



BENEFITS BOOKLET

TRS-Care Standard Plan for Participants
under Age 65 without Medicare

Plan Year: Jan. 1, 2020 – Dec. 31, 2020



How to find what you're looking for

Want to get to a topic quickly?
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- Web addresses
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WELCOME

TRS-Care provides coverage for many of your health care needs, including physician office visits, inpatient and outpatient services, behavioral health, prescription drugs and more. This booklet is your guide to your TRS-Care health benefits. Included is detailed information about your TRS-Care Standard plan, tips on how to use the plan effectively, and a comprehensive table of contents to help you locate information you may need.

About this plan

The TRS-Care program is uniquely designed for retired Texas public school employees. It is separate and distinct from both the TRS pension trust fund and from any program providing health care benefits to actively employed public school employees.

TRS-Care is established through Chapter 1575 of the Texas Insurance Code and through Title 34, Part 3, Chapter 41, Subchapter A of the Texas Administrative Code. This booklet, along with any amendments thereto located in an updated online version of the benefits booklet appearing on the TRS website, is your primary source of information about TRS-Care Standard plan provisions and no other representations, expressed or implied, will prevail over the information contained therein.

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.

As trustee, TRS administers TRS-Care for the benefit of participating retirees and their dependents. TRS may alter the plan provisions or costs at any time. The TRS-Care program can be discontinued at any time. Participants will be notified in writing of any revisions.

If you have any questions, please feel free to call the TRS-Care Customer Service line at **1-800-367-3636** or refer to the website at **www.trscarestandardaetna.com**.

Important Phone Numbers

TRS-Care Customer Service

1-800-367-3636
8 a.m. – 6 p.m. (CT)
Monday – Friday

Precertification

1-800-367-3636
8 a.m. – 6 p.m. (CT)
Monday – Friday

Aetna Nurse Care Advocate Team

1-866-227-5065

Aetna Disease Management

1-866-269-4500

Aetna Nurse Informed Health Line

1-800-556-1555
Available 24 hours/day, 7 days/week

CVS Caremark

1-844-345-4577
Available 365 days/year, 24 hours/day

TRS Health Benefits – Austin

1-888-237-6762
8 a.m. – 6 p.m. (CT)
Monday – Friday

Websites

www.trscarestandardaetna.com
www.trs.texas.gov
info.caremark.com/trscarestandard

Overview of your plan

- TRS-Care participants who are not eligible for Medicare have a single plan option administered by Aetna. The TRS-Care Standard Plan is a federally-compliant high deductible health plan (HDHP). This means it is compatible with a health savings account (HSA). TRS does not administer an HSA, but you can open an account at a bank, credit union or other financial institution.
- The TRS-Care Standard plan includes a deductible, coinsurance and out-of-pocket maximum. There are no copays. Once the deductible is met, the plan pays a percentage of your covered expenses, and you pay a percentage of the services; this is referred to as a coinsurance.
- Before your coverage begins paying, you will need to meet an annual deductible. If you have individual-only coverage, you will meet the individual-only deductible. If you cover one or more dependents, such as a spouse, you must meet the family deductible before the plan begins to pay for any covered family member. The family deductible can be met by one person or a combination of family members. The deductible applies to all covered expenses EXCEPT in-network preventive care (including certain generic preventive prescription drugs).
- TRS-Care Standard plan has an out-of-network deductible and out-of-network out-of-pocket maximum. The in-network and out-of-network deductible and out-of-pocket maximums are separate limits. Only in-network expenses will apply to meet the in-network deductible and apply towards the in-network out-of-pocket maximum. Only out-of-network expenses will apply to meet the out-of-network deductible and apply towards the out-of-network out-of-pocket maximum.
- The TRS-Care Standard plan has a maximum out-of-pocket limit in place to protect you. The maximum out-of-pocket is the most that you will pay for covered medical services and prescription drugs within a calendar year.
- TRS Virtual Health offers telemedicine medical visits through Teladoc. Teladoc is a telemedicine program. This service lets you talk by phone or video chat with board-certified doctors 24/7. They can diagnose, treat and prescribe medications. Effective Sept. 1, 2019, the consultation fee was lowered to \$30. This fee will count toward your deductible and will also be applied to your out-of-pocket maximum. It is a convenient and less expensive way to get some types of care.

In absence of any benefit not specifically listed in this booklet TRS-Care Standard defaults to Aetna's standard claims administration processing guidelines and policy.

- You can receive confidential TRS Virtual Health mental health care through Teladoc. Adults 18 and over can receive care for anxiety, depression, grief, family issues and more. Choose to see a psychiatrist, psychologist, social worker or therapist and establish an ongoing relationship. Appointments must be scheduled online or through the Teladoc app. There is a cost for care:
 - After the deductible is satisfied, the plan pays 80%, you pay 20%. The fee for the consult is:
 - Psychiatrist (initial visit), \$185
 - Psychiatrist (ongoing visits), \$95
 - Psychologist, licensed clinical social worker, counselor or therapist, \$85
- TRS Virtual Health includes general medical consults through Teladoc for some family members, even if they are not enrolled on your TRS-Care Standard plan. The family member must be age 18 and over and could be your adult child or an elderly parent. You can extend the TRS Virtual Health general medical consult to someone you care for with a two-way or three-way video or phone consult with a board-certified physician for a flat fee of \$45.
- With a HDHP like the TRS-Care Standard plan, it's important to be a good consumer and get the most out of your plan. You will save money and reduce your out of pocket costs by:
 - Choosing in-network providers. To locate in-network providers, log in to Aetna Navigator at **www.trscarestandardaetna.com**.
 - Taking advantage of preventive services, such as your annual physical, cancer screenings, immunizations, flu shots and certain generic preventive prescription drugs that are available at no cost to you.
 - Getting care at the right place for the right situation. For example, visit the emergency room for life threatening situations and use urgent care or Teladoc for services to treat an ankle sprain or cold/flu symptoms.

- The TRS-Care Standard plan is not insured, but self-funded through the Texas Public School Retired Employees Group Insurance Fund. To help conserve our shared resources, you can be an informed consumer and spend your benefit dollars wisely. You should contact Aetna for medical appeals and CVS Caremark for prescription drug appeals.
- This booklet addresses the TRS-Care Standard plan medical and prescription drug benefits for retirees and their dependents under age 65 and not covered by Medicare.
- **Do not depend on others to manage your coverage.** TRS-Care does not pay for every medical or drug expense you may incur. You may be responsible for a share of or all of the cost, so please be an informed consumer. Read this booklet carefully and consult the website or call TRS-Care Customer Service at **1-800-367-3636** with questions before you make health care decisions.
- You are responsible for the decisions you make and for complying with the TRS-Care rules.

If you have questions, refer to the website **www.trscarestandardaetna.com** or call TRS-Care Customer Service at **1-800-367-3636**.

Some drug therapies may require pre-authorization and/or a conversation between your doctor and CVS Caremark, the pharmacy benefit manager for TRS-Care. Call CVS Caremark for more information at **1-844-345-4577**.

- If you use an **out-of-network** provider, regardless of the circumstances, you will most likely have to pay more than the out-of-network **deductible** and **coinsurance** amounts. The **“allowed amount”** can be significantly less than what the provider bills when using an out-of-network provider. You will be responsible for any amount that is not covered under the plan including your deductible and coinsurance when applicable.
- A Claim Information Form (CIF) is required every 12 months for TRS-Care primary **participants** (those without Medicare). This information may be reported by calling TRS-Care Customer Service at **1-800-367-3636**.

Visit **www.trs.texas.gov** and go to the “Forms” section.

Aetna Claims Address:

Aetna
PO Box 981106
El Paso, TX 79998-1106
1-800-367-3636

Do not assume anything. Refer to this booklet or call TRS-Care Customer Service at **1-800-367-3636** if you have any questions about your coverage.



What happens when you turn 65?

When you turn 65 or become eligible for Medicare, it is important to notify TRS of your Medicare status.

1. 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).
2. 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.
3. 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.*
4. 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.

- **When you are first eligible (usually at age 65 or after you qualify for Social Security Disability Benefits for Medicare Part B), you should purchase it.** TRS strongly urges you to enroll in Medicare as soon as you're eligible for it. If you don't sign up early enough to make your effective date the first day of your birthday month, you risk having a gap in TRS-Care coverage.

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 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 provide your Medicare information to TRS (so it can be sent to Humana) before the first day of your birthday month. If you do not provide TRS with your Medicare information you may be terminated from TRS-Care and will not be able to re-enter the program unless you have a Special Enrollment Event.
- **Turning age 65 is an enrollment opportunity for retirees and surviving spouses.** If you've never enrolled in TRS-Care before but were eligible for the program when you retired, you have an additional opportunity to enroll yourself and your eligible dependents at age 65. TRS will send TRS retirees a postcard prior to your 65th birthday inviting you to contact us for an enrollment packet (TRS 700EO). TRS-Care retirees, including those who are currently enrolled in TRS-Care, may add their eligible dependents to their TRS-Care coverage when the retiree reaches age 65.

NOTE: this enrollment opportunity is not available to dependent spouses or children when they turn 65.



YOUR TRS-CARE BENEFITS

This section, along with the next two sections, will help you understand how the TRS-Care Standard Plan works. This section outlines the benefits, limitations, coinsurance, deductibles and specific maximum benefit amounts. The plan does not cover all expenses incurred for medical care. There are exclusions, deductibles and stated maximum benefit amounts.

Coverage for your TRS-Care benefits begins on your plan effective date with the program. No benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated. An expense is incurred on the day you receive a health care service or supply (date services were rendered).

Neither TRS-Care, nor Aetna, assumes responsibility for the outcome of any covered services or supplies. Neither TRS-Care, nor Aetna, makes express or implied warranties concerning the outcome of any covered services or supplies.



TRS-Care Standard Plan Benefit Matrix

Plan Deductible	Annual TRS-Care Accumulators	Network	Out-of-Network
	Plan Deductible Family Deductible is aggregate: expenses for one family member or a combination of family members may meet the deductible.	\$1,500 individual only \$3,000 family	\$3,000 individual only \$6,000 family
	Annual Out-of-pocket Maximum When an individual meets their out-of-pocket maximum the plan pays 100% for covered charges for that person. A combination of family members can meet the family out-of-pocket maximum, once met it is met for the entire family.	\$5,650 individual \$11,300 family	\$11,300 individual \$22,600 family
	Out-of-pocket maximum includes deductibles, any medical and prescription coinsurance and Teladoc consultation fees. Network and Out-of-Network deductibles are separate limits. Network and Out-of-Network Out-of-Pocket Maximums are separate limits.		

When using network physicians, certain age-specific and gender-specific preventive care services are paid at 100 percent and the deductible is waived. However, covered services under this benefit must be billed by the doctor as "preventive care." For example, a blood pressure screening is covered at 100 percent, but if you are screened to monitor a condition or get a prescription, it may be billed as "diagnostic", therefore you would be responsible for paying out-of-pocket until you meet your deductible. Preventive care office visits—network or out-of-network—are limited to one physical exam per calendar year; one OB/GYN well-woman exam per calendar year; and one routine mammogram per calendar year.

Benefit Levels

Preventive Service**	Benefit Categories	Network	Out-of-Network*
	Routine Physical Exam (One per calendar year, includes office visit, lab work and childhood immunizations)	You pay \$0, no deductible, paid at 100%	You pay 40% after deductible
	Cervical Cancer Routine Screening (One per calendar year for females age 18 and over; HPV screening included for females age 30 and over)	You pay \$0, no deductible, paid at 100%	You pay 40% after deductible
	Colorectal Cancer Screening and Exam (Ages 45 and over; fecal occult blood annual with office visit, and flexible sigmoidoscopy every 5 years; or colonoscopy every 10 years as an outpatient service)	You pay \$0, no deductible, paid at 100%	You pay 40% after deductible
	Flu Shot (One per calendar year)	You pay \$0, no deductible, paid at 100%	You pay 40% after deductible
	Mammogram Screening (One per calendar year for females age 35 and over)	You pay \$0, no deductible, paid at 100%	You pay 40% after deductible
	Prostate Screening and Office Visit (One per calendar year for males age 40 and over)	You pay \$0, no deductible, paid at 100%	You pay 40% after deductible
	Zostavax Vaccine ("Shingles" one per lifetime)	You pay \$0, no deductible, paid at 100%	You pay 40% after deductible

*Out-of-Network Allowable Amounts are based on a reduced fee schedule, you will be responsible for charges exceeding the fee schedule in addition to your deductible and coinsurance.

**Please see the website, www.trs.texas.gov for a list of common preventive services.

TRS-Care Standard Plan Benefit Matrix (Continued)

Benefit Levels			
Physician Services	Benefit Categories	Network	Out-of-Network*
	Office Visits (Includes lab, X-ray and injections if billed with office visit)	You pay 20% after deductible	You pay 40% after deductible
	Specialist Visits (Includes lab, X-ray and injections if billed with office visit)	You pay 20% after deductible	You pay 40% after deductible
	Walk-In Clinics (Includes lab, X-ray and injections if billed with office visit)	You pay 20% after deductible	You pay 40% after deductible
	TRS Virtual Health Telemedicine Services (Applies to deductible and out-of-pocket maximum)	Consult fee of \$30 applies to deductible. After deductible, plan pays 80%; you pay 20%	Not applicable
	Allergy Testing	You pay 20% after deductible	You pay 40% after deductible
	Office Surgery	You pay 20% after deductible	You pay 40% after deductible
	Allergy Injections	You pay 20% after deductible	You pay 40% after deductible
	Non-Office Based Physician Services	You pay 20% after deductible	You pay 40% after deductible
Other Medical Services	Ambulance (Emergency)	You pay 20% after deductible	You pay 20% after deductible
	Ambulance (Non-Emergency – See page 28 for coverage criteria)	You pay 20% after deductible	You pay 20% after deductible
	Chiropractic Care (20 Visits Maximum per calendar year)	You pay 20% after deductible	You pay 40% after deductible
	Durable Medical Equipment (Precertification required for select equipment, See page 33)	You pay 20% after deductible	You pay 40% after deductible
	Home Infusion Services (Precertification required)	You pay 20% after deductible	You pay 40% after deductible
	Physical, Occupational and Speech Therapy (May require periodic medical review. See Rehabilitation Services page 40)	You pay 20% after deductible	You pay 40% after deductible
	Prosthetics	You pay 20% after deductible	You pay 40% after deductible
	Lab Services	You pay 20% after deductible	You pay 40% after deductible

*Out-of-Network Allowable Amounts are based on a reduced fee schedule, you will be responsible for charges exceeding the schedule in addition to your deductible and coinsurance.

Once you have met \$1,400 of your deductible, which is the minimum deductible required to meet high deductible health plan federal limits, your cost share for diagnostic mammograms will be the same as mammograms performed for preventive cancer screenings. Diagnostic mammograms are not subject to any age or frequency limitations.

TRS-Care Standard Plan Benefit Matrix (Continued)

Benefit Levels			
Extended Services	Benefit Categories	Network	Out-of-Network*
	Convalescent Care (See page 31 – for definition & criteria)	You pay 20% after deductible	You pay 40% after deductible
	Home Health Care	You pay 20% after deductible	You pay 40% after deductible
	Hospice	You pay 20% after deductible	You pay 40% after deductible
	Private Duty Nursing	You pay 20% after deductible	You pay 40% after deductible
Hospital/Facility Services	Emergency room (care in an outpatient hospital for an accident or other medical emergency)	You pay 20% after deductible	You pay 40% after deductible
	Emergency room (care in an outpatient hospital for all other conditions)	You pay 20% after deductible	You pay 20% after deductible
	Inpatient Hospital (semi-private room and board or intensive care unit)	You pay 20% after deductible	You pay 40% after deductible
	Other Inpatient Charges	You pay 20% after deductible	You pay 40% after deductible
	Outpatient Hospital	You pay 20% after deductible	You pay 40% after deductible
	Surgical Facilities	You pay 20% after deductible	You pay 40% after deductible
Behavioral Health (Mental Health and Chemical Dependency)	Inpatient Facility	You pay 20% after deductible	You pay 40% after deductible
	Inpatient Physician	You pay 20% after deductible	You pay 40% after deductible
	Outpatient Services	You pay 20% after deductible	You pay 40% after deductible
	Office Visit	You pay 20% after deductible	You pay 40% after deductible
	TRS Virtual Health Telemedicine Services	After deductible, plan pays 80%; you pay 20% • Psychiatrist (initial visit): \$185 • Psychiatrist (ongoing visit): \$95/session • Psychologist, licensed clinical social worker, counselor or therapist: \$85/session	Not applicable

TRS-Care Standard Plan Benefit Matrix (Continued)

Prescription Drug Coverage	Tier 1 Generic drugs	You pay 20% after deductible	
	Tier 2 Preferred brand-name drugs	You pay 20% after deductible**	
	Tier 3 Non-preferred brand-name drugs	You pay 20% after deductible**	

*Out-of-Network Allowable Amounts are based on a reduced fee schedule, you will be responsible for charges exceeding the fee schedule in addition to your deductible and coinsurance

**Starting Jan. 1, 2020, if you obtain a brand-name drug when a generic equivalent is available, you are responsible for the difference in cost between the brand-name drug and the generic drug, in addition to the generic coinsurance. This cost difference will not apply to your accumulations (deductible or maximum out of pocket).



