiding Unexpected or Unnecessary Health Care Expenses

Most of us don't like surprises, especially when it comes to how much we pay for something. Too often, it feels like health care can be full of these financial "gotchas." Use these tips to help avoid unpleasant surprises.

✔ Try to always stay in-network

Make sure your doctors, specialists, hospitals, labs and diagnostic facilities are in-network. It's easy to look up the doctors and facilities you use to see if they're in the network at www.aetna.com/docfind/custom/trscare.

✔ Shop around for diagnostic services

From MRIs to CT scans, there can be a huge difference in price for the same screening, service or procedure, depending on where you get it. In health care, higher cost doesn't necessarily mean better quality. The same applies for routine hospital procedures, such as hip or knee replacements. Make sure to use the Member Payment Estimator tool through the Aetna Navigator tool to do some price comparisons before you get the service.

✔ Consider alternatives

For example, Teladoc gives you access to doctors through a phone or video visit for non-emergency issues. You can even use it to get quick medical advice 24/7. And at only \$40 per consultation, it can be a more cost-effective option than a traditional doctor's visit for a minor health condition. If you need to see a doctor in person or after hours, consider a retail clinic or urgent care center instead of the emergency room. If you must go to the emergency room, be sure to avoid freestanding emergency rooms. You'll save time and money.

✔ Use generic drugs

Ask your doctor about switching to a generic drug if you've been prescribed a brand medication. If there's no generic available, ask your doctor to choose a preferred brand from the CVS Caremark formulary list. And don't forget that many generic preventive medications are available to you at no cost.

✔ Trust, but verify.

There are literally millions of claims filed every year through the health care system. So it's a good idea to compare the amount your doctor is charging you against the cost of the same procedure listed in your Explanation of Benefits you receive in the mail. If there's a discrepancy, call Aetna at 1-800-367-3636 to get it corrected.

✔ Mediation

You may have received emergency care, health care, or medical services or supplies from a facility, emergency care provider, or facility-based provider that is out-of-network. If you get a bill that is more than \$500 (not including your copayment, coinsurance and deductible), you may have the right to dispute the claim and ask for a mediation of the claim amount. You can get more information, and you may be able to reduce some of your out-of-pocket costs for an out-of-network claim if the claim is eligible for mediation by visiting the Texas Department of Insurance at www.tdi.texas.gov/consumer/cpmmediation.html or calling 1-800-252-3439. If you get a bill from any out-of-network provider that concerns you, call customer care at the number on your ID card for a claim review.

Saving Money with a Health Savings Account

A health savings account (HSA) is a special type of savings account designed to help people save money tax-free to pay for health care expenses. It's a popular choice for many people because it's easy to open, easy to use, and offers you an opportunity to save on health care costs.

The TRS-Care Standard health plan is considered an "HSA-qualified" plan, which means that you can take advantage of the savings associated with opening and funding one. Any deposits you make into the account can be deducted from your income taxes, as long as you spend the money in the account to cover medical expenses. In addition, any interest your deposits earn is tax-free as long as the money is spent on medical care. HSAs are often used with high-deductible health plans to help cover out-of-pocket medical costs.

How an HSA works

If you decide to open an HSA, you will need to visit a financial institution that offers them. You will own the account and make all deposits to it.

You can make deposits to your HSA account, up to a maximum of \$3,500 a year for an individual and \$7,000 for a family in 2019. (Just be aware that the limit may change each year.) You can then use the money you deposit to help pay your health care deductible and for most other health care expenses, including dental and vision services. However, because you will likely deduct those deposits from your income taxes and because the money grows tax-free, be certain that you spend these funds only on approved medical costs.

If you spend them on other things, you will have to pay both taxes and penalties. For a complete list, go to www.IRS.gov and search for *Publication 502*.



QUICK TIP

Find out if your specialty medication qualifies for a discount.

Some specialty medications may qualify for third-party copayment assistance programs that can lower your out-of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, you will not receive credit toward your out-of-pocket maximum or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.



Using the funds in your HSA is easy! You can either:

- A. **Transfer the money from your HSA to your checking account** to cover the cost of a health care service; or
- B. **Open an account with a bank that offers debit cards with their HSAs** and use the HSA debit card to pay for the health care service.

In either case, it is important that you keep track of medical receipts so that you can prove to the IRS that the money was used properly should you be required to do so.

Another important feature of an HSA – you own the HSA and the money deposited in the account is yours. Unlike a flexible

spending account, any money and interest earned that you do not spend will remain in the account and roll over into the next plan year.

Please Note:

TRS does not administer an HSA option, but you can easily obtain one on your own. Most banks offer HSAs, and opening one is as simple as opening any other type of savings account. You can start looking around for your HSA institution at any time; however, your account cannot be funded until your TRS-Care Standard plan coverage begins.

Eligibility and Enrollment

This section provides an overview of TRS-Care eligibility requirements and enrollment. For additional information about your health plan, please refer to the *TRS-Care Benefits Booklet*, available online at www.trs.texas.gov.

Who can enroll in TRS-Care?

Service Retirees

A service retiree must have at least 10 years of service credit in TRS at the time of retirement. This service credit may include up to five years of military service credit, but it may not include any other purchased special or equivalent service credit. In addition to the “10 years of service credit” requirement, you must meet one of the following requirements at retirement:

1. the sum of your age and years of service credit in TRS equals or exceeds 80 (with at least 10 years of service credit), regardless of whether you had a reduction in the retirement annuity for early age (years of service credit can include purchased service); or
2. you have 30 or more years of service credit in the TRS pension (including purchased service).

Note: *Combined service credit under the Proportionate Retirement Program may not be used to establish eligibility for TRS-Care or any type of benefits other than service retirement benefits. A service retiree is not eligible to enroll in the TRS-Care program if eligible for ERS, UT System, or the Texas A&M System health benefit program coverage.*

Disability Retirees

Individuals are eligible to participate in TRS-Care when they become a disability retiree under the TRS pension. Once enrolled in TRS-Care as a disability retiree, participation continues as long as the individual is a disability retiree under the TRS pension fund. If you’re applying for health coverage because of a disability, you may be contacted to validate your Medicare Social Security Disability status.

NOTE: *Coverage for a disability retiree with fewer than 10 years of service credit in the TRS pension only continues up to the total number of years of service credit. Consequently, coverage for such a disability retiree will end when disability retirement benefits under the TRS pension fund end. A disability retiree is eligible to enroll in TRS-Care even if he or she is eligible for ERS, UT System, or A&M System health benefit program coverage.*

Dependents

The following dependents are eligible to enroll in TRS-Care:

- A. Your spouse (including a common-law spouse);
- B. A child under the age of 26 who is:
 - a natural child;
 - an adopted child, or one lawfully placed for adoption;
 - a foster child;
 - a stepchild;
 - a grandchild who lives with you and depends on you for at least 50 percent of the child’s support; or
 - any other child who is in a regular parent-child relationship as determined by TRS.
- C. A child (regardless of age) who lives with or has his or her care provided by the retiree or surviving spouse on a regular basis, if the child has a mental disability or physical incapacity to such an extent to be dependent on the retiree or surviving spouse for care and support, as determined by TRS.

Some types of dependents will require additional documentation to establish they meet eligibility criteria.

Other Scenarios

I am already enrolled in TRS-ActiveCare:

TRS-Care (for retirees) is a plan separate and distinct from TRS-ActiveCare (for working school employees). When you retire, you must submit an application form that tells TRS if you’d like to enroll yourself and your dependents in, or defer enrollment in, TRS-Care.

Also, be sure to contact your school official to verify your TRS-ActiveCare termination date.