How your medical plan works

What type of plan is TRS-Care?

The TRS-Care Standard Plan is a high deductible health plan (HDHP). These 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 an HDHP. With this plan, you are eligible to open a health savings account (HSA) and make personal contributions to pay for current and/or future medical expenses. TRS does not administer an HSA, but you can open one at a bank, credit union or other financial institution.

How the plan works when you need care

The best way to get the most from your TRS-Care Standard Plan is to understand how it works before you need to access health care.

You have a calendar year deductible

The deductible applies to all covered expenses EXCEPT in-network preventive care (including certain generic preventive prescription drugs).

- If you have retiree-only coverage, you must meet the individual deductible before benefits begin to pay.
- If you have family coverage, the family deductible may be met by one family member or a combination of family members. However, no benefits are paid for any family member until the entire family deductible is met.

You pay a share of expenses

Once the deductible is met, the plan pays a percentage of allowed amounts for your covered expenses, and you pay a percentage (coinsurance). You pay less out of pocket when you choose in-network providers.

Remember: Only in-network expenses apply to the in-network deductible and only out-of-network expenses apply to the out-of-network deductible.

You're protected from high out-of-pocket costs

There is a limit on the amount you pay in a single year for health care costs, 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 resets annually, just like your deductible.

Remember:

- Under a family plan, each person's individual claims count toward the family out-of-pocket maximum. After a person meets the individual out-of-pocket maximum their expenses will be covered at 100%.
- Only in-network expenses count toward the in-network out-of-pocket maximum, and only out-of-network expenses count toward the out-of-network out-of-pocket maximum

PHASE 1	
Preventive care (covered at 100% with no deductible)	Preventive care services and certain generic preventive drugs are covered at 100% when you use in-network providers.
PHASE 2	
Meet your deductible	You pay for covered non-preventive medical and prescription drug expenses out of your own pocket (or using HSA dollars) until you meet the deductible. If you have family coverage, the family deductible must be met before benefits are paid for any covered individual.
PHASE 3	
Pay coinsurance	Once you meet the deductible, the plan pays a percentage of covered expenses, and you pay the rest (coinsurance). When you stay in the network, you pay 20% and the plan pays 80%. If you have an HSA, you may use your account to pay your share of expenses or pay out of your own pocket.
PHASE 4	
Meet the out-of-pocket maximum	Once your share of covered expenses (deductible and coinsurance) reaches the out-of-pocket maximum, the plan pays 100% of covered expenses for the rest of the plan year. If you have family coverage, the plan will pay the 100% benefit for each covered individual once his/her expenses reach the individual out-of-pocket maximum, or once the family out-of-pocket maximum has been reached.

How do I locate a provider in the network?

You may log on to www.aetna.com/docfind/custom/trscore for the most current network provider listings or you may call TRS-Care Customer Service at **1-800-367-3636**.

What happens if I use an in-network provider?

When you receive care from a network doctor, or **hospital**, or dialysis center, TRS-Care pays a larger portion of your health care costs. **When you use a network provider, you are protected from charges that are greater than the allowed amount.**

What happens if I use an out-of-network provider?

When you use an out-of-network provider (**physician**, facility or other provider), you will most likely have to pay for any of the charges that are greater than the allowed amount in addition to your deductible and coinsurance.

NOTE: Out-of-network expenses can significantly increase your liability and do not count toward your in-network deductible or in-network out-of-pocket maximum.

Refer to the comparison of network benefits vs. out-of-network benefits below (example below assumes the deductible has been met):

	Network Hospital	Out-of-network Hospital
Charges	\$16,500	\$18,000
Allowed	\$6,500*	\$5,250**
Plan pays	80% or \$5,200	60% or \$3,150
You pay	20% or \$1,300	40% or \$2,100
Hospital Write Off	\$10,000	\$0
Not Covered	\$0	\$12,750
Your total obligation	\$1,300	\$14,850

* Example of a contracted case rate of \$6,500
** **Out-of-network fee** example, three inpatient days, \$1,750 allowed/day



How does TRS-Care work when you live outside of Texas in an area where Aetna does not have a network?

Most areas in the United States have an **Aetna network** and Aetna continues to add more areas to the existing networks.

However, some TRS-Care participants may reside in areas outside of Texas where there may be no network.

TRS-Care has provided regular benefits for those participants so their care will be paid at the network coinsurance rate (80% of the allowed amount). In addition, if those participants travel to a network area, they can receive network benefits if they receive services from an **Aetna network** provider.

There could be a financial advantage for the participant that chooses to travel to a network area. In addition to the coinsurance benefit, the participant would also benefit from negotiated rates that Aetna has with network providers.

How does TRS-Care work when you travel in the United States?

TRS-Care participants who are traveling in the United States can obtain network medical services from Aetna network providers. You may access the network Provider Directory (DocFind) **www.aetna.com/docfind/custom/trscare** or by calling TRS-Care Customer Service at **1-800-367 3636**.

If you are in an Aetna network area and receive non-emergency care from an **out-of-network provider**, the out-of-network benefits will apply.

How does TRS-Care work when you travel outside of the United States?

If you receive medical care when traveling outside the United States, generally you must pay the medical bill first and then submit an itemized bill for reimbursement. For reimbursement, submit an itemized bill to the TRS-Care/Aetna Service Center. If the original bills are in a foreign language, you should obtain an English translation of the services rendered, if possible. Bills should be submitted in the foreign currency. Aetna will convert the bills to U.S. dollars based on the exchange rate on the day the services were provided. Mail this information with your **Aetna identification number** to the TRS-Care/Aetna Service Center for reimbursement based on your TRS-Care plan benefits.

Aetna Claims Address:

Aetna
PO Box 981106
El Paso, TX 79998-1106
1-800-367-3636

How does TRS-Care work when you receive services at a network hospital but the hospital-based physicians are not in the network?

Sometimes the doctors and specialists (radiologists, pathologists, emergency room physicians and anesthesiologists) contracted with a hospital are not in-network. You can ask whether your doctors belong to the hospital, and which are in-network.

For example, when you receive services at a network hospital, but the radiologist who reads your X-rays is out-of-network, TRS-Care will pay 80% of the allowed radiologist's charges (if the deductible has been met). However, TRS-Care only considers charges that are within the **reasonable and customary charge** for those services. If the radiologist charges more than the reasonable and customary amount, then the patient will be responsible for that additional amount as well as the 20% coinsurance.

What is the allowed amount for network providers?

TRS-Care covers medical expenses at the allowed amount. If the **provider** is contracted and participating in a network, the allowed amount is determined by the contract. The contracted allowed amount is usually less than the billed amount. Some contracts state that the allowed amount is the lesser of billed or the contracted fee.

What is the allowed amount for out-of-network providers?

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

What is precertification?

Precertification is the process of determining medical necessity for specific medical services. Precertification may also determine if the approved service should be provided in a hospital or in another setting.

If precertification is obtained, plan benefits will be paid for all covered services deemed **medically necessary** for eligible participants.

Precertification approval does not mean that network benefits will be paid for out-of-network providers. Failure to precertify may result in a penalty or in a denial of all benefits if the services were not medically necessary.

How to precertify

The precertification process begins with a telephone call to TRS-Care Customer Service at **1-800-367-3636** BEFORE the procedure or service is performed. When a network physician or hospital is providing the medical service, that provider is responsible for obtaining the precertification.

If the participant does not use a network provider, the participant is responsible for obtaining the precertification by contacting TRS-Care Customer Service.

Precertification for days of confinement can be obtained as follows:

- For a non-emergency admission, notify TRS-Care Customer Service at the toll-free number shown on your ID card **1-800-367-3636**. This must be done before the date the person is scheduled to be confined as a full-time inpatient.
- For an **emergency** admission, TRS-Care Customer Service must be notified by calling the toll-free number at **1-800-367-3636**. This must be done no later than one business day after the start of a confinement as a full-time inpatient resulting from an emergency admission, unless it is not possible to request precertification within that time. In that case, the request must be made as soon as reasonably possible.

If, in the opinion of the patient's physician, it is necessary for the person to be confined for a longer time than already certified, the participant, the physician, or the hospital may request that more days be certified by calling TRS-Care Customer Service at **1-800-367-3636**. This must be done no later than the last day that has already been certified.

Written notice of the number of days precertified will be sent promptly to the hospital. A copy will be sent to the retiree or **surviving spouse** and to the physician.

Benefits will not be paid if the service is deemed not medically necessary.

No benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of the plan.

A provider submitting supporting documentation before a procedure is done should **fax the documentation to: 1-860-262-7881** or **call 1-800-367-3636** for more information.

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

What types of services require precertification?

The following are examples of services that need to be precertified. **This list is not all-inclusive and is subject to change.** You should call TRS-Care Customer Service at **1-800-367-3636** to determine whether your procedure requires precertification.

Precertification penalty –This list is not all-inclusive and is subject to change.

A \$400 precertification penalty is applied for out-of-network providers to the allowed amount for each failure to precertify the following:

- Inpatient confinements (all)
 - Surgical and non-surgical confinements
 - Skilled Nursing Facilities
 - Rehabilitation facilities
 - Inpatient mental health
 - Inpatient hospice
- Private Duty Nursing (all)
- **Convalescent Care** (per disability)

A \$200 precertification penalty is applied to the allowed amount for each failure to precertify for out-of-network providers.

- **Durable Medical Equipment** such as:
 - Electric or motorized wheelchairs and scooters
 - Clinitron and electric beds
 - Limb and torso prosthetics
 - Customized braces
- Medical Injectables such as:
 - IVIG (Intravenous immunoglobulin)
 - Growth hormone
 - Interferons when used for hepatitis C
 - Blood clotting factors
 - Synagis
 - Erythropoiesis stimulating agents such as Aranesp, Epogen, Procrit, and Micera

- Bariatric Surgery - please visit **www.aetna.com** for more information on the selection criteria for Bariatric surgery.
- Reconstructive procedures that may be considered cosmetic, for example; Septorhinoplasty, Blepharoplasty, Excision of excessive skin due to weight loss, Gastroplasty, Pectus excavatum repair, Mammoplasty, Surgical treatment of gynecomastia, Lipectomy, Sclerotherapy
- Transplants (See page 42 or contact number and additional information)
 - Include kidney, liver, lung, heart and pancreas transplants
 - Bone marrow replacement or stem cell transfer after high-dose chemotherapy
 - Transplant work-ups
- Uvulopalatopharyngoplasty (UPPP), including laser-assisted procedures
- Orthognathic surgery procedures, osteotomies and surgical management of the temporomandibular joint
- Artificial intervertebral disc surgery
- Lumbar spinal fusion surgery

- Outpatient mental/behavioral health testing, intensive outpatient therapy and electroconvulsive therapy (ECT)
- Air ambulance
- Services that may be considered experimental or investigational
- The following conditionally eligible services:
 - Stereotactic radiosurgery
 - Somatosensory evoked potential studies
 - Cognitive skill development
 - Hyperbaric oxygen therapy
 - Osteochondral allograft/knee
 - Cochlear device and/or implantation
 - Percutaneous implant of neuroelectrode array, epidural
 - GI tract imaging through capsule endoscopy
 - Botox injections–botulinum toxin type A
 - Alpha 1-proteinase inhibitor–human
 - Negative pressure wound therapy pump
 - High-frequency chest wall oscillation generator system

How can you appeal when precertification or continued certification is denied?

There are several reasons that a request for a certification of services might be denied. These reasons include, but are not limited to: a lack of appropriate clinical information for the plan to make a determination of medical necessity, the requested service is experimental or investigational, the place of service is not appropriate for the care being provided and the requested supply or service is not covered by the plan. You may want to work with your provider of care to ensure that all the relevant information regarding your case is submitted for appeal. Refer to the appeal process on page 82.

Continuity of care

How does TRS-Care work if my network doctor terminates while I am in the middle of treatment?

All network providers are required to continue to provide services to patients under certain circumstances for a period of time after the contract between the provider and Aetna has been terminated. This is a continuity of care requirement. To qualify for continuity of care, a TRS-Care participant must be:

- A patient under the network physician's care who, at the time of the termination is a registered bed patient at a network hospital or institution until such patient's discharge or until an orderly transition to another network physician's care can be arranged, whichever is sooner or;
- A patient with "special circumstances" such as a disability, acute condition or life threatening illness or a pregnant patient that is past the 24th week of gestation. "Special Circumstances" shall mean a condition such that the network physician reasonably believes that discontinuing care by him/her could cause harm to the patient. The special circumstance will be identified by the network physician who requests that the patient continue treatment under his/her care and agrees not to balance bill the patient for any amounts greater than the current network contracted rate.

Special circumstances do not obligate the network physician to accept the contracted rate:

- Beyond 90 days after the termination of the contract with Aetna
- Beyond 9 months in the case of a TRS-Care patient who has a terminal illness
- Beyond 6 weeks after the delivery of the child in the case of a pregnant patient.

To request continuity of care benefits, contact TRS-Care Customer Service at **1-800-367-3636**.

Transitional care

How does TRS-Care work when I have just enrolled and the doctor from whom I am receiving treatment is not participating in the network?

If you or a covered dependent are undergoing a course of medical treatment at the time of enrolling in the TRS-Care Standard Plan and your doctor is not in the network, ongoing care with the current doctor may be requested for a period of time. Transitional care benefits may be available if being treated for any of the following conditions by an out-of-network doctor:

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

Transitional care benefits are subject to approval. To request transitional care benefits, complete a Transitional Care Request Form available from TRS-Care Customer Service at **1-800-367-3636**. 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 out-of-network doctor and receive the network level of benefits. If the transitional care request is denied, you may still continue to see your current doctor, but benefits will be paid at the out-of-network level.

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



COVERED SERVICES

What does TRS-Care cover?

TRS-Care covers medical services that are medically necessary as determined by Aetna and covered under your plan benefits. TRS-Care also covers those preventive services that are listed in the benefit summary table in the previous section.

What does “medically necessary” mean?

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.

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 the 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.

Aetna's Clinical Policy Bulletins are available online on Aetna's website at www.aetna.com.

Medical necessity is determined by Aetna and does not guarantee payment unless the service is covered by the TRS-Care plan. Decisions regarding medical necessity are guided by current guidelines viewed at www.aetna.com.

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

- 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
- Any other relevant information brought to Aetna's attention.

In no event will the following services be considered to be medically necessary;

- Services rendered by a provider that do not require the technical skills of that provider
- 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
- 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.



NOTE: A determination of medical necessity does not guarantee payment unless the service is covered by TRS-Care.

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

Acquired Brain Injury

An “acquired brain injury” is a neurological injury to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

The following services, as defined below, are covered if they are medically necessary as a result of, and related to, an acquired brain injury unless such injury was sustained in an activity or occurrence for which other similar coverage under the plan is limited or excluded.

- a) **Cognitive rehabilitation therapy:** Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual’s brain-behavioral deficits.
- b) **Cognitive communication therapy:** Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
- c) **Neurocognitive therapy:** Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
- d) **Neurocognitive rehabilitation:** Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- e) **Neurobehavioral testing:** An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews with the individual, family, or others.

- f) **Neurobehavioral treatment:** Interventions that focus on behavior and the variables that control behavior.
- g) **Neurophysiological testing:** An evaluation of the functions of the nervous system.
- h) **Neurophysiological treatment:** Interventions that focus on the functions of the nervous system.
- i) **Neuropsychological testing:** The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning
- j) **Neuropsychological treatment:** Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- k) **Neurofeedback therapy:** Services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters, and are designed to result in improved mental performance and behavior and stabilized mood.



- l) **Remediation:** The process(es) of restoring or improving a specific function.
- m) **Post-acute transition services:** Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- n) **Post-acute care treatment services:** Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include treatment goals of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.
- o) **Community reintegration services:** Services that facilitate the continuum of care as an affected individual transitions into the community.
- p) **Other similar coverage:** The medical/surgical benefits provided under a health benefit plan. This term recognizes a distinction between medical/surgical benefits, which encompass benefits for physical illnesses or injuries, and benefits for mental/behavioral health under a health benefit plan.
- q) **Outpatient day treatment services:** Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.
- r) **Psychophysiological testing:** An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- s) **Psychophysiological treatment:** Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Coverage will also include outpatient day treatment services, or other post-acute care treatment services.

Allergy Care

Coverage is provided for testing and treatment for medically necessary allergy care. Allergy injections are not considered immunizations. Allergy injections and antigens are covered at the coinsurance benefit level unless billed in conjunction with an office visit.

Ambulance Services

TRS-Care covers local professional **ambulance** services at 80% after the plan deductible. Many areas are served by ambulance services that do not contract with any provider networks. These providers often charge more than TRS-Care will pay, and you will be responsible for charges exceeding the Aetna allowed amount.