Both spouses are TRS pension retirees:

If both spouses are TRS pension retirees, and each meet the TRS-Care eligibility requirements individually, each can enroll separately in TRS-Care as individuals, which may be financially advantageous. Call 1-888-237-6762 if you’d like additional information.

A TRS pension retiree can be covered under TRS-ActiveCare as a dependent of an active employee who is enrolled in TRS-ActiveCare.

How to Enroll

After you submit your retirement application (Form TRS 30) to TRS and it is processed, you will receive a TRS-Care enrollment packet that includes an application for TRS-Care (Form TRS 700A). If you want to enroll in TRS-Care, complete the application and send it back to TRS.

If you're applying for disability retirement, TRS will send you a TRS-Care enrollment packet if your disability retirement is approved.

During your Initial Enrollment Period for TRS-Care, if you choose not to enroll, you do not need to take any action. You only need to submit an application if you want to enroll in TRS-Care.

When You May Enroll

Initial Enrollment Period at Retirement

If you're a service retiree, your Initial Enrollment Period is the later of:

- A. the period that begins on the effective date of your retirement and expires at the end of the last day of the month that is three consecutive calendar months, but in no event less than 90 days, after your effective retirement date; or
- B. the period that begins on the last day of the month in which your election to retire is received by TRS and expires at the end of the last day of the month that is three consecutive calendar months, but in no event less than 90 days, following the last day of the month in which your election to retire is received by TRS.

Your application for TRS-Care (TRS Form 700A) is due no later than the last day of your Initial Enrollment Period. Please see the chart "Initial Enrollment Period for TRS-Care" below for more information.

Initial Enrollment Period at Disability Retirement

If you are a disability retiree, your Initial Enrollment Period begins on the date that your disability retirement is approved by the TRS Medical Board and expires at the end of the last day of the month that is three consecutive calendar months, but in no event less than 90 days, after the date that your disability retirement is approved by the TRS Medical Board.

Initial Enrollment Period due to Death of a Retiree or Active Member

The initial enrollment period in TRS-Care for an eligible surviving spouse of a deceased retiree and for an eligible surviving dependent child of a deceased retiree expires on the last day of the month that is three consecutive calendar months, but in no event less than 90 days, after the retiree died.

The initial enrollment period in TRS-Care for an eligible surviving spouse of a deceased active member and for an eligible surviving dependent child of a deceased active member expires on the last day of the month that is three consecutive calendar months, but in no event less than 90 days, after the active member died.

Initial Enrollment Period for TRS-Care

Three consecutive months but no less than 90 days

RETIREMENT DATE	TRS 700A DUE DATE
Sept. 30	Dec. 31
Oct. 31	Jan. 31
Nov. 30	Feb. 28 (or 29)
Dec. 31	March 31
Jan. 31	May 1
Feb. 28 (or 29)	May 31
March 31	June 30
April 30	July 31
May 31	Aug. 31
June 30	Sept. 30
July 31	Oct. 31
Aug. 31	Nov. 30

When is My Coverage Effective?

Effective date of coverage

The effective date of coverage will be (1) the first day of the month following your effective date of retirement if TRS receives your TRS-Care Initial Enrollment Application (Form TRS 700A) on or before your effective retirement date; or (2) the first day of the month following the receipt of the application for coverage by TRS-Care if your TRS 700A form is received after your effective retirement date but within your Initial Enrollment Period.

If you want your coverage to take effect the first of the month after your retirement date, TRS must receive the application before your retirement date. This also applies for disability retirees.



During your Initial Enrollment Period, you may still make changes to your coverage elections. The effective date of coverage for any new elections is the first day of the month after TRS receives the new application requesting the retirement coverage.

Deferring coverage

During your Initial Enrollment Period, you may postpone the effective date of your TRS-Care coverage to the first of any of the three months immediately following the month after your retirement date. For example, if your retirement date is May 31, the TRS-Care coverage effective date (normally June 1) may be deferred to July 1, Aug. 1, or Sept. 1. For a deferred effective date, you must write the coverage effective date in the space provided on the Initial Enrollment Application. If you have questions about deferring your effective date, please call 1-888-237-6762.