TRS-Care provides coverage for professional local ground ambulance 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 facility equipped and staffed to treat the condition. Payment for ambulance services will be limited to the allowable amount.

Non-emergency ambulance transport requires a letter of medical necessity and must include the medical rationale for this service from the attending physician. If this service is for patient/family convenience, it will not be covered. The patient must be bed or stretcher bound.

Air ambulance is covered when medically necessary and the patient is transported to the nearest facility equipped and staffed to treat the condition. Precertification is required. Other travel expenses, including transfers for the convenience of the patient or doctor, are not covered.

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:

- 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

PRECERTIFICATION REQUIRED

Coverage may be provided if all medical criteria are met. Please refer to the Clinical Policy Bulletin at www.aetna.com for more information.

Chemical Dependency, Including Alcoholism

PRECERTIFICATION REQUIRED

Both inpatient and outpatient coverage is available under TRS-Care to the extent specifically described as follows:

Effective Treatment

"Effective Treatment" means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a physician and meets either of the following:

- The physician certifies that a follow-up program has been established that includes therapy by a physician or group therapy directed by a physician at least once per month
- It includes attendance at least twice a month at meetings of organizations for the therapeutic treatment of alcoholism or drug abuse, whichever is being treated.

Admission solely for detoxification or mainly for maintenance care is not considered Effective Treatment. Detoxification is care primarily for overcoming the aftereffects of a specific episode of drinking or drug abuse. Maintenance care provides an environment without access to alcohol or drugs.

Inpatient Treatment of Alcoholism or Drug Abuse

These are **covered medical expenses** if a participant is an inpatient in a hospital solely for:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- Effective Treatment of alcoholism or drug abuse is covered only if there is not a separate **Alcoholism or Drug Abuse Treatment Facility**.

Certain charges for the Effective Treatment of **Alcoholism or Drug Abuse** in a Treatment Facility are covered. The charges covered are those for:

- Room and board. Charges for daily room and board in a private room over the institution's semiprivate rate are not covered.
- Other necessary services and supplies.

Outpatient Treatment of Alcoholism or Drug Abuse

Expenses incurred for the Effective Treatment of alcoholism or drug abuse are covered medical expenses if a participant is not an inpatient either in a hospital or in a Treatment Facility.

Covered expenses include charges:

- Made by hospitals and facilities for outpatient treatment of alcoholism and substance abuse.
- Made by physicians for outpatient treatment of alcoholism and substance abuse.
- For medical services and supplies (other than inpatient charges) used in connection with the treatment of mental disorders.
- For day care or evening care sessions (partial hospitalization) made by facilities meeting the standard treatment facility recognition requirements.

Partial hospitalization treatment

Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be medically necessary and provided by a behavioral health provider with the appropriate license or credentials. Services are designed to address a mental disorder or substance abuse issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.

Expenses incurred for the treatment of alcoholism or drug abuse will be covered only as provided above.

Treatment Facility

As the term applies to the treatment of alcoholism or drug abuse, a "Treatment Facility" is an institution, or a distinct part of an institution, meeting all of the following tests:

- It mainly provides a program for diagnosis, evaluation, and Effective Treatment of alcoholism or drug abuse.



- It provides all detoxification services on the premises, 24 hours a day.
- It provides all normal infirmity-level medical services required for the treatment of any disease or injury incurred during treatment, whether or not related to the alcoholism or drug abuse. It also has an agreement with a hospital in the area to provide any other required medical services.
- At all times during treatment, it is under the constant supervision of a staff of physicians and it provides Skilled Nursing services at all times by licensed nursing personnel directed by a full-time Registered Nurse (RN).
- It prepares and maintains a written treatment plan for each patient based on a diagnostic assessment of the patient's medical, psychological, and social needs, which states that the care is supervised by a physician.
- It meets any licensing standards set by the jurisdiction in which it is located

NOTE: As with all hospitalizations, inpatient treatment must be precertified. If treatment is not precertified, a precertification penalty will apply (per confinement).

Chiropractic Care

TRS-Care covers a maximum of 20 visits for chiropractic services per calendar year. Precertification is not required.

Compassionate Care and Hospice

NOTIFICATION REQUIRED

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
- 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 at **www.aetnacompassionatecare.com** or by calling TRS-Care Customer Service at **1-800-367-3636**.

Limitations to Convalescent Facility/Skilled Nursing Facility Expenses

This benefit does not cover charges for the treatment for the following primary diagnoses: drug addiction, Alzheimer's disease, Alcoholism, senility, mental disability or any other mental disorder and non-psychotic chronic organic brain syndrome.

It does not matter what caused the condition or the duration of the condition.

The care provided, not the type of facility or Medicare guidelines, determines if care can be classified as medically necessary "skilled" care.

No benefit will be paid for expenses incurred for any day of confinement as a full-time inpatient if excluded by any other terms of the plan. These confinements are subject to the same precertification requirements that apply to hospitalization.

The maximum inpatient benefit is limited to 365 days for the same or similar condition unless separated by 90 consecutive days between confinements.

Cosmetic, Reconstructive or Plastic Surgery

PRECERTIFICATION REQUIRED

Plastic and Reconstructive surgery is covered to the extent needed to:

- Improve function to a part of the body that:
 - Is not a tooth or structure that supports the teeth
 - Is malformed because of a severe birth defect (including cleft palate or webbed fingers or toes) as a direct result of disease; or due to surgery performed to treat a disease or injury (including reconstructive surgery of the breast following a medically necessary mastectomy)
- Repair an injury that occurs while the person is covered by TRS-Care or when the person was covered under a group health plan for up to one year prior to TRS-Care coverage effective date.

Surgery must be performed:

- In the plan year of the accident which causes the injury; or
- In the next plan year.

Covered Oral Surgery and Dental Services

PRECERTIFICATION REQUIRED FOR SOME PROCEDURES

Only expenses for those services and related supplies needed for the treatments shown below are covered medical expenses. Predeterminations are recommended for procedures involving the mouth, teeth and jaw. For these expenses, treatment must be performed by a physician or **dentist**.

- Surgery needed to:
 - Treat a fracture, dislocation, or wound
 - Cut out:
 - Teeth partly or completely impacted in the bone of the jaw;
 - Teeth that will not erupt through the gum;
 - Other teeth that cannot be removed without cutting the bone;
 - The roots of a tooth or cysts without removing the entire tooth;
 - Tumors
 - Cut into the gums and tissues of the mouth when not done in connection with the removal, replacement, or repair of teeth
 - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
 - Dental work due to an injury or accident, including surgery and orthodontic treatment needed to remove, repair, replace, restore, or reposition natural teeth damaged, lost or removed or other body tissues of the mouth fractured or cut. The accident or injury must have occurred while the person is covered under this benefit section at the time of the injury or accident, or the person was covered under a group health plan for up to one year prior to the TRS-Care coverage effective date.
 - Any such teeth must have been free from decay or restoration (no more than two surface amalgam fillings) and firmly attached to the jawbone at the time of the injury.
 - The treatment must be done in the calendar year of the accident or the next subsequent year.

- Charges for the first crown (caps) to repair the damaged tooth, dentures (false teeth) or fixed bridgework to replace lost teeth, or in-mouth appliances used in the first course of orthodontic treatment after the injury are covered medical expenses.

Not included are charges:

- To remove, repair, replace, restore, or reposition teeth lost or damaged in the course of biting or chewing
- To repair, replace, or restore fillings, crowns, dentures, or bridgework;
- For non-surgical periodontal treatment
- For in-mouth scaling, planing, or scraping
- For myofunctional therapy that is muscle training therapy or training to correct or control harmful habits
- For in-mouth appliances, crowns, bridge work, dentures, tooth restorations, or any related fitting or adjustment services, except as provided for injury, whether or not the purpose of such services or supplies is to relieve pain
- For root canal therapy or dental cleaning
- For routine tooth removal (not needing cutting of bone), except as provided for injury
- For non-surgical treatment of temporo-mandibular joint dysfunction.

Diabetic Management Service

TRS-Care follows all applicable state and federal laws, including mandates regarding diabetic care and treatment.

Durable Medical Equipment (DME)

PRECERTIFICATION REQUIRED FOR CERTAIN EQUIPMENT

Durable medical equipment or surgical equipment determined to be medically necessary is covered when it is:

- Made to withstand prolonged use
- Made for and mainly used in the treatment of a disease or injury
- Not normally used by people who do not have a disease or injury
- Not for use in altering air quality or temperature
- Not for exercise or training
- Suited for use in the home

Purchase, rental, repair, or replacement of durable medical or surgical equipment will be determined by Aetna as follows:

- The initial purchase of such equipment and accessories needed to operate it will be covered only if Aetna is shown that long-term use is planned; the equipment cannot be rented; or it will cost less to buy than to rent.
- Rental benefits will be allowed up to the purchase price of the equipment.
- Repair or replacement of such purchased equipment and accessories is covered only if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

Not included are charges for more than one item of equipment for the same or similar purpose.

Emergency Care

Benefits for emergency care rendered by a network or out-of-network provider are paid based on allowed amounts according to regular plan provisions. The deductible and coinsurance apply.

Emergency Room Treatment – The first treatment given in a hospital's emergency room right after the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition that:

- Requires hospital level care because:
 - The care could not safely and adequately have been provided other than in a hospital; or
 - Adequate care was not available elsewhere in the area at the time and place it was needed;
 - And could reasonably be expected to result in an emergency condition. This means a recent and severe medical condition, including, but not limited to, severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
 - Placing the person's health in serious jeopardy; or
 - Serious impairment to bodily function; or
 - Serious dysfunction of a body part or organ; or
 - Serious disfigurement; or
 - Serious jeopardy to the health of a fetus.

If you are admitted to a network hospital, network providers will precertify your hospital admission. If you are admitted to an **out-of-network hospital**, the hospital admission must be precertified within 48 hours by calling TRS-Care Customer Service at **1-800-367-3636**.

NOTE: Services and/or supplies that cannot be reasonably provided by a network hospital or physician will be considered at the participating network allowed amount and coinsurance. The TRS-Care participant will still be responsible for any billed amount that is greater than the network-allowed amount.

Eye Exams and Treatment

Benefits are limited to treatment of illness or injury to the eye with coverage in the same manner as for any other illness. After intraocular surgery or accidental injury, the first eyeglasses, frames and lenses, or contact lenses purchased within 12 months of the surgery are covered. There is no coverage for the cost of subsequent eyeglasses or contact lenses. Routine eye exams are not covered.

Family Planning

Voluntary sterilization is a covered medical expense. Oral contraceptives are covered under the prescription benefit plan. Depo-Provera is covered under the medical benefit plan.

Hearing Aid or Cochlear Implant

Coverage is provided for medically necessary hearing aids or cochlear implants and related services and supplies for a covered dependent to age 19. Replacement parts will be covered every three years.

Home Health Care

The charges made by a **Home Health Care Agency** for the following services and supplies furnished to a participant in the person's home and in accordance with a **home health care plan** are included as covered expenses:

- Part-time or intermittent care by an RN or an LVN and Home Health Aide where medically appropriate under the supervision of an RN
- Master of Social Work (MSW) or Social Worker (SW)
- Physical, occupational, speech, and respiratory therapy
- Medical equipment and supplies, drugs and medicines prescribed by a physician, and lab services provided by or for a Home Health Care Agency, but only to the extent that such charges would have been covered if the person had been confined in a hospital or **convalescent facility**.

No more than 120 combined **home health care** visits and Private Duty Nursing shifts will be covered in any one calendar year. Each visit of up to four hours by an RN or an LVN to provide nursing care or by a therapist to provide physical, occupational, speech, or respiratory therapy will be considered one visit.

Home health care or private duty nursing expenses will not be included if they are in connection with any of the following:

- Services or supplies not specified in the home health care plan;
- Transportation services;
- Services of a person who ordinarily resides in the participant's home or is included in the family of either the participant or the participant's wife or husband.

Private Duty Nursing service expenses must be precertified. If this is not precertified, a precertification penalty will apply (per disability). If a private duty nursing service is not precertified and is not medically necessary, the expenses will not be covered.



NOTE: Custodial Care is not a covered service. Please refer to page 101 for the Glossary.

Home Infusion Services

NOTIFICATION IS REQUIRED

TRS-Care 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 service
- Patient and family education
- Nursing services

Over-the-counter products that do not require a prescription, including standard nutritional formulas used for enteral nutrition therapy (tube feedings) may be covered based on medical necessity.

Hospital Admissions

PRECERTIFICATION REQUIRED

These are services provided by a hospital, including room and board and other hospital services and supplies to a person who is confined as a full-time inpatient for treatment of an injury or disease.

Any charge for daily room and board in a private room over the semiprivate rate is not a covered medical expense unless Medically Necessary, as determined by Aetna.

Confinement in a **Long Term Acute Care (LTAC)** facility is an eligible benefit for those patients who no longer require the level of care in an acute inpatient hospital unit, but require skilled care not available at a **Skilled Nursing Facility** when medically necessary as determined by Aetna.

Coverage does not include custodial, nursing, rest, or extended care facilities, and facilities operated exclusively for the treatment of the elderly, drug addicts or alcoholics, whether or not such facilities are operated as a separate institution by a hospital.

The care must be determined to be medically necessary. Benefits will not be paid for expenses incurred for any day of confinement as a full-time inpatient in a LTAC facility if excluded by any other terms of the plan.

If the admission is not precertified, a precertification penalty will apply. This penalty will apply to each confinement in a facility that is not precertified.

The maximum confinement period for any inpatient treatment is limited to 365 days for the same or similar condition unless separated by 90 consecutive days between confinements. This maximum applies to each type of confinement.

VA and Military Hospitals

Medically necessary services provided by VA and military hospitals are covered in the same manner as medically necessary services provided by other legally constituted institutions providing inpatient and outpatient care. Precertification will be required for the following medical services: All inpatient admissions and all listed services on page 21 - 23 when care is provided by a military hospital or VA hospital.

Lab, Radiology and other Ancillary 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 expected to refer 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.

In some situations, the network 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 of lab tests and X-ray will be paid at the network coinsurance level whether performed by a network or out-of-network provider. However, if an out-of-network provider is used, the participant will be responsible for any expenses exceeding the allowable amount.

Diagnostic testing for the treatment or diagnosis of a medical condition will not be covered under the preventive benefit. Except for diagnostic mammograms, you will pay the cost sharing specific to eligible health services for diagnostic testing.

Mental Health Care

PRECERTIFICATION REQUIRED

Charges for inpatient treatment of a **mental or nervous disorder** are covered medical expenses to the same extent as for any other disease.

Any charge for daily room and board in a private room over the semiprivate rate is not a covered medical expense unless medically necessary, as determined by Aetna.

Mental Disorders may include the following:

- Schizophrenia
- Bipolar disorder
- Pervasive mental developmental disorder (Autism)
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive-compulsive disorder

Inpatient Treatment Facilities include:

- **Crisis Stabilization Units**
- **Residential Treatment Centers** Hospitals.

A treatment facility must:

- Provide all normal infirmity-level medical care required for the treatment of any disease or injury incurred during a treatment period, whether or not related to the mental or nervous disorder. The facility must also provide, or have an agreement with a hospital in the area to provide, any required medical services.
- Be supervised at all times by a psychiatrist who is responsible for coordinating patient care and is at the facility on a regular basis.
- Be staffed by psychiatric physicians involved in the treatment program, and one of these physicians must be present at all times during the treatment day.

- Provide, at all times, psychiatric social work and nursing services.
- Provide, at all times, skilled nursing care by licensed nurses who are supervised by a full-time RN
- Prepare and maintain a written individual plan of treatment for each patient based on medical, psychological and social needs. The treatment must be supervised by a psychiatric physician.
- Charge for services actually provided.

Day Care or Night Care Treatment

Covered medical expenses include charges made by a hospital or treatment facility for effective treatment of a mental disorder and given through a Day Care or a Night Care Treatment Program that is at least four hours but not more than eight hours in any one 24-hour period. A treatment session starts when the person enters the place of treatment. It ends when he or she leaves after one Day Care or one Night Care treatment. All services and supplies must be furnished by the facility, including drugs and medicines prescribed by a physician for the treatment of the mental disorder. Charges made for Day Care or Night Care treatment are considered to be inpatient facility charges.

Outpatient Treatment/Facility

Charges for outpatient treatment of a mental or nervous disorder are covered medical expenses to the same extent as for any other disease. The deductible and coinsurance apply.

Outpatient Treatment and Office Visits

The deductible and coinsurance applies to participants, as well as for out-of-network covered services

For both Outpatient and Inpatient Services, no benefits are paid for:

- Services of a physician who is not on the staff of the place treatment is given
- Psychiatric nursing and social work services if not ordered by a staff psychiatric physician
- Diagnostic psychological tests if not given by personnel licensed or certified to do so
- Missed appointments
- Telephone consultations
- Personal comfort items
- Services and supplies that are not part of care by an institution on a regular basis

NOTE: Outpatient mental/behavioral health testing, intensive outpatient therapy and electroconvulsive therapy (ECT) must be precertified as well.