Special Enrollment Events

Special enrollment events are opportunities to enroll in TRS-Care outside of your Initial Enrollment Period. You may become eligible for TRS-Care under the special enrollment provisions of the Health Insurance Portability and Accountability Act (HIPAA).

There are two general categories of special enrollment events.

1. An individual has an involuntary loss of comprehensive health coverage; and
2. An individual acquires a new dependent.

Loss of Eligibility for Other Coverage

If a retiree or surviving spouse loses coverage

If you, as a retiree or surviving spouse, are not enrolled in TRS-Care, and through no fault of your own, you lose comprehensive health coverage with another health plan, you may be able to enroll in TRS-Care under a special enrollment event. However, you must otherwise be eligible for TRS-Care and you must be able to show that you involuntarily lost comprehensive health coverage. **Loss of disability, specified disease, vision, dental, or other coverage that is not comprehensive health coverage does not trigger a special enrollment event.**

If you are not already enrolled in TRS-Care at the time you experience an involuntary loss of comprehensive coverage through no fault of your own, you may enroll yourself and your eligible dependents in TRS-Care within 31 days following the loss of coverage under the other comprehensive health plan. However, if you are already enrolled in TRS-Care at the time you lose other comprehensive health plan coverage, you will not be able to enroll any of your otherwise eligible dependents.

Should you lose coverage with another plan, it will be important to keep your notice of termination letter in order to confirm to TRS that the loss of coverage was involuntary.

If a spouse or other eligible dependent loses coverage

When a spouse or other eligible dependent is not enrolled in TRS-Care, and through no fault of their own, they lose comprehensive health coverage with another health plan, you may enroll your eligible dependents in TRS-Care within 31 days following the dependent's involuntary loss of the other health plan coverage. If you enroll an eligible dependent, you must also become enrolled in TRS-Care (if you are not already enrolled).

Examples of involuntary loss of comprehensive health coverage include:

- Divorce or legal separation results in you losing coverage under your spouse's comprehensive health plan;
- A dependent is no longer considered a "covered" dependent under a parent's comprehensive health plan;
- Your spouse's death leaves you without comprehensive health coverage under his or her plan;
- Your employment ends along with coverage under your employer's comprehensive health plan, or your spouse's employment ends along with your coverage under your spouse's employer's comprehensive health plan;
- Your employer reduces your work hours to the point where you are no longer covered by the comprehensive health plan;
- Your plan decides it will no longer offer comprehensive health coverage to a certain group of individuals (for example, those who work part time);
- An individual loses coverage under the state's Children's Health Insurance Program (CHIP) or Medicaid, or becomes eligible to receive premium assistance under those programs for group health plan coverage;
- An individual involuntarily loses coverage under a Medicare supplement plan (e.g., Medigap) or an individual Medicare Advantage plan; and
- You no longer live or work in an HMO's service area and lost comprehensive health coverage.

Among other possible events, the following do not qualify for a special enrollment event:

- Dropping other coverage because premiums increased;
- Termination of coverage for failure to pay your premiums; and

- Termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the coverage).

New Dependents

A retiree or surviving spouse (enrolled or otherwise eligible for TRS-Care) who acquires an eligible dependent through marriage, birth, adoption, placement for adoption, or guardianship, must notify TRS in writing within 31 days of the date he/she acquires the eligible dependent, in order for the enrollment to be valid.

For example, if an otherwise eligible retiree is not currently enrolled in TRS-Care at the time he/she gets married, the retiree may enroll himself or herself, along with any eligible dependents, during a special enrollment period. A surviving spouse, however, may not enroll a new spouse if the surviving spouse remarries.

Enrollment is effective:

- In the case of the dependent's birth, the date of the birth;
- In the case of the dependent's adoption, the date of such adoption or placement for adoption; and
- In the case of guardianship, the first day of the month after TRS-Care receives the written request.

Documentation is required to establish the eligibility for all new dependents.

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.

Other Enrollment Rules

Adjustment Rule

If, for any reason, a person is enrolled in an inappropriate level of coverage, coverage will be adjusted as provided in this Booklet.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of the plan in effect prior to the date of any adjustment.

Any increase in the level of benefits because of a change in any of the above amounts will not provide additional benefits for covered medical expenses incurred before the date the change took effect.

Letter of Coverage

TRS may request that you obtain a letter of coverage that states the exact period of time your prior insurer provided comprehensive health coverage to you and the reason you

lost coverage. TRS may also request that you provide other letters of coverage for any eligible dependents you desire to enroll in TRS-Care.

Under what circumstances can TRS-Care terminate my coverage?

Retiree coverage under TRS-Care ceases at the earliest occurrence of the following:

- You are no longer eligible;
- It is established that fraud was committed by you or your covered dependent;
- You fail to make the required contribution; or
- TRS-Care is discontinued.

Dependent coverage will cease at the earliest occurrence of any of the following:

- Discontinuance of all dependent coverage under TRS-Care;
- A dependent becomes enrolled in a plan offered by TRS-ActiveCare or a plan offered by a Texas public school that is not participating in TRS-ActiveCare;
- A dependent becomes eligible for coverage under a plan provided under a program administered by the Employees Retirement System of Texas, the University of Texas, or Texas A & M;
- A dependent enrolls in TRS-Care as a retiree;
- The person ceases to meet TRS-Care's definition of a dependent;
- The retiree's coverage ceases;
- The retiree fails to make any required contributions; or
- It is established that the dependent committed fraud.

Failure to make a timely payment of the full amount of a required contribution for coverage will result in termination of coverage at the end of the month for which the last contribution was made.

Turning 65: A new enrollment opportunity

If you're a retiree or surviving spouse who isn't yet 65, and you either terminated TRS-Care or didn't enroll during your initial enrollment opportunity, you can enroll in TRS-Care when you turn 65. You may also add eligible dependents at that time.

Prior to your 65th birthday, TRS will send instructions on how to enroll. To enroll in TRS-Care at 65, you must request an application for TRS-Care (Form 700EO) and submit your application for coverage no later than 31 days from the end of the month in which you turn 65. Call TRS Health and Insurance Benefits at **1-888-237-6762** to request an application.

TRS does not always have information about surviving spouses in its records. Surviving spouses are responsible for requesting and submitting their application for coverage no later than 31 days from the end of the month in which they turn 65.

Please note: *This enrollment opportunity is not available to dependent spouses or children when they turn 65.*

When you become eligible for Medicare, you must purchase and maintain Medicare coverage, including Medicare Part B coverage, to enroll in the TRS-Care Medicare Advantage® medical plan and TRS-Care Medicare Rx® prescription drug plan. You risk losing all TRS-Care coverage if you do not have Medicare Part B coverage when you're eligible to purchase it.

What should you know?

When you reach age 65, you may have the opportunity to enroll in TRS-Care and you may have an opportunity to add eligible dependents. In most cases, you will also become eligible for Medicare, which works with the TRS-Care Medicare Advantage® plan and TRS-Care Medicare Rx® plan. Just submit an application and, upon confirmation of your eligibility for TRS-Care and the plan(s) available to you, TRS will enroll you.

When am I eligible for Medicare?

In most cases, you are eligible for Medicare at age 65. Or, if you have received Social Security disability benefits for a certain length of time, you may be eligible at any age.

Medicare eligibility at age 65

TRS strongly urges you to enroll in Medicare as soon as you're eligible for it. You can enroll three months prior to the month you turn 65. The earlier you sign up, the sooner TRS can verify your Medicare status and enroll you. Ideally, your Medicare coverage will take effect the first day of your birthday month. If your birthday is on the first of the month, your Medicare coverage will take effect the first of the previous month.