Orthotics and Prosthetics

TRS-Care 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 if you are above 18, hearing aids).

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 32)
- Splints or bandages provided by a physician in a non-hospital setting or purchased over-the-counter for support of strains and sprains
- Orthopedic shoes that are a separable part of a covered brace
- Specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or effect changes in the foot
- Foot alignment, arch supports, elastic stockings and garter belts

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

Outpatient Facility Services

When medically necessary, TRS-Care covers the following services provided through a hospital outpatient department or a free-standing facility:

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

Normally, it is less expensive for TRS-Care and the participant when these services are delivered in a free-standing network facility.

Pregnancy

For Retiree and Spouse

Benefits are paid for pregnancy-related expenses of female retirees and dependent female spouses on the same basis as any other medical condition.

In the event of an inpatient confinement, covered medical expenses include inpatient care of a participant and any newborn child for a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a cesarean delivery. If the participant is discharged earlier, benefits will be payable for two post-delivery home visits by a health care provider. This change applies only to retiree and spouse coverage.

For Dependent Children Covered under TRS-Care or Covered by COBRA

Normal pregnancies are not a covered benefit for dependent children. Per eligibility requirements on page 68, newborns of dependent children are also not covered. (See exceptions to this on page 69) When one of the following complications occurs during pregnancy, it is covered on the same basis as any other medical condition:

- An ectopic pregnancy
- A complication that requires intra-abdominal surgery after termination of pregnancy
- Pernicious vomiting of pregnancy (hyperemesis gravidarum)
- Toxemia with convulsions (eclampsia of pregnancy)
- Cesarean section
- Preeclampsia
- Termination of pregnancy during a period of gestation where a viable birth is not possible
- Any condition that requires hospital confinement prior to termination of pregnancy, the diagnosis of which condition is distinct from pregnancy, but is adversely affected by pregnancy or caused by it, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, or any similar medical and surgical condition of comparable severity.

Excluded are charges for false labor, occasional spotting, physician-prescribed rest or morning sickness, and any similar condition associated with the management of a difficult pregnancy that does not constitute a complication of pregnancy.

Elective Abortions — coverage is limited to abortions performed because a serious medical complication would put the life of the mother in danger if the fetus was carried to term.

Prior plans — any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under TRS-Care.

Pre-existing Conditions

Pre-existing conditions are covered on the same terms and conditions as any other illness.

Preventive Services

TRS-Care 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 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 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 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.

Professional Services

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

Who are covered health providers?

TRS-Care covers services only from the following providers:

- Doctor of Chiropractic
- Doctor of Dentistry
- Doctor of Medicine
- Doctor of Optometry
- Doctor of Osteopathy
- Doctor of Podiatry
- Doctor of Psychology
- Psychological Associates who work under the supervision of a Doctor in Psychology
- Licensed Audiologist
- Licensed Speech-Language Pathologist
- Licensed Master Social Worker – Advanced Clinical Practitioner
- Licensed Dietician
- Licensed Professional Counselor
- Licensed Chemical Dependency Counselor
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Advanced Practice Nurse (APN) (Nurse Practitioner)
- Certified Registered Nurse Anesthetist (CRNA)
- Physician Assistant (PA)
- Nurse First Assistant (NFA)
- Surgical First Assistant
- Christian Science Practitioner (listed in the *Christian Science Journal*)

NOTE: Not all services provided by a recognized health care provider are a covered benefit under TRS-Care.

Rehabilitation Services

TRS-Care covers rehabilitation services including physical, speech, and occupational therapies that are medically necessary, meet or exceed treatment goals for the participant, and are provided on an inpatient basis with precertification. Physical, speech, and occupational therapies provided on an outpatient basis or in the provider's office may require periodic review of services for medical necessity. Speech therapy is expected to restore speech function or correct a speech impairment resulting from illness or injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech therapy does not include educational training or services designed to improve physical function except as provided for Developmental Delay and Autism.

Skilled Nursing Facility

The charges for a Skilled Nursing Facility are covered expenses if the participant is confined in the facility during a recovery period. These charges will be treated as hospital expenses in determining the amount of benefits payable. A recovery period is a period of consecutive days, beginning on the day that the participant first becomes confined in a facility for Skilled Nursing Care.

The patient requires "medically necessary" Skilled Nursing Care that cannot be met at a lower level of care.

It is expected that the care received will improve the patient's condition and facilitate discharge. Custodial care is not a covered benefit regardless of provider, prescriber, or facility.

The types of facilities providing recovery care may include hospitals, Skilled Nursing Facilities that:

- Are licensed to provide inpatient Skilled Nursing AND physical restoration services
- Are supervised by a doctor or RN
- Provide 24-hour care by a staff of licensed nurses under the direction of a full-time RN

- Keep complete medical records on each patient
- Have a utilization review plan for each patient
- Are not mainly a place for rest, for the elderly, drug addicts, alcoholics, custodial or educational care, or for care of mental disability or mental disorders

The types of services and supplies that are covered when confined in a Skilled Nursing Care Facility are room and board at **the semiprivate room rate**, routine medical services, supplies, and equipment provided by the skilled nursing facility. Care must be determined to be medically necessary.

A recovery period ends when the person has not been confined in a hospital, Skilled Nursing Facility, or other place providing nursing care for 90 consecutive days. The maximum inpatient benefit is limited to 365 days for the same or similar condition unless separated by 90 consecutive days between confinements.

Limitations to Convalescent Facility/Skilled Nursing Facility Expenses

This benefit does not cover charges for treatment for the following primary diagnoses: drug addiction, alcoholism, Alzheimer's disease, senility, mental disability or any other mental disorder and nonpsychotic chronic organic brain syndrome. It does not matter what caused the condition or the duration of the condition.

The care provided, not the type of facility or Medicare guidelines, determines if care can be classified as medically necessary "skilled" care. No benefit will be paid for expenses incurred for any day of confinement as a full-time inpatient if excluded by any other terms of the plan. These confinements are subject to the same precertification requirements that apply to hospitalization. In the event that Medicare benefits are exhausted, care provided for any day of confinement as a full-time inpatient requires precertification. The maximum inpatient benefit is limited to 365 days for the same or similar condition unless separated by 90 consecutive days between confinements.

TRS Virtual Health – Medical Care

TRS Virtual Health telemedicine is available through Teladoc. A TRS Virtual Health medical consult is an affordable alternative to emergency room and urgent care. Many common medical issues can be resolved through the convenience of a phone or video consult. Simply call 855-835-2362, 24/7/365 or download the Teladoc app and log into your Teladoc portal to schedule.

- The \$30 consult fee applies to the deductible, then the plan pays 80%. Once your deductible is met you can have a medical visit with a board-certified physician and your cost share would be \$6.
- Convenient medical care available in the privacy of your own home.
- Guaranteed call back within 60 minutes. The average call back time is less than 15 minutes.
- Treatment from a board certified physician for acute, non-urgent conditions like bronchitis, urinary tract infections or sinus infections. Medications are prescribed when appropriate.
- A copy of the consult record will be sent to your primary care provider upon request.

TRS Virtual Health – Mental Health Care

You can receive care for mental health conditions by board-certified psychiatrists, psychologists, licensed social workers, counselors or therapists. They can treat anxiety, depression, substance abuse, stress, grief, family issues and more. This TRS Virtual Health telemedicine benefit is available through Teladoc.

- The patient must be 18 years or older.
- You can have an ongoing relationship with the provider.
- Mental health visits are only available over video. You can test your video connection when you schedule the appointment.

All appointments must be scheduled online or through the Teladoc app and must be scheduled at least 72 hours in advance. Request a time that works best for you and the provider can either accept that time or propose

a different time. There is flexible scheduling and appointments are available seven days a week from 7 a.m. to 9 p.m. local time. Confidential treatment is available at your convenience over video. To schedule a visit:

- Register for a Teladoc account via the web or log in to your account if you have already registered
- Request a visit
- Answer a few questions
- Select your psychiatrist or therapist
- Request a time for your appointment

Psychiatrists are the only mental health providers that can prescribe medications; they currently prescribe from a limited formulary, including antidepressants. Medications that Teladoc psychiatrists can prescribe include:

- Antidepressants: Asendin, Celexa, Desyrel, Lexapro, Paxil, Prozac, Remeron, Sinequan, Viibryd, Vivactil, Wellbutrin and Zoloft
- Anxiolytics/Sedatives/Hypnotics – Schedule II and IV medications: BuSpar, Benadryl, Melatonin and Rozerem
- Chemical Dependency Adjuncts: ReVia and Vivitrol
- Monoamine Oxidase Inhibitors: Emsam
- Miscellaneous: Luvox and Neurontin

Teladoc's psychiatrists do not prescribe antipsychotics, mood stabilizers or stimulants. Teladoc's therapists (psychologists, counselors, therapists, etc.) do not prescribe medications.

TRS Virtual Health – Caring for Your Family

Some family members that are age 18 and over, like adult children or elderly parents, can receive medical care from a board-certified physician too, even if they are not covered by your TRS-Care Standard Plan. This TRS Virtual Health benefit is available through Teladoc. You can extend the general medicine service to someone you care for with a two-way or three-way video or phone visit with a licensed doctor for a flat fee of \$45.

- Sign up to add family members or loved ones that are not covered by your TRS-Care Standard Plan.
- Provide legal authorization specifying Caregiver status for the person that is receiving care.
- Request a phone consult with a board-certified doctor.
- The Teladoc physician can share a visit summary with the PCP if requested.

Transplants

PRECERTIFICATION REQUIRED

Aetna's National Medical Excellence (NME) Program includes the National Transplantation Program component that coordinates care and provider access through the Institutes of Excellence™ (IOE) network. Hospitals/ facilities have been contracted on a transplant-specific basis and are considered to be participating ONLY for the specific transplants for which they are contracted.

This program is designed to help arrange covered care for organ and tissue transplants including heart, lung, liver, kidney, pancreas, peripheral stem cell and bone marrow transplants. **For questions regarding transplant coverage, claims payment, or to precertify services, please call Aetna's National Medical Excellence (NME) at 1-800-232-1931.**

This program provides:

- Access to covered care when precertified through the NME unit, a nationwide network of health care providers and hospitals in the Institutes of Excellence™ network demonstrating continual achievement in complex care
- Specialized case management by nurses experienced in coordinating complicated transplant care. Working with the patient, physician, facility and family members, Aetna's case managers coordinate all phases of the procedure from initial assessment and treatment to follow-up.
- Coordination of follow-up care that permits participants to get after-care services close to home, when possible. Aetna selects facilities with experience and a history of successful clinical outcomes.
- Specifically, facilities must meet selection criteria for:
 - **Experience:** Transplants and other specialized procedures are performed with a certain frequency.
 - **Outcomes:** Graft and patient survival rates at three-month, one-year, and three-year intervals following transplants are evaluated.

- **Continuity of Care:** Patients have access to follow-up care after the procedure.
- **Concurrent Review:** Patient information is reported to Aetna on an ongoing basis.
- **UNOS Membership:** Hospitals have active membership in the United network of Organ Sharing (UNOS).
- **Centers for Medicare and Medicaid Services (CMS) approval:** Hospitals have approval from CMS for solid organ transplantation.
- **Reports:** Annual statistical information is reported to a national procedure registry and to Aetna.

A participant in TRS-Care can choose to receive treatment at a non-IOE (Institutes of Excellence) facility. The facility payment will be subject to the deductible, out-of-network allowable amounts, and coinsurance percentages. The facility payment will be subject to the out-of-network allowable amounts and the out-of-network deductible, coinsurance and out-of-pocket maximum.

Services and supplies for transplant donors who are not TRS-Care participants are not covered when a TRS-Care participant chooses to receive treatment at a non-IOE facility.

Travel and lodging are not covered.

NOTE: A participant who is already on a transplant list at a specific facility at the time of retirement will be able to continue his or her treatment plan. Facility payment will be based on the Aetna contracted rate.

Refer to the Benefits Summary for the TRS-Care Standard Plan on page 13 - 16 of this booklet for more detailed information, including the applicable deductible and coinsurance. A list of excluded services begins on page 44.

Aetna's Clinical Policy Bulletins are available online on Aetna's website at www.aetna.com.





EXCLUSIONS/LIMITATIONS OF THE PLAN

Coverage is not provided for the following services:

- Services and supplies not medically necessary, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if the services or supplies are prescribed, recommended, or approved by the person's attending physician or dentist.
- Care, treatment, services, or supplies that are not prescribed, recommended, and approved by the person's attending physician or dentist
- Hearing aids, hearing aid evaluation tests, hearing aid batteries, hearing exams required as a condition of employment and special education for a person whose ability to speak or hear is lost or impaired for a participant over 18 (this includes lessons in sign language).
- Routine foot care, including shoe orthotics, insoles or shoe inserts of any type (except when prescribed for a diagnosis of, or related to, diabetes)
- Environmental sensitivity, clinical ecology, or inpatient allergy testing or treatment
- Primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training, carbon dioxide therapy, or chelation therapy except for treatment of acute metal poisoning
- Services received by health care professionals who specialize in the mental health care field as part of their required training
- Travel services and accommodations, whether or not recommended or prescribed, except for medically necessary ambulance services
- Services of a resident physician or intern rendered in that capacity
- Services or supplies provided by yourself or an immediate family member (including spouse, mother, father, sister or brother)
- Physical therapy for maintenance purposes
- Charges that are greater than **reasonable charges** as determined by Aetna
- Charges made only because there is health coverage
- Charges that a covered person is not legally obliged to pay
- Custodial care or respite care (unless authorized under the Aetna Compassionate Care Program).

- Services and supplies:
 - Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government unless superceded by federal law
 - Furnished, paid for, or for which benefits are provided or required under any law of a government. (This does not include a plan established by a government for its own employees or their dependents or Medicaid.) An example would be benefits provided to the extent required by law under “no-fault” auto insurance.
- Eye surgery mainly to correct refractive errors
- Orthopedic shoes not attached to an artificial limb or brace, unless mandated by law
- Education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment
- Plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies, that improve, alter, or enhance appearance, whether or not for psychological or emotional reasons except to the extent needed to:
 - Improve the function of a part of the body that is not a tooth or structure that supports the teeth; is malformed because of a severe birth defect including cleft palate, or webbed fingers or toes, and as a direct result of disease or due to surgery performed to treat a disease or injury
 - Therapy, supplies, or counseling for sexual dysfunctions, or inadequacies without a physiological or organic basis
- Sex change surgery
- Artificial insemination, in vitro fertilization, or embryo transfer procedures
- Reversal of a sterilization procedure
- Marriage, family, child, career, social adjustment, pastoral, or financial counseling
- Acupuncture therapy unless performed by a physician as a form of anesthesia in connection with surgery that is covered under the plan
- Expenses for any services and supplies in excess of a reimbursement arrangement as specified in any agreement between TRS-Care and any network hospital, physician, or provider
- Multiple services performed on the same day will be reviewed for bundling and incidental purposes and may not be allowed as billed
- Any weight-loss programs sponsored by a particular physician and/or commercial weight-loss programs and products (e.g., Weight Watchers, Herbalife, Jenny Craig)
- General dental services, including dental appliances and any medical/surgical expense incurred for dental surgery (except as allowed under Dental and Covered Oral Surgery on page 32)
- Charges that result from the failure to keep a scheduled visit with a physician or other professional provider, for the completion of insurance forms or the acquisition of medical records
- Services or supplies provided for the 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 a Workers’ Compensation plan
- Services or supplies that Aetna determines to be experimental or investigational

What does Aetna consider to be experimental or investigational?

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

- There is insufficient 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
- If required by the FDA, approval has not been granted for marketing or a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
- The written protocol or protocols used by the treating facility or the 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, investigational, or for research purposes.

This exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease if Aetna determines that:

- The disease can be expected to cause death within one year, in the absence of effective treatment; and the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. A Medical Director selected by Aetna will review the case. Aetna will use the results when making this determination.
- The available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

Participants and providers should verify the status of relevant medical policies immediately before services are provided. Current medical policies are available on the TRS-Care Standard or Aetna websites, or by calling customer service.

Also, this exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND) or Group c/treatment IND status or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute.

Aetna's Clinical Policy Bulletins are available online on Aetna's website at www.aetna.com.

Any exclusions above will not apply to the extent that coverage is specifically provided by name in this Booklet or coverage is required by applicable law. The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. The plan sponsor will insure that benefits are administered in accordance with the provision of applicable law.





CLAIMS, APPEALS AND EXTERNAL REVIEW

Non-Assignment of Benefits

Except to the extent required by law, this Program will not accept the sale, transfer, pledge or assignment of any benefits under this Program (including, but not limited to, any benefits due, the right to receive payments, the right to file claims, any claim you make for damages resulting from a breach, or alleged breach of the terms of any plan offered under this Program, whether constituting legal or equitable relief). Except as provided under a Qualified Medical Child Support Order, no benefit under the Program prior to actual receipt thereof by an enrollee shall be subject to any debt, liability, contract, engagement, or tort of any enrollee, nor subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other involuntary alienation or other legal or equitable process. Any such attempt at disposition will be void. Notwithstanding anything to the contrary above, any purported assignment to a medical provider shall be considered by the Program to be merely a direction from an enrollee to provide direct payment to the medical provider as a facilitation of payment and shall not be construed as an assignment to the medical provider regardless of its content. The Program's direct payment to a medical provider pursuant to such a direction shall not constitute a recognition of a legal assignment.

How to Appeal a Claim Denial

A claim denial is a decision on a claim that results in:

- Denial, reduction, or termination of a benefit or the amount paid for a service or supply.
- A decision not to provide a benefit, service or supply.

Aetna will send you an Explanation of Benefits (EOB). The EOB notifies you of Aetna's determination concerning your claim(s), indicating the portion of each claim that is approved for coverage. The part of the EOB that indicates that a portion, if any, of a claim is denied coverage is your notice of a claim denial. The EOB may be electronic or in writing. The notice of a claim denial will give the reason for the denial of coverage and will explain what steps you must take if you wish to appeal the denial. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal.

Three Steps in the Appeal Process

TRS-Care provides for two mandated levels of appeal to Aetna, with the option to thereafter seek a voluntary external review for claims that qualify. In order to seek a voluntary external review of qualifying claims, you must first request both a Level One appeal and a Level Two appeal, discussed immediately below.

1. If you are dissatisfied with the portion of your claim that was denied coverage, you may ask for an initial appeal review by Aetna. You must request this first appeal (a Level One appeal) within 180 calendar days after you receive the notice of the claim denial (in the EOB).
2. If you are dissatisfied with the outcome of your Level One appeal to Aetna, you may ask for a second review (a Level Two appeal). You must request a Level Two appeal no later than 60 calendar days after you receive a notice of denial of your Level One appeal.
3. If you have already requested both a Level One appeal and a Level Two appeal, your claim denial may be eligible for review by an independent external review organization (ERO). You must submit a request for external review within 123 calendar days of the date you receive a notice of denial of your Level Two appeal.

Level One and Level Two Appeals to Aetna

Your appeals may be submitted in writing to Aetna Member Services or by making a telephone call to Aetna Member Services, and should include:

- Your name
- A copy of Aetna's notice of the claim denial (located in the EOB)
- Your reasons for making the appeal
- The group name (TRS-Care)
- Any other information you would like to have considered in your appeal to Aetna.

Send your appeal to Aetna Member Services at the address shown on your ID card or call Aetna Member Services at **1-800-367-3636**.

Based on the type of claim, Aetna must respond to your appeal within the time frames shown in the following chart:

Type of Claim	Level One Appeal Aetna Will Notify You Within:	Level Two Appeal Aetna Will Notify You Within:
Urgent Care Claim	36 hours	36 hours
Pre-Service Claim	15 calendar days	15 calendar days
Concurrent Care Claim Extension	Treated like an urgent care claim or a pre-service claim, depending on the circumstances	Treated like an urgent care claim or a pre-service claim, depending on the circumstances
Post-Service Claim	30 calendar days	30 calendar days

You may also choose to have another person (an authorized representative) make the appeal on your behalf. To do so, you must provide Aetna with acceptable written evidence of your delegation of authority for another person to act on your behalf. Acceptable written evidence of a delegation of authority may include, among others, a power of attorney, a court order, or a hospital form signed by the enrollee. Aetna shall have the right, in its sole judgment, on a case-by-case basis, to determine what written evidence will be acceptable to prove a delegation of authority. In the case of an urgent care claim or a pre-service claim, a physician familiar with your case may represent you in the appeal.

External Review

An external review is an optional review of a claim denial (an adverse benefit determination) by an External Review Organization (ERO). You may request an external review of certain qualifying claim denials (see below). However, you are not required to file for review by an ERO. This is a voluntary review.

Claim Denials That Qualify for External Review

You or your authorized representative may request an external review of:

- A claim denial that is based upon a rescission (a decision in which coverage is cancelled or discontinued retroactively)
- A claim denial that involves a claim that is over \$500 and deemed not medically necessary
- A claim denial based on medical judgment if:
 - You have exhausted the appeal process provided by TRS-Care, as described above
 - Aetna or TRS-Care did not follow all claim and appeal rules (described above) under federal law (except for minor violations), and the appeal process was therefore considered complete. This is called “deemed exhaustion.”

Keep in Mind

A claim denial based upon your eligibility for enrollment in TRS-Care does not qualify for external review.

If you file for an external review of a qualified claim denial, any applicable statute of limitations will be suspended while the appeal is pending. Your request for an external review will not affect your rights to any other benefits under TRS-Care.

The External Review Process

1. You must submit a request for external review within 123 calendar days of the date you receive a notice of denial of your Level Two appeal. The request must be in writing (oral requests are not accepted) and include a copy of the denial notice and include all other information that (i) you believe supports your position and (ii) you believe will be important for the ERO to consider during its review.
2. Aetna will do a preliminary review of your request for an external review within five business days of receiving the request. This preliminary review determines whether the claim denial qualifies for external review (i.e., you were covered under TRS-Care at the time the service was requested or provided, the review does not relate to eligibility, and you have exhausted the two internal appeals), and includes all necessary documentation (i.e., a copy of the denial notice and LIST ANY OTHER DOCUMENTATION).

Aetna must notify you in writing of the results of this preliminary review within one business day after completing the review.

3. If your request for an external review is approved, Aetna will assign an accredited ERO to conduct the review. An independent clinical reviewer associated with the ERO, who possesses appropriate expertise in the area in question, will review all of the information and documents you have submitted in support of your appeal. The ERO reviewer will not be bound by any decisions made by Aetna during the above-noted claims and appeals process. The ERO must provide written notice of its final decision within 45 business days after receiving your request for external review. The ERO must deliver the final decision to you, Aetna, and TRS-Care.

If the ERO reverses the previous claim denial(s) made by Aetna, TRS-Care will take the appropriate measures to abide by the ERO determination.

Expedited External Review

You may be eligible for an expedited external review if your treating physician believes that a delay in decision making during your external review might seriously put your life or health at risk or jeopardize your ability to regain maximum function. The ERO will make a decision within 72 hours after receiving your written request for the expedited review

Urgent Care Claim

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.

Pre-Service/Post-Service Claim

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.

Concurrent Care Claim Extension

A "concurrent care claim" is a request to extend a course of treatment beyond the period of time or number of treatments previously approved. Concurrent care claims are treated like an urgent care claim or pre-service claim, depending on the circumstances.

Mediation

Effective through Dec. 31, 2019, 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 completing the Texas Department of Insurance form at www.tdi.texas.gov/consumer/cpmmediation.html or by calling **1-800-252-3439** to request a form. If you get a bill from any out-of-network provider that concerns you, you can also call the number on your ID card for a claim review.

With claims incurred Jan. 1, 2020 the guidelines change. Balance billing occurs when an out-of-network provider (e.g., a doctor or hospital) bills you the difference between the amount they billed and what you and your health plan may have already paid under the terms of your health coverage. Effective Jan. 1, 2020, the following types of balance billing will be prohibited: (1) by out-of-network health care providers for emergency care, (2) by out-of-network providers providing services at in-network facilities (such as a hospital or surgery center), unless the enrollee elects in advance to receive non-emergency health care or medical services from these providers, and (3) by out-of-network diagnostic imaging providers or out-of-network laboratory service providers if the provider performed the service in connection with a health care or medical service performed by an in-network provider, unless the enrollee elects in advance to receive non-emergency health care or medical services from these providers.



HOW YOUR PRESCRIPTION PLAN WORKS

About CVS Caremark

CVS Caremark administers the prescription drug portion of your TRS-Care benefit.

CVS Caremark provides you access to:

- **Local pharmacies.** A network of nearly 60,000 participating retail pharmacies throughout the United States and its territories.
- **The CVS Caremark Pharmacy mail-order service.** For your long-term medications, such as those used to treat high blood pressure or high cholesterol, you can access convenient mail-order service and possible savings through the CVS Caremark retail Pharmacy.
- **Retail-Plus pharmacies.** You can also receive your long-term medications at select retail pharmacies.
- **CVS Caremark Network Pharmacists.** CVS Caremark Network Pharmacists are trained and have expertise in specific conditions. One can help you service the long-term medications used to treat your chronic condition.
- **Online resources.** Go to info.caremark.com/trscarestandard for useful health and benefit information, along with online pharmacy services.
- **TRS-Care Customer Service.** Representatives will be available to you 24 hours a day, seven days a week. Pharmacists are also available around the clock for consultation.



Drug Exclusions

CVS 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 happens on an ongoing basis.

Drug exclusions from the formulary will occur once per year and will typically go into effect on Jan. 1st. During the four months preceding January 1st, patients utilizing drugs that are to be excluded will receive notification prior to the changes to assist with identifying potential substitute therapies. For a complete list of this year's formulary exclusions, please click on the link below: info.caremark.com/trscarestandard

Preferred Drug list

The TRS-Care Standard Plan includes 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-Care encourages the use of the preferred drugs on this list to help control rising prescription drug costs. You will usually pay a lower coinsurance amount for generic drugs (Tier 1) and brand-name medications that are on the formulary (Tier 2).

Generic Preventive Drugs

Take advantage of no-cost generic preventive medications. If you take certain generic medications classified as "preventive," such as a prescription drug used for hypertension, a heart condition or depression, you may be able to receive your medication at no cost to you.

Find the list of no-cost drugs under this benefit by visiting info.caremark.com/trscarestandard or call CVS Caremark toll-free at **1-844-345-4577**.

Save Money On Prescriptions

You will pay:

- The lowest coinsurance amount for Tier 1 generic drugs
- A higher coinsurance amount for Tier 2 preferred brand-name drugs
- The highest coinsurance 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 info.caremark.com/trscarestandard to check the price and coverage of medications under your plan.

Simply select "Price a medication" from the left-hand menu and search for your medication to see its pricing. Click "View coverage notes" on the pricing results page to see any coverage details. If you are a first-time visitor to info.caremark.com/trscarestandard, please take a moment to register. (Be sure to have your CVS Caremark ID number and a recent prescription number handy.)

Generic Medications

FDA-approved generics may have unfamiliar names, but they are considered safe and effective. Generic drugs and their brand-name counterparts:

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

Generic drugs may differ in color, size, or shape, but the FDA requires that the active ingredients have the same strength, purity, and quality as the brand-name alternatives. Prescriptions filled with generic drugs lower your coinsurance under TRS-Care's prescription drug program. For more information about your plan's formulary, visit info.caremark.com/trscarestandard or contact CVS Caremark at **1-844-345-4577**.

Education and Safety

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

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.

Prescription Drug Synchronization

Prescription drug synchronization is a pharmacy capability that aligns a patient's maintenance medication fill schedules, making it easier for them to stay on the therapies they need to effectively manage their conditions. Prescription drug synchronization offers members the convenience to pick up multiple maintenance 31-day prescriptions in a single visit to their preferred pharmacy. By aligning prescription fill schedules for participants, CVS Caremark aims to make it easier and more convenient for patients to take their medications as prescribed.

Retail Pharmacy Program

Prescriptions and refills dispensed at a retail pharmacy are filled for up to a 31-day supply. The amount that you pay for each purchase or refill depends on whether you obtain generic or brand- name drugs and whether you use a drug store that participates in the retail pharmacy network.

The CVS Caremark retail pharmacy network is a national network comprised of over 60,000 retail pharmacies. The network includes most major chains, discount, grocery, and independent pharmacies. To find a local participating pharmacy, visit **www.caremark.com** and click "Locate a National pharmacy" or contact TRS-Care Customer Service at **1-844-345-4577**.

How to Purchase Retail Prescriptions

AT A PARTICIPATING RETAIL PHARMACY

When you purchase your medications at a participating retail pharmacy, simply present your prescription drug ID card and pay the applicable amount. Participating network retail pharmacies will charge you the lesser of the negotiated CVS Caremark price or the usual and customary cost for up to a 31-day supply of your prescription.

Your standard 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-Care program and get your medication on the same day.

Retail-*Plus* Pharmacies

Retail pharmacies that participate in the Retail-*Plus* network are able to dispense a 60- to 90-day supply of medication. To find a local participating pharmacy, visit **info.caremark.com/trscarestandard** and click "Locate a Retail- *Plus* pharmacy" or contact TRS-Care Customer Service.

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 CVS 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.

Diabetic Management Services

The TRS-Care Standard Plan 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.

If you have diabetes, you may qualify for a preferred blood glucose meter at no cost to you. Your prescription benefit plan is offering a value-added program through which meters are available at no cost to eligible participants. For more details, please contact the CVS Caremark® Member Services Diabetic Meter Team at **1-800-588-4456**.

Diabetic Supplies

Certain diabetic supplies (e.g. lancets, test strips, and syringes) are covered at 100% even before your deductible is met as long as the services are rendered by a network provider. Please be advised this benefit is available only on prescriptions filled for 90-days through Mail Order Delivery or at a participating Retail-Plus pharmacy.

- 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.

Diabetic Supplies	
Preferred brand glucose meter	Free
31-day (short term) retail supply	Formulary (list of covered drugs): Deductible and coinsurance waived for needles and syringes. Non-Formulary: Deductible and coinsurance apply
90-day supply at Retail-Plus or mail-order service	Formulary: Deductible and coinsurance waived for needles and syringes regardless of brand. To receive test strips and lancets at no cost, you must use the preferred brand. Non-Formulary: Deductible and coinsurance apply

You must have a prescription for diabetic supplies from your doctor for supplies to be covered at 100% by the TRS-Care Standard Plan.

The formulary is the list of covered drugs. To determine if the brand of diabetic supplies you are using is on the formulary and is a preferred brand, you can call CVS Caremark at 1-**844-345-4577**, or visit **info.caremark.com/trscarestandard**.

CVS Caremark Mail Order Program

Mail-Order Service through the CVS Caremark Pharmacy

Filling prescriptions via mail order is a cost-effective option for participants taking long-term medications (such as those used to treat high blood pressure or high cholesterol) on a regular basis. The CVS Caremark Pharmacy provides up to a 90-day supply of medication, delivered directly to your home or other requested location, postage paid for standard delivery. Retail-*Plus* network pharmacies can also dispense up to a 90-day supply of maintenance medications at the same cost as the mail-order service.

To fill your prescription through the CVS Caremark Pharmacy, mail your prescription order form and payment to the address on the order form. If there is a balance due, an invoice will be included with your prescription order. If you overpaid, your account will be credited.

Or, you may also ask your doctor to call or fax your prescription to the CVS Caremark Pharmacy FastStart.

Prescriber Phone Number: **1-800-378-5697**

Prescriber Fax Number: **1-800-378-0323**

Your medication will usually be delivered within seven days after CVS Caremark receives your order.



To order refills, call the automated refill system at **1-844-345-4577** or visit **www.caremark.com**. Refills are normally delivered more quickly. If you are a first-time visitor to the site, please take a moment to register, and have your ID number and a recent prescription number available.

To ensure timely delivery, please place your orders at least 2 weeks in advance of your anticipated need. If you have any questions concerning your order, or if you do not receive your medication within the designated timeframe, please contact CVS Caremark at **1-844-345-4577**.

If a new medication has been prescribed for you to take immediately, please ask your doctor to issue two prescriptions. One should be written for a 14-day supply and filled at a local participating retail pharmacy, and the second should be written for up to a 90-day supply and sent to the CVS Caremark Pharmacy.

When using the CVS Caremark Pharmacy to fill a prescription for less than a 90-day supply, the full mail order coinsurance still applies.

You can pay by e-check, check, money order, or credit card. Make checks and money orders payable to CVS Caremark and write your CVS Caremark ID number on the front. Call CVS Customer Care at **1-844-345-4577** if you have questions.

Split Payments at Caremark Mail Order Pharmacy

You can split payments for your 90-day supply prescription into 3 separate payments only at Caremark Mail Order Pharmacy. For more information contact CVS Caremark Customer Care at **1-844-345-4577**.

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 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-Care.

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 CVS Caremark at **1-844-345-4577**.

Supply Limits

Some prescription drugs are subject to supply limits that restrict the amount dispensed per prescription order or refill. To determine if a prescription drug has been assigned a maximum quantity level for dispensing, visit info.caremark.com/trscarestandard or call CVS Caremark at **1-844-345-4577**.

Drugs Requiring Prior Authorization

Under TRS-Care, CVS 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 CVS Caremark at **1-844-345-4577**.

Prior Authorization

For some medications, you must obtain approval through a coverage review process before the medication can be covered under your plan. The coverage review process will allow CVS 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-Care.

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's or clinically-approved guidelines and are subject to periodic review and change.

For example, if you or your covered dependent is taking a sleep aid, you may not receive more than a 60-day supply within a 90-day period without a coverage review from CVS Caremark and your doctor.