Keep in mind, the period for enrolling in the TRS-Care program is shorter than the enrollment period for Medicare. The enrollment period for Medicare extends for three months after the month of your 65th birthday, but you must submit an application for enrollment in the TRS-Care program no later than 31 days from the end of the month in which you turn 65.

You must buy and maintain Medicare Part B to be eligible for TRS-Care benefits after you become eligible for Medicare. This is required even if you are not eligible for premium-free Medicare Part A. You don't have to buy Part A if you aren't already getting it for free, but you do need to buy Medicare Part B. If you do not buy and maintain Medicare Part B, you risk losing all TRS-Care coverage.

Medicare eligibility for End Stage Renal Disease (ESRD)

If you're eligible for Medicare due to ESRD, Medicare pays secondary to TRS-Care because federal rules require TRS-Care coverage to be primary for a certain period of time. Once your Medicare Part A becomes your primary coverage, your TRS-Care monthly premium and your TRS-Care deductible will go down. If you're eligible due to ESRD, please let TRS know by phone or in writing.

What steps do I need to take when I turn 65?

You're eligible for Medicare at age 65 and can enroll three months prior to the month you turn 65.

- If you're eligible for premium-free Medicare Part A (hospitalization), sign up for it through the Social Security Administration. You can apply online at www.ssa.gov/medicare, visit your local Social Security office, or call Social Security at 1-800-772-1213 (TTY: 1-800-325-0778).
- Purchase Medicare Part B through the Social Security Administration as soon as enrollment becomes available to you. You must buy and maintain Medicare Part B to be eligible for TRS-Care benefits. The Social Security Administration can confirm your Part B premium; please note that it will not be deducted from your TRS pension.
- If you're currently enrolled in TRS-Care, when you turn age 65, Humana will send you a packet with form requesting your Medicare number. Please complete the form and return it to TRS.*
- Separately, TRS will send you an enrollment kit. Review the materials inside. If you're adding dependents, complete and submit the application for TRS-Care no later than 31 days from the end of the month in which you retire or turn 65.

If you are eligible for TRS-Care coverage, and once TRS verifies your Medicare information, TRS will enroll you in the TRS-Care Medicare Advantage® and TRS-Care Medicare Rx® plans. If TRS does not receive your Medicare number, TRS will not be able to enroll you, and you risk losing TRS-Care coverage altogether.

**If you're a retiree or surviving spouse who isn't yet 65, and you either terminated TRS-Care or didn't enroll during your initial enrollment opportunity, you also can enroll in the TRS-Care when you turn 65. You may add dependents then, too. To enroll in TRS-Care at 65, you must request an application and submit it no later than 31 days from the end of the month in which you turn 65. Call TRS Health and Insurance Benefits at 1-888-237-6762 to request an application.*

Glossary of Terms

Additional Enrollment Opportunity at Age 65

The opportunity for retirees eligible for TRS-Care to enroll in coverage for the first time and add eligible dependents. TRS retirees who are eligible and covered by TRS-Care when they reach age 65 may also add eligible dependents at this time.

Any Other Child Who is in a Regular Parent-Child Relationship

A child that is not your grandchild; the child is unmarried; the child's primary residence is your household; you provide at least 50 percent of the child's support; neither of the child's natural parents reside in your household; you have the legal right to make decisions regarding the child's medical care; and you have full legal guardianship (documentation will be required).

Deductible

The plan deductible is the amount of covered medical expenses that you pay each plan year before TRS-Care pays for eligible, non-preventive covered medical expenses.

Coinsurance

The percentage of allowed amounts for covered medical expenses that the participant is required to pay, after the TRS-Care deductible has been met. Coinsurance is in addition to the deductible, office visit copayment (copay), charges for services not covered, precertification penalties and out-of-network charges, which are the patient's responsibility.