Example: Participant fills a 30-day supply of Ambien on May 1
Participant refills a 30-day supply of Ambien on June 1
The participant has exhausted the quantity allowed for this 90-day period and would not be eligible to receive an additional quantity until Aug. 1

If you plan to take an extended vacation or travel outside the U.S., call TRS-Care at **1-888-237-6762** to request approval for an additional supply of medicine. Please call in your request to TRS-Care at least four weeks in advance of your trip.



Coverage review process

You can check to see if your medication requires prior authorization (coverage review) by calling CVS Caremark at **1-844-345-4577**.

If your medication requires a coverage review, you or your doctor may start the process by calling CVS Caremark toll-free at **1-844-345-4577**.

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, CVS 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 CVS Caremark toll-free at **1-844-345-4577**.
- CVS Caremark will contact your doctor to request more information than appears on the prescription. After receiving the necessary information, CVS Caremark will notify you and your doctor to confirm whether or not coverage has been authorized.
- 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 CVS Caremark Pharmacy:

- If you are filling a prescription through the CVS Caremark Pharmacy and a coverage review is required, CVS Caremark will contact your doctor to request more information than appears on the prescription. After receiving the necessary information, CVS 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. If coverage is not authorized, CVS Caremark will send you a notification in the mail, along with your original prescription if it was mailed to the CVS Caremark Pharmacy.

Specialty Pharmacy Program

To get started using Caremark Specialty Pharmacy, call the number on the back of your prescription drug ID card or log in to your account at **www.caremark.com**. If you are a first-time visitor to the CVS Caremark website, take a minute to register, and have your ID number and a recent prescription number handy. If you would like to learn more about specialty medications and services, visit **www.cvsspecialty.com**

Starting Sept. 1, 2017, you will need to use CVS Specialty to get your specialty medications.

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 the TRS-Care Standard Plan. A list of medications that must be dispensed by CVS Caremark Specialty Pharmacy can be obtained by calling CVS Caremark Specialty Pharmacy at **1-800-237-2767**.

Our Complete Services

With CVS Specialty, you get more than just specialty medication. You can count on personalized specialty pharmacy services like:

- Access to a pharmacist and nurse specially trained in your condition. You can call them with questions anytime, any day of the year.
- Option to pick up your medication at your local CVS Pharmacy®, or have it delivered to your home, doctor's office or location of your choice.*
- Digital tools available on **CVSSpecialty.com** and our mobile app to help you stay on track with your prescriptions, order refills, get reminders and more.
- Help finding financial assistance to pay for your medications.

Questions?

Call us at **1-800-237-2767** from 6:30 a.m. to 8 p.m. (CT) Monday through Friday.

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.

Coordination of Benefits (COB)

TRS-Care/CVS 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 CVS Caremark along with an **Explanation of Benefits (EOB)** from the primary payer or a receipt for out-of-pocket costs. CVS Caremark then reimburses you up to the amount that TRS-Care 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 CVS Caremark real-time claims processing system for the balance unpaid by the primary payer. CVS Caremark then reimburses the pharmacy up to the amount that TRS-Care 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-Care if there were no 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 CVS 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.

If a patient is confined to a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution and they obtain their drugs through the facility's pharmacy, those claims can be reimbursed through pharmacy rather than medical.

- 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, unless pre-authorized
- Ostomy supplies

- Topical fluoride products
- Growth hormones, unless pre-authorized
- Injectables (contact CVS 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
- Drugs with cosmetic implications
- Respiratory Therapy Supplies



Claim Denials and Appeals

Under TRS-Care, 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 CVS Caremark Pharmacy, your doctor will be contacted directly. CVS Caremark will need the following information:

- Patient name
- CVS 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 (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 CVS 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 documentation 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 CVS Caremark does not have the necessary information needed to complete the review, they 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 will be deemed denied and you have the right to appeal as described below.

Urgent Claims (Expedited Reviews)

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.

In the case of an urgent care claim, CVS 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 review the claim. If further information is needed, CVS Caremark will notify you within 24 hours of receipt of your claim and advise you have 48 hours to submit the additional information. Additional information must be submitted within 48 hours of the request. CVS 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.

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
- CVS 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)
- Any additional information that may be relevant to your appeal

This information should be mailed to:

CVS Caremark
Attn: Appeals
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 CVS 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. Your physician may call **1-866-443-1183** 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 appeal 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 CVS 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 CVS 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, CVS Caremark must receive your external review request within 4 months of the date of the adverse benefit determination (if the date which 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, CVS 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, CVS Caremark will randomly assign the review request to an ERO and compile your appeal information and send it to the ERO within 5 business days. The ERO will notify you in writing that they received the request for an external review. The letter will describe your right to submit additional information for consideration to the ERO. Any additional information you submit to the ERO will also be sent back to CVS Caremark for reconsideration.

The ERO will review your claim within 45 calendar days and send you and CVS 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.

Therapeutic Resource Centers

Get the reassurance of expertise. Talk to a Specialist Pharmacist.

If you need a medication used to treat certain long-term conditions, take advantage of the personalized care and medication expertise of an CVS Caremark Specialist Pharmacist. These pharmacists have received specialized training in the medications used to treat various conditions, including:

- High cholesterol
- Asthma
- High blood pressure
- Osteoporosis
- Depression
- Cancer
- Diabetes
- Migraine headaches

This enhanced level of care is at no cost to you and is already part of your prescription drug benefits.

- CVS Caremark Specialist Pharmacists at the CVS Caremark Specialty Pharmacy are available by phone 24 hours a day, seven days a week to help you understand and manage the medications used to treat conditions such as those listed.
- These pharmacists can help identify potential health risks, such as side effects and unsafe drug interactions.
- They also know your plan, so they can talk with you or your doctor about lower-cost alternatives, such as generics and preferred brand-name medications.
- Conversations with CVS Caremark Specialist Pharmacists are private, which means that you can feel comfortable asking even personal and sensitive questions about your medications.
- A CVS Caremark Specialist Pharmacist may even call you or your doctor to help make sure your medications will work safely together.

Gaps in Care

Get automatic alerts when you may be at risk.

Each year, millions are at risk for potential health complications and hospitalization due to medication-related safety issues. Help protect yourself with an online safety feature that's available at no cost to you as part of your prescription plan. It works 24 hours a day, seven days a week whether you get your medications at a retail pharmacy or through the CVS Caremark Pharmacy.

You'll receive an email whenever you have a personalized alert waiting for you. Alerts could help you:

- Avoid unnecessary hospitalization
- Prevent setbacks to your health
- Stay on track with taking your medications as prescribed by your doctor

Simply register at **www.caremark.com**. To register and receive alerts, you will need your prescription drug ID card and a recent prescription number. Your spouse and anyone in your household over 18 must register separately to receive alerts.

Extended Enterprises

Unwanted side effects? Unsure of how to manage your medications?

Get information and safety advice at no cost to you.

Each year, millions are at risk for potential health complications and hospitalization due to medication-related safety issues. Take advantage of free safety features available through TRS-Care: the online prescription safety tools available at www.caremark.com.

Do you take medications regularly? Register at www.caremark.com today and help protect yourself from certain medication-related health risks. You'll receive an email whenever you have a personalized alert waiting for you. These alerts could help you:

- Avoid unnecessary hospitalization
- Prevent setbacks to your health
- Stay on track with taking your medications as prescribed by your doctor

You'll need your Caremark prescription ID card and a recent prescription number.

Log on to www.caremark.com

- Select Update your Profile
- Under your information, enter a prescription number
- Under personal preferences, ensure your email updates are set to on.

Caregiver Program

With the caregiver program, your caregiver can help you manage your health, however, your approval is required.

People with caregivers know the important role that caregivers have in managing prescription care. CVS Caremark can link online accounts for patients and their caregivers. Designated caregivers are able to act on the patient's behalf at www.caremark.com while still signed on with his or her own ID. If both the patient and the caregiver are CVS Caremark participants that means the caregiver can manage both sets of prescriptions with a single log-in.

This feature can help save time and make it easier for a caregiver to manage the patient's prescriptions.



TRS-Care Standard Prescription Drug Coverage

In-network	
Tier 1 Generic drugs	20% after deductible
Tier 2 Preferred brand-name drugs	20% after deductible*
Tier 3 Non-preferred brand-name drugs	20% after deductible*
Under the TRS-Care Standard Plan, before benefits begin to pay, you must meet the plan deductible. Your plan deductible includes both your medical and prescription drug expenses. In-network deductible: \$1,500 for retiree-only coverage; \$3,000 for family coverage.	

*Starting Jan. 1, 2020, if you obtain a brand-name drug when a generic equivalent is available, you are responsible for the difference in cost between the brand-name drug and the generic drug, in addition to the generic coinsurance. This cost difference will not apply to your accumulations (deductible or maximum out of pocket).

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 (FDA) 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 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.

Prescription Drug ID Cards

CVS Caremark will provide you with a prescription drug ID card. Present your ID card when filling a prescription at a participating retail pharmacy. Should you need additional or replacement ID cards, please contact CVS Caremark at **1-877-680-4881** or visit **www.caremark.com** to either request a new card or print a temporary card.



Preventive Medications

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.” These are drugs that are used to prevent a chronic condition, not treat an existing one. If you are prescribed a medication in one of the classes below, your medication may be on the list 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. This list is subject to change.

TYPES OF GENERIC PREVENTIVE MEDICATIONS THAT MAY BE OFFERED AT NO COST TO YOU

Cardiovascular Antiarrhythmic agents Antianginal agents Coronary artery disease Antihyperlipidemics and combinations Diabetes Antidiabetics Diabetic diagnostic products and supplies Hematologic agents Coagulation factors Hypertension ACE inhibitors, ARBs, CCBs Beta blockers Diuretics Antihypertensives and combinations	Immunizing Agents Vaccines, toxoids, passive Immunizing agents and biologicals Mental Health Antidepressants Antipsychotics Osteoporosis Calcium regulators Hormone receptor modulators Preventive Care Anti-obesity agents Smoking deterrents Agents for chemical dependency Bowel preparations	Respiratory Disorders Antiasthmatics Seizure Disorders Anticonvulsants Stroke Anticoagulants Platelet aggregation inhibitors Women's Health Aromatase inhibitors and antiestrogens Contraceptives Prenatal vitamins Various Conditions Anti-malarial agents Dental caries prevention Hereditary angioedema (HAE) agents Immunosuppressive MS agents Antiretroviral agents
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PLAN PROVISIONS

Eligibility and Enrollment

This section provides an overview of TRS-Care eligibility requirements and enrollment.

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 they are eligible for ERS, the 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, the UT System, or the 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. (See Glossary.)
- 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.
 - Any other child under age 26 (unmarried) who is in a regular parent-child relationship with the retiree or surviving spouse.
 - Appropriate documentation will be required to establish that these children meet the TRS-Care eligibility criteria. When the responsible adult is not a grandparent, the normal parent/child relationship means that:
 - You provide at least 50% of the support for the child
 - The natural parent of the child does not reside in the same household
 - You have the legal right to make decisions regarding the child's medical care
 - You have full legal guardianship (documentation will be required)

Coverage for your dependents will generally become effective on the date your coverage becomes effective if, by then, you have requested dependent coverage.

Children who must be covered due to a qualified medical child support order will become eligible on the date of the court decision if a written request is made within 31 days of the legal event. Coverage will be effective the first

day of the following month from the date of the court order is signed. A court order on a spouse (or ex-spouse) does not require the plan to provide dependent coverage.

If you are the non-custodial parent of a child who must be covered due to a qualified medical child support order, you should provide proof of claim to the custodial parent. Benefits for such a claim will be paid to the custodial parent.

Eligible dependents may also be enrolled if they experience a special enrollment event as described on page 71.

Dependent coverage will continue as long as the monthly payment is made and the dependent remains eligible. The monthly contributions are subject to change.

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

Can a disabled dependent child be an eligible dependent even though the child is 26 or older?

A disabled child, regardless of the child's age, can be enrolled only within the initial enrollment period of the retiree or surviving spouse, during a special enrollment event, or when the retiree or surviving spouse reaches age 65 if the retiree or surviving spouse is already enrolled in TRS-Care when he/she turns 65. Medical expense benefits for a fully disabled child will not be terminated because the child reaches the maximum age for a dependent child as long as the child continues to be disabled, dependent upon you for support, and unmarried.

However, medical documentation will be required to determine incapacitation.

Children will be considered incapacitated if they are unable to earn their own living because they are mentally or physically disabled, and they depend chiefly on you for support and maintenance. "Incapacitated child" forms will be mailed to the participant. One is to be completed by the child's physician and the other is to be completed by the participant. Proof that your child is fully disabled must be submitted to TRS no later than 31 days after the date your child reaches age 26 or at the time first enrolled.

Aetna may require proof of the continuation of the disability. Aetna, at its own expense, also may require an examination of your child as often as needed while the disability continues. An exam will not be required more often than once each year after two years from the date that your child reaches age 26.

Coverage ceases at the earliest occurrence of the following:

- Cessation of the disability
- Failure to provide proof that the disability continues
- Failure to have any required exam
- Marriage of the disabled child
- Termination of dependent coverage for the child for any reason other than reaching age 26

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 due to 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 the 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 retiree 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**.

Are my children and I eligible for TRS-Care as surviving dependents?

You are eligible to elect coverage as a surviving spouse of a retiree if you were married to a TRS retiree at the time of the retiree's death; and that retiree was eligible for, or would have been eligible for, coverage under this program. The surviving spouse must elect coverage in order for the dependent children to be covered. If the dependent children of a deceased eligible retiree have survived the retiree and the retiree's spouse, they are then eligible to elect coverage.

You are eligible to continue and/or elect coverage as a surviving spouse of a deceased active member who died on or after Sept. 1, 1986, if the deceased active member had 10 years of service credit in the retirement system for actual service in Texas public schools and had made contributions to TRS-Care at the last place of employment in public education in this state. Surviving spouse and surviving dependent children coverage will continue so long as the monthly payment is made. Surviving dependent children must meet the applicable TRS-Care eligibility criteria.

Eligibility for coverage begins on the first day of the month following the death of the retiree, active member, or surviving spouse. An application to make changes (TRS700C or TRS700D) must be returned to TRS-Care by the later of 31 days after the death of the retiree, active member, or surviving spouse or 31 days following the date the application to make changes is sent by TRS-Care.

A surviving spouse of a deceased retiree or deceased active member who was eligible for TRS-Care may continue his or her own coverage but may not cover a spouse upon remarriage.

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.

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.

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.

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.

2020 Monthly Premiums

Most non-Medicare retirees	
Retiree only	\$200*
Retiree + spouse	\$689
Retiree + child(ren)	\$408
Retiree + family	\$999
Surviving child(ren)	\$208
Non-Medicare retirees with disabled children (of any age)*	
Retiree + child(ren)	\$208
Retiree + family	\$799

*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 page 73, 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.

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 you may be eligible at any age if you have received Social Security disability benefits.

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 (the first of the month prior to your birthday 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 TRS-Care when you turn 65. You may add dependents then, too. To enroll in TRS-Care at age 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.

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.

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
- 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
- It is established that the dependent committed fraud.

Failure to timely pay 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.

If my coverage or my dependent's coverage is terminated, are there ways to continue the coverage?

TRS-Care is required to offer to the TRS-Care retiree's spouse and dependent children who are enrolled in TRS-Care the right to temporarily continue group health coverage if the coverage would cease upon the occurrence of certain qualifying events. The COBRA continuation coverage that a spouse or dependent child elects to obtain, if any, provides benefits that are identical to the coverage's provided to similarly situated retirees, surviving spouses, and their dependents. TRS-Care will notify the spouse or dependent children of any changes in coverage or benefits available.

COBRA continuation coverage is available if a TRS-Care retiree's spouse or dependent children will lose coverage under TRS-Care due to any of the following:

1. Your death;
2. Your divorce or legal separation; or
3. A dependent child ceasing to be a dependent as defined in the TRS-Care Benefits Booklet.

If the spouse or dependent children would lose coverage upon the occurrence of one of these three qualifying events, they must notify TRS-Care of the event within 60 days of the later of (1) the date on which the qualifying event occurs; or (2) the date coverage would be lost as a result of the qualifying event.

For a written notice of a qualifying event to be timely, it must be post marked or otherwise sent to TRS-Care on or before the last day of the 60-day notification period.

There are two ways that a TRS-Care participant whose coverage is terminated may continue coverage. Continuation of TRS-Care coverage through COBRA is explained on page 86 in the "Notices" section. (Please note that a surviving spouse of a TRS-Care retiree can continue TRS-Care participation without enrolling through COBRA.)

How does TRS-Care work when there is other coverage?

Some persons have group health coverage in addition to coverage under this Program. When this is the case, the benefits from "other plans," including group plans not purchased by an employer, will be taken into account.

This may mean a reduction in benefits under TRS-Care. The combined benefits will not be more than the expenses recognized under all plans. This is called Coordination of Benefits (COB). At no time will TRS-Care pay more than the covered person is legally obligated to pay.

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.

If you currently have TRICARE, TRS-Care will always be primary. It is important that you notify TRS-Care Customer Service at **1-800-367-3636** when you have other insurance coverage. They will help you determine the order of benefit determination for your claims.

How is Coordination of Benefits (COB) determined when a patient is covered by more than one health benefits plan?

The following chart will help you understand which plan is primary and how the various plans coordinate.

TRS-Care participant	Other coverage as employee	Other coverage working under spouse	Other coverage under retired spouse or as a surviving spouse	Medicare	COBRA	Order of benefit determination
Retiree	Other					Employee plan 1 st TRS-Care 2 nd
Retiree		Yes				TRS-Care 1 st Spouse plan 2 nd
Retiree				Yes		Medicare 1 st TRS-Care 2 nd
Retiree	Yes			Yes		Employee plan 1 st Medicare 2 nd TRS-Care 3 rd
Retiree		Yes		Yes		Spouse plan 1 st Medicare 2 nd TRS-Care 3 rd
Retiree					Yes	TRS-Care 1 st COBRA 2 nd
Retiree	Covered as retiree of previous employer			Yes		Medicare 1 st Group plan with earliest effective date 2 nd Group with last effective date 3 rd
Retiree				Yes, but ESRD on dialysis		First 30 months TRS-Care 1 st Medicare 2 nd

A person at age 65 is considered “eligible for Medicare” if he/she is covered, refused coverage, dropped or failed to make the proper request for Medicare.

How is Coordination of Benefits (COB) determined when a patient is covered by more than one health benefits plan? Continued

TRS-Care participant	Other coverage as employee	Other coverage working under spouse	Other coverage under retired spouse or as a surviving spouse	Medicare	COBRA	Order of benefit determination
Retiree			Yes			TRS-Care 1 st Spouse plan 2 nd
Retiree			Yes	Yes		Medicare 1 st TRS-Care 2 nd Spouse plan 3 rd
Spouse	Yes					Employee plan 1 st TRS-Care 2 nd
Spouse		Yes				Spouse plan 1 st TRS-Care 2 nd
Spouse				Yes		Medicare 1 st TRS-Care 2 nd
Spouse	Yes			Yes		Employee plan 1 st Medicare 2 nd TRS-Care 3 rd
Spouse		Yes		Yes		Employee plan 1 st Medicare 2 nd TRS-Care 3 rd
Spouse					Yes	COBRA 1 st TRS-Care 2 nd
Spouse	Covered as retiree of previous employer			Yes		Medicare 1 st Spouse's retirement plan 2 nd TRS-Care 3 rd
Spouse				Yes, but ESRD on dialysis		First 30 months TRS-Care 1 st Medicare 2 nd

A person at age 65 is considered “eligible for Medicare” if he/she is covered, refused coverage, dropped or failed to make the proper request for Medicare.

The preceding chart is based on generally accepted rules for health benefit plans. TRS has adopted the Texas Department of Insurance rules to administer Coordination of Benefits along with the federal regulations used for Medicare and established by the Center for Medicare and Medicaid Services.

To determine how non-Medicare benefits under this plan will be coordinated, the order in which the various plans will pay benefits must be determined. This will be done as follows, using the first rule that applies:

1. A plan with no rules for COB will be deemed to be the primary plan and pay its benefits before a plan that contains such rules.
2. A plan that covers a person other than as a dependent will be deemed the primary plan and pay its benefits before a plan that covers the person as a dependent.
3. Except in the case of dependent children whose parents are divorced or separated, the plan that covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan that covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan that covered one parent longer are determined before those of a plan that covered the other parent for a shorter period of time. If the other plan does not have the rule described in this provision but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
4. In the case of dependent children whose parents are divorced or separated:
 - a. If there is a court decree that states that the parents shall share joint custody of dependent children, without stating that one of the parents is responsible for the health care expenses of the children, the order of benefit determination rules specified in (3) above will apply.
 - b. If there is a court decree that makes one parent financially responsible for the medical, dental or other health care expenses of such children, the benefits of the plan that covers the children as a dependent of such parent will be determined before the benefits of any other plan that covered the children as dependent children.
 - c. If there is not a court decree: If the parent with custody of the children has not remarried, the benefits of a plan that covers the children as dependents of the parent with custody of the children will be determined before the benefits of a plan which covers the children as dependents of the parent without custody.
 - d. If the parent with custody of the children has remarried, the benefits of a plan that covers the children as dependents of the parent with custody shall be determined before the benefits of a plan that covers the children as dependents of the stepparent. The benefits of a plan that covers the children as dependents of the stepparent will be determined before the benefits of a plan that covers the children as dependents of the parent without custody.
5. If items 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be primary. This is true except when the benefits of a plan that covers the person on whose expenses claim is based as a laid-off or retired employee or the dependent of such person shall be determined after the benefits of another plan that covers such person as an employee who is not laid-off or retired or a dependent of such person. If the other plan does not have a provision regarding laid-off or retired employees and, as a result, each plan determines its benefits after the other, then the above paragraph will not apply.

The benefits of a plan that covers the person for whom a claim is filed who has a right of continuation pursuant to federal or state law (COBRA, as discussed on page 86) shall be determined after the benefits of any other plan that covers the person other than under such right of continuation. If the other plan does not have a provision regarding right of continuation pursuant to federal or state law and as a result, each plan determines its benefits after the other, then the above paragraph will not apply.

Subject to the provision of the Health Insurance Portability and Accountability Act (HIPAA) and Section 1575.456, Texas Insurance Code and other applicable laws regarding confidentiality of records, Aetna can release or obtain information and make or recover any payment it considers necessary to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under TRS-Care during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of TRS-Care.

Q. I have coverage under my spouse's insurance. Why does my TRS coverage have to be primary?

A. TRS-Care coordinates benefits with other group health insurance plans in accordance with the rules established by the Texas Department of Insurance. See the Coordination of Benefits chart on page 77-78.

Subrogation, Reimbursement and Third Party Recovery Provision

When this Provision Applies: If you, your spouse, one of your dependents or anyone who received benefits under TRS-Care 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-Care are secondary, not primary, and will be paid only if you fully cooperate with the terms and conditions of TRS-Care.

As a condition of receiving benefits under TRS- Care, 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 immediate 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 recovered funds.

The employee or covered person agrees to fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the covered person to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the covered person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or other condition sustained by the covered person. The covered person and his/her agents shall provide all information requested by the plan, the Claims Administrator or its representatives, including, but not limited to, completing and submitting any application or other forms, including but not limited to reimbursement and/or subrogation agreements the plan or its agent(s) may request. 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 and may result in the termination of benefits.

The plan has first priority to any settlement or recovery received by the covered person and this recovery 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 covered person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement that attempts to reduce or exclude the full cost of all benefits provided by 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. In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

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 to enforce its subrogation or other rights of recovery.

Filing and Paying Claims

Network providers will submit the claims directly to Aetna for you.

Most out-of-network providers will submit a claim directly to Aetna. If your provider does not submit the claim, you will be required to submit the claim yourself.

Q: How do I file a claim if my provider does not file for me?

A: Your claim must be submitted to Aetna, and it must give proof of the nature and extent of the expenses incurred. No form is necessary for the filing of claims. Aetna will accept a bill or receipt that lists the name, address and tax identification number of the provider, the name of the patient, the date of service, the procedure and diagnostic codes, the cost of each service rendered and the retiree's unique identification or Social Security number.

All claims should be reported promptly. If, through no fault of your own, you are unable to file your claim promptly, that claim will still be considered if you file as soon as reasonably possible, but not later than two years after the deadline. The maximum filing period is 27 months from the date of service. Claims submitted after the maximum filing period will not be considered.

TRS-Care is administered by the Aetna Service Center in San Antonio, Texas. The address for mailing claims is:

Aetna
PO Box 981106
El Paso, TX 79998-1106

Q: To whom are benefits paid?

A: Benefits payable for any covered medical expenses will be paid no later than 60 days upon receipt of claim. Benefits will be paid to:

- The physician or provider if he or she is a network provider;
- The hospital, convalescent facility or hospice; or
- The retiree, surviving spouse or surviving dependent child if the physician is out-of-network and an assignment of benefits is not on file with the physician's office or the claim indicates that patient has already paid for the services.

If you receive payment from Aetna, it will be your responsibility to settle your account with your provider.

Recordkeeping

Be careful to keep complete records of the expenses of each person.

- Names of physicians, dentists and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts and Explanation of Benefits (EOBs).

Be sure to keep your original documents, and send copies to the TRS offices in Austin, e.g., Medicare cards.

Texas Health and Human Services Commission

Medical expenses payable because you are eligible for medical assistance payments under the Texas Medical Assistance Act of 1967, as amended, or Medicaid, will be paid directly to the Texas Health and Human Services Commission or its designee if you request in writing that such direct payment be made.

Medical expenses payable on behalf of your children will be paid to the Texas Health and Human Services Commission or its designee if, when you submit proof of loss, you notify Aetna in writing that the following applies and you request such direct payment be made if:

- The Texas Health and Human Services Commission is paying benefits for your children under the medical assistance program administered pursuant to the Human Resource Code; and
- You either have possession or access to the children pursuant to a court order; or
- You are not entitled to access or possession of the children and are required by the court to pay child support.

Payment of Benefits to a Managing Conservator

Benefits payable on behalf of your minor children for health expenses incurred by such children will be paid to the person named as the managing conservator of the children by a court of competent jurisdiction in Texas or any other jurisdiction if, when proof of loss is submitted to Aetna, the following is also submitted:

- A written notice that the person to whom benefits are payable is the managing conservator of the children
- A certified copy of a court order establishing the person as managing conservator or other evidence designated by rule of the Texas Board of Insurance that the person qualifies for the benefit. The certified copy of the court order should be mailed to:

Aetna

Attn: Legal Support Services
151 Farmington Ave., W121
Hartford, CT 06156

The above will not apply to benefits payable for health expenses for which a valid assignment for payment to the provider has been made or expenses that you have paid in whole or in part.

How can a denied claim be appealed?

The Aetna complaints and appeals process addresses benefit determinations and claim processing issues, complaints and problems. Contact TRS-Care Customer Service at **1-800-367-3636**. A representative will address your concerns. If you are dissatisfied with the outcome of your initial contact, you may appeal the decision. An Aetna representative will advise you on the appeal procedures. The appeal must be submitted in writing within 180 days after you receive the explanation of benefits from Aetna. It must include your reasons for requesting the review, along with a copy of your Explanation of Benefits (EOB). Also included should be any additional documents that you feel support information to your claim. Forward written appeal to:

Aetna

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

Physicians and facilities providing medical services to TRS-Care participants may also request an appeal in writing. They should forward the request and additional documentation to:

Aetna Provider Resolution Team

PO Box 14020
Lexington, KY 40512

The physician and facility appeal must also be submitted in writing within 180 days after you receive the explanation of benefits from Aetna.

Recovery of Overpayments

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator – Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

General Provisions

This Booklet explains group health benefits currently available to those eligible for coverage under TRS-Care. TRS-Care may be changed in the future to provide a plan that is different from the plan described in this Booklet, or TRS-Care may be discontinued. In the event of a conflict between the information in this Booklet and any applicable federal or state law, federal or state law will control.

The following additional provisions apply to your coverage:

- You cannot receive coverage as both a retiree and a dependent under TRS-Care.
- In the event of a misstatement of any fact affecting your coverage under TRS-Care, the true facts will be used to determine the coverage in force, if any.

Policy of Nondiscrimination

TRS-Care shall not discriminate against any individual in a manner that violates any applicable provision of the law.

Legal Action

No legal action can be brought to recover under any benefit before the end of 60 days after a written claim is required to be filed. Also, no action can be brought after three years from the time written claim is required. The right to bring a legal action may be limited by sovereign immunity. Nothing in this Booklet shall be construed as a waiver of sovereign immunity on behalf of TRS or of those individuals or entities acting on its behalf.

Health Expense Coverage After Termination

If at the time your coverage terminates and you are totally disabled due to a covered illness or injury, benefits under TRS-Care may continue for up to 12 months from the date of termination, as long as the monthly premiums are paid.

This continuation of coverage will cease on the date the person becomes covered under any other group plan with similar or greater benefits.

The words “totally disabled” mean that due to injury or disease you are not able to engage in most of the normal activities of a person of like age and gender in good health. Aetna will not reduce or deny a benefit payment on the grounds that a condition existed before a person’s coverage went into effect if the loss occurs more than two years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Resources

Phone Numbers and Addresses

TRS Health Benefits (Teacher Retirement System of Texas)

Contact TRS Health Benefits for eligibility, enrollment, effective dates, plan design and monthly premium cost.

Phone: **1-888-237-6762**

Monday – Friday

8 a.m. – 5 p.m. CT

TRS-Care

1000 Red River Street

Austin, TX 78701



Contact **Aetna** for claim information, medical claim status, locate network providers, request explanations of benefits, obtain duplicate medical insurance cards, precertification, and medical case management.

TRS-Care Customer Service

Phone: 1-800-367-3636

Available 8 a.m. – 5 p.m. CT, Monday – Friday.

TDD: If you're hearing impaired, dial **1-800-841-4497** or 711,
8 a.m. – 5 p.m. CT, Monday – Friday

Aetna

PO Box 981106

El Paso, TX 79998-1106

Aetna Voice Advantage is a telephone self-service system that allows callers to Aetna to complete transactions 24 hours a day, seven days a week, using only their voice. Use this service for claims information and eligibility.

Aetna Informed Health Line

1-800-556-1555

Get answers from a registered nurse, day or night. With one simple call, you can:

- Learn more about your health conditions and those of your family members
- Find out more about a medical test or procedure
- Get help preparing for a doctor's visit, speak to one of our nurses 24 hours a day, 7 days a week, 365 days a year.



Contact **CVS Caremark** to order medication, check the status of an order, review the tier status of medications, generic drugs, medication costs, and obtain a prescription drug card.

Phone: 1-844-345-4577

24 hours a day, seven days a week. If you require telecommunications device (TTY) assistance, please dial toll-free **1-800-231-4403**.

Caremark, L.L.C.

2211 Sanders Road

Northbrook, IL 60062

Websites

www.trs.texas.gov

Click on the Health Care Benefits dropdown on the website and click the link for TRS-Care for Non-Medicare Retirees to access the following:

- Link to Aetna DocFind to locate network providers in and out of Texas
- Link to Aetna Navigator to check medical claim status and payment
- TRS-Care Benefits Booklet
- TRS-Care Plan Guide
- Aetna Claim Information Form.
- TRS-Care Plan Highlights

www.trscarestandardaetna.com

This website includes information regarding all of the TRS-Care health plans and provides links to:

- Aetna DocFind
- Aetna Navigator
- TRS
- CVS Caremark
- Medicare Advantage
- Benefit booklets
- Protected Health Information forms, and much more.

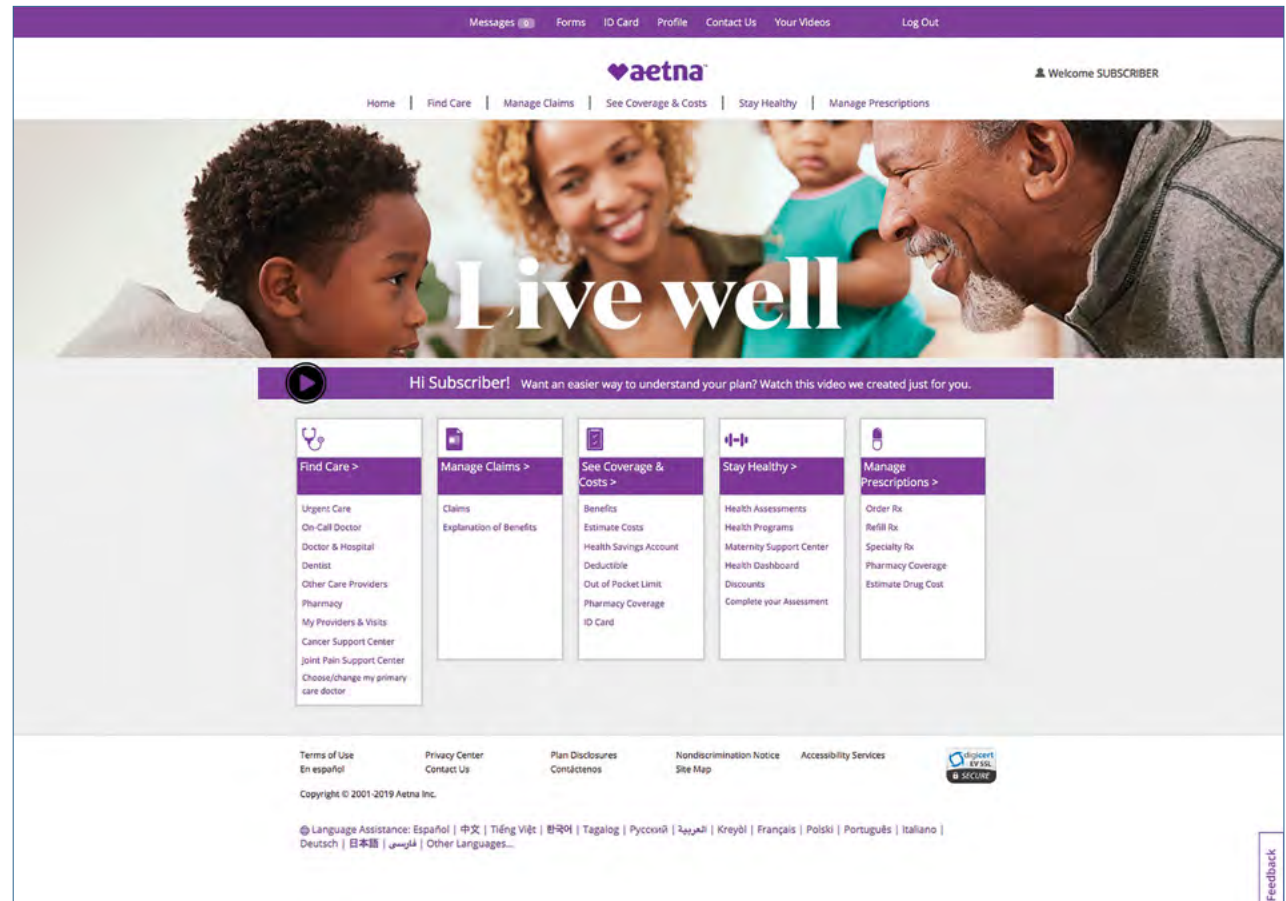
Aetna Website: www.aetna.com

You can access the following without registering for Aetna Navigator:

- Forms library
- Coverage policy bulletins
- DocFind provider directory.