Deferring Coverage

To delay the effective date of TRS-Care coverage by completing the enrollment application and submitting it during your Initial Enrollment Period.

Initial Enrollment Period

The first time the retiree has the opportunity to enroll in TRS-Care at retirement. Please refer to the TRS-Care Initial Enrollment Period chart on [page 17](#) for time frames specific to your situation.

Out-of-Pocket Maximum

The most you are required to pay for covered medical expenses out of your own pocket in a plan year. When you reach the plan's out-of-pocket maximum, the plan pays 100 percent of any eligible expenses for the rest of the plan year. The out-of-pocket maximum includes the deductible, any medical copays (if applicable), and medical coinsurance.

Premiums

The monthly contribution made by a retiree or surviving spouse for TRS-Care coverage for himself/herself and eligible dependents.

Special Enrollment Event

An opportunity to enroll in TRS-Care at a time other than during the Initial Enrollment Period and is based on a set of criteria.

TRS-Care Enrollment Form

May refer to the Initial Enrollment Period application or special enrollment application.

Program Contacts

Teacher Retirement System of Texas
Health and Insurance Benefits Department
1000 Red River Street
Austin, Texas 78701-2698
1-888-237-6762
7 a.m. – 6 p.m., Monday – Friday
www.trs.texas.gov

TRS-Care Standard Plan
Medical Coverage
Administered by Aetna
Aetna Retiree Advocate:
1-800-367-3636 (TTY: 711)
www.trscarestandardaetna.com
Teledoc: 1-855-835-2362

Prescription Coverage
Administered by CVS Caremark
Customer Care:
1-844-345-4577

About the TRS-Care Standard Plan

The TRS-Care program may be changed in the future to provide coverage levels that are different from the levels described in this TRS-Care Standard Plan Guide, or the TRS-Care program may be discontinued. The cost to participants in the TRS-Care program may be changed with the approval of the TRS Board of Trustees. To the extent that any information in this guide is not consistent with or contradicts TRS laws and rules, the TRS laws and rules control. The TRS-Care Benefits Booklet will always control over information in this guide. TRS-Care 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.

Discrimination is against the law

The Teacher Retirement System of Texas (TRS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. TRS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Teacher Retirement System of Texas:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call 1-888-237-6762 (TTY: 711).

If you believe that TRS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email:

MAIL: Section 1557 Coordinator, 1000 Red River St., Austin, Texas, 78701

FAX: 512-542-6575

EMAIL: section1557coordinator@trs.texas.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services online, by mail, or by phone at:

ONLINE: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

MAIL: U.S. Dept. of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, D.C. 20201

PHONE: 1-800-368-1019, 1-800-537-7697 (TDD)

MULTI-LANGUAGE INTERPRETER SERVICES

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-237-6762 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-237-6762 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-237-6762 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-237-6762 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-237-6762 (TTY: 711)번으로 전화해 주십시오.

ملحوظة: إذا لقيت صعوبة في فهم خدمات المساعدين لغويين فتتلفون إلى بالمجان. اتصل بـ 1-888-237-6762 بـ رقم هاتف الصم والبكم: 711).

ضردار: گھر آپ اردو بولتے ہیں تو آپ کو زبان کی مدد کی خدمات مفت میں دستیابی کال کریں 1-888-237-6762 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-237-6762 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-237-6762 (ATS: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-237-6762 (TTY: 711) पर कॉल करें।

توجه: گھرب زوبان فرانس فگت گھو مھکری ہتس ھیلات زیل وی بصورت ریگان برایش مھر اھم میبش دبا 1-888-237-6762 (TTY: 711) ت م سب گھو د.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-237-6762 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-237-6762 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-237-6762 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-237-6762 (TTY:711) まで、お電話にてご連絡ください。

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-237-6762 (TTY: 711).



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