If you register for Navigator, you have access to secure, personalized features including:

- Replace an ID card
- View/Print Eligibility Confirmation
- Change email preferences
- Change your login password
- View/Print Explanations of Benefits (EOB)
- View Claim Status
- Evaluate your provider
- Use the Hospital Comparison Tool
- Use Price-A-Medical Procedure Tool



Aetna Navigator Sample Screen

Notices

Notice to TRS-Care plan participants

Federal and state law requires that TRS-Care advise all plan participants and covered dependents of their rights to continue health coverage that would otherwise cease under certain circumstances.

Continuation Coverage under COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) created a right to COBRA continuation coverage, which is a temporary extension of coverage under the plan to your spouse or your dependent children who are covered under the plan when they would otherwise lose the group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to your family and what you need to do to protect the right to receive it.

You and your covered dependents should read this information carefully for a generalized understanding of your spouse's or dependent children's rights and obligations under COBRA. This notice provides only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the plan and under federal law, contact TRS-Care at the Teacher Retirement System of Texas, Group Health Benefits Division.

Either the plan administrator or a third party named by the plan administrator is responsible for administering COBRA continuation coverage. Contact your plan administrator for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage.

Individuals entitled to COBRA coverage are called "qualified beneficiaries." Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered retiree who experience a loss of coverage under the plan solely as a result of a "qualifying event" under COBRA. In order to be a qualified beneficiary, an individual must have been enrolled in the plan the day before the date of the qualifying event that causes the loss of coverage for that individual. Dependents not previously enrolled in the plan cannot elect to begin coverage under COBRA. Your spouse may elect to continue plan coverage for himself or herself and/or dependents, or each dependent child may elect individually.

Any election made on behalf of a dependent will be binding on that dependent.

A child who is born to or placed for adoption with a covered retiree or surviving spouse during the period of COBRA continuation coverage may be eligible for enrollment in COBRA coverage as a qualified beneficiary. Such child would need to be added to the plan within 31 days of the date of birth or the date the child is placed for adoption.

The maximum coverage period for a child added to COBRA continuation coverage is measured from the same date as for qualified benefits with respect to the same qualifying event and not from the date of the child's birth or placement for adoption.

A summary of the COBRA provisions is as follows:

- A. The plan is required to offer to your spouse and your dependent children who are enrolled under the plan the right to temporarily continue group health coverage if the coverage would cease upon the occurrence of certain qualifying events. The COBRA continuation coverage that your spouse or dependent children elect to obtain, if any, provides benefits that are identical to the coverage's provided to similarly situated retirees and their dependents. The plan will notify your spouse or dependent children of any changes in coverage or benefits available. COBRA continued coverage is available if your spouse or dependent children will lose coverage under the plan due to any of the following:
 - 1. Your death;
 - 2. Your divorce or legal separation; or
 - 3. A dependent child ceasing to be a dependent as defined in this Booklet.

If your spouse or dependent children would lose coverage upon the occurrence of one of these three qualifying events, your spouse or dependent children must notify TRS-Care at the Teacher Retirement System of Texas Group Health Benefits Division of the event within 60 days of the later of (1) the date on which the qualifying event occurs; or (2) the date coverage would be lost as a result of the qualifying event. For a written notice of a qualifying event to be timely, it must be post marked or otherwise sent to TRS-Care on or before the last day of the 60-day notification period.

Once TRS-Care received notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. COBRA continuation coverage will begin for each qualified beneficiary who timely elects that coverage on the date the plan coverage would otherwise have been lost.

To elect COBRA continuation coverage, a qualified beneficiary must elect that coverage within 60 days after the later of the date coverage would be lost under the plan by reason of a qualifying event or the date a qualified beneficiary receives the COBRA notice. To be timely, the COBRA election form must be postmarked or otherwise sent to Aetna on or before the last day of the 60-day election period.

If TRS-Care is not timely notified of a qualifying event or a qualified beneficiary does not timely elect COBRA continuation coverage, your spouse's and or dependent children's group health benefit coverage under the plan will end and cannot be reinstated under COBRA.

Your spouse or dependent children may be eligible to elect to continue coverage under another provision of the plan in lieu of this COBRA continuation.

B. If a qualified beneficiary elects COBRA continuation coverage, the maximum period that COBRA coverage will continue for that qualified beneficiary is 36 months from the date of the qualifying event that triggered loss of coverage. COBRA continuation coverage for your spouse or dependent children will automatically terminate before the end of this 36-month period only when any of the following events occurs:

1. The plan terminates.
2. Your spouse or dependent children fail to make timely payment of a required premium.
3. Your spouse or dependent children covered under another group health plan that does not contain any exclusion or limitation applicable to the individual, or contains a preexisting limitation or exclusion, but it does not apply to the individual because he or she has been credited with prior creditable coverage for the duration of the exclusion or limitation period.
4. Your spouse or dependent children are no longer eligible for COBRA continuation coverage because of any other reason permitted by law.

The law permits TRS-Care to charge any person who elects COBRA continuation coverage 102% of the full cost to the plan for the period of coverage for a similarly situated beneficiary for whom an event triggering loss of coverage has not occurred. If your spouse or dependent children elect to continue coverage, their initial payment must be submitted to Aetna within 45 days of their election date. This initial payment must cover the period from the termination date of coverage to the date of the COBRA election.

Once the initial COBRA payment is made, COBRA contributions are due on the first day of the month and must be paid before the last day of each month for which a COBRA contribution is required.

The plan sponsor determines the amount of the COBRA contribution and may change that amount annually. Notification of any change in contribution amounts will be given. COBRA continuation coverage is contingent upon the timely election of COBRA continuation coverage and the receipt of any required contribution that is due. If the COBRA election is untimely or the COBRA payments are not received when due, the elected COBRA continuation coverage will terminate permanently, retroactive to the first day of the period for which the missed payment applies. Your spouse or dependent children COBRA coverage may not be reinstated in such an event.

A qualified beneficiary does not have to show that he or she is insurable to choose COBRA continuation coverage. However, COBRA continuation coverage under the law is provided subject to the individual's eligibility for coverage under the plan. TRS-Care reserves the right to terminate an individual's COBRA continuation coverage retroactively if you are determined to be ineligible. Once COBRA continuation coverage terminates for any reason, it cannot be reinstated.

If you have any questions, contact TRS-Care at the Teacher Retirement System of Texas, Group Health Benefits Division.

Statement of Rights under the Newborn and Mother's Protection Act of 1996

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, a plan or issuer may pay for a shorter stay if the attending provider (e.g., the physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact the TRS-Care Customer Service at **1-800-367-3636**.

Women's Health and Cancer Rights Act of 1998

Covered Medical Services include the following for a participant who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all states of mastectomy, including lymphedema.

Teacher Retirement System of Texas 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.

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 June 10, 2017. 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 a law enforcement official for the purpose of alerting law enforcement of your death if TRS has a suspicion that your death may have resulted from criminal conduct;
 - To the Texas Attorney General to collect child support or to ensure health care coverage for your child;
 - In response to a subpoena if the TRS Executive Director determines that you will have a reasonable opportunity to contest the subpoena;
 - To a governmental entity, an employer, or a person acting on behalf of the employer, to the extent that TRS needs to share the information to perform TRS’s business;

- 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, (iii) 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, (iii) 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, Humana, CVS/Caremark and Gabriel, Roeder, Smith & Company. 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 purpose 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, such as disclosures to prevent disease, help with product recalls, report adverse reactions to medications, or report suspected abuse, neglect or domestic violence.
- **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.
- **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 Uses and Disclosures Requiring an Opportunity to Agree or to Object.

Under the following circumstances, TRS may use or disclose protected health information, provided that TRS informs you in advance of the use or disclosure and you have an opportunity to agree to or prohibit or restrict the use or disclosure of your protected health information. TRS may inform you orally or in writing of and obtain your oral or written agreement or objection to the use or disclosure of your protected health information. TRS will follow your instructions.

- TRS may disclose to a family member, other relative, or a close personal friend, or any other person you identify, your protected health information that (i) is directly relevant to such person's involvement with your health care or payment related to your health care, or (ii) serves to notify or assist in the notification of your location, general condition, or death.
- TRS may use or disclose your protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of notifying or assisting in the notification of your location, general condition, or death.

If you are not able to communicate your preference to TRS, for example because you are unconscious, TRS may share your protected health information if TRS believes it is in your best interest to do so.

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, 151 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.

If you are enrolled in TRS-Care, you may request a restriction by writing to: Aetna Legal Support Services, 151 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 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.

- **The 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 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 to **(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

Please contact in writing the Privacy Officer, at the following address, if you have any questions about the privacy practices described in this notice or how to file a complaint.

Privacy Officer

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

If you want more information about this notice or how to exercise your rights, please contact the TRS Telephone Counseling Center at **(800) 223-8778**. For the Hearing Impaired: Dial Relay Texas **711**.


Unauthorized, Fraudulent, Improper, or Abusive Actions

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered dependents will include, but not be limited to, the following actions, when intentional:
 - a. Use of the Identification Card prior to your effective date of coverage;
 - b. Use of the Identification Card after your date of termination of coverage under TRS-Care;
 - c. Obtaining prescription drugs or other benefits for persons not covered under TRS-Care;
 - d. Obtaining prescription drugs or other benefits that are not covered under TRS-Care;
 - e. 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 TRS-Care;
 - f. Obtaining covered drugs without a prescription order or through the use of a forged or altered prescription order;
 - g. Obtaining quantities of prescription drugs in excess of medically necessary or prudent standards of use or in circumvention of the quantity limitations of TRS-Care;
 - h. Obtaining prescription drugs using prescription orders for the same drugs from multiple providers;
 - i. Obtaining prescription drugs from multiple pharmacies through use of the same prescription order.
2. The committing of fraud, as defined under applicable laws and regulations, against TRS-Care is prohibited. Such action includes, but is not be limited to, (i) providing information that results in the enrollment of individuals not eligible for TRS-Care and (ii) failing to promptly provide information concerning a change in status of an individual enrolled under your coverage as a dependent that could affect the dependent's eligibility for TRS-Care (e.g., a divorce).
3. The commitment of fraud or intentional misrepresentation of a material fact by that individual and the fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any individual enrolled in TRS-Care may result in, but is not limited to, the following sanctions being applied to you and all dependents enrolled under your coverage:
 - a. Denial of benefits under TRS-Care;
 - b. Refusal for up to five (5) years to renew your coverage under TRS-Care and the coverage of any dependent enrolled under your coverage;
 - c. Cancellation of coverage under TRS-Care for you and all dependents enrolled under your coverage;
 - d. Limitation on the use of the Identification Card to one designated physician, other provider, or participating pharmacy of your choice;
 - e. Recoupment from you or any of your covered dependents of any benefit payments made, including the offsetting of premium payments against unrecovered funds paid by TRS-Care on behalf of individuals ineligible for coverage under TRS-Care;
 - f. Pre-approval of drug purchases and medical services for you and all dependent enrolled under your coverage;
 - g. Notice to proper authorities of potential violations of law or professional ethics.

If you want more information about this notice, how to exercise your rights, or how to file a complaint, please contact the TRS Health Benefits at **1-888-237-6762**. TDD users should call **711**.



FORMS



TEACHER RETIREMENT SYSTEM OF TEXAS
1000 Red Forge Street, Austin, Texas 78701-2698
Telephone 1-800-527-6767 www.trstexas.gov

TRS 628
08-18

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NOTICES

I understand and agree to the following:

1. I have the right to receive a copy of this authorization form after I sign it.
2. As a general rule, TRS may not require me to sign this authorization as a condition of enrolling in a health plan offered under TRS-Care or TRS-ActiveCare, or being eligible for benefits under or TRS-ActiveCare. However, TRS may condition my enrollment or eligibility upon a signed TRS needs the information (other than psychotherapy notes) to make enrollment or determination related to me, or to make underwriting and/or risk rating determinations. If I sign this authorization, TRS may not be able to make or obtain these determinations.
3. I have the right to revoke this authorization at any time and prevent future releases of my confidential health information, except to the extent that (a) I provided the authorization as a condition of health care coverage, and the law allows the payor to contest the coverage or a claim coverage; or (b) TRS has already used or disclosed my health information in reliance on this authorization. A revocation must be in writing, clearly identify the authorization I am revoking, signed by me or a person authorized to sign on my behalf. I must submit my written revocation to the mailing address listed at the top of this form.
4. If I sign this authorization and TRS discloses my health information, the person or entity to whom TRS discloses it may re-disclose the information without telling TRS or me, or asking for permission from TRS or from me. If this occurs, my confidential health information may no longer be protected by federal or state privacy laws.

Reverse of
Form TRS 628
08-18

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, TRS Participant ID No. _____, *
hereby authorize the Teacher Retirement System of Texas, in its capacity as trustee of the Pension, TRS-Care and/or TRS-ActiveCare, its employees, and agents to use and/or disclose protected health information ("PHI") about me as follows:

1. Person (name) or class of persons who may use the PHI or to whom TRS may make the requested disclosure (name of person or company to use or receive information and their address, including street address, city, state, and zip code):

2. PHI that TRS may use or disclose (please describe specifically the information you are authorizing to be released):

3. Purpose of the authorized use or disclosure (you may state "at my request" if you do not wish to identify a particular purpose):

4. Expiration date or event (please list a specific date or a specific event when you want this authorization to terminate): _____

I HAVE READ, AND I UNDERSTAND, THE STATEMENTS ON THE REVERSE PAGE.

Signature of person authorizing release _____ Date _____

If a representative is signing this authorization, please describe your authority to act for the individual and attach any authorizing documents, such as a power of attorney or a court order granting guardianship:

* If you do not have your Participant ID Number, please contact TRS for this information at (800) 223-8778.

TRS Authorization for Release of Protected Health Information
Visit www.trstexas.gov and go to the "Forms" section.

aetna **Authorization for Release of Protected Health Information (PHI)** ECHS Category - PHIA

My health record is private and is known under the law as "Protected Health Information (PHI)."

By completing and signing this form, I, or my legal representative, agree to allow Aetna to share my PHI with the people or companies listed below. By Aetna, I also mean the company's subsidiaries, affiliates, employees, agents and subcontractors. PLEASE COMPLETE ALL SECTIONS.

1. My information

My first name	Last name	Middle initial
My member ID number	My birth date (MMDDYYYY)	My phone number
My street	My city, state, ZIP code	

2. Aetna can share my PHI with the following people or companies:

Person or company name	Phone number
Street	City, state and ZIP code
Person or company name	Phone number
Street	City, state and ZIP code

3. Aetna can share ONLY my records chosen below.

I only want to share the PHI I have checked below. This authorization cannot be used to share psychotherapy notes.

☐ Any information requested

☐ Health (medical, dental, pharmacy, vision and flexible spending account information)

☐ Long term care ☐ Patient management records

Sensitive information: (this information may include diagnosis and/or treatment information)

☐ Substance use disorder (alcohol/drug) ☐ HIV/AIDS ☐ Sexually transmitted disease

☐ Behavioral health/Mental health (but NOT psychotherapy notes).

☐ Other (please explain)

4. By signing this form I authorize Aetna to disclose information below for the following purpose:

Check one of the following options:

☐ At my request - no specific purpose ☐ Specific purpose: _____

5. This form will be valid for 1 year unless a shorter time period is listed below.

My authorization is valid from _____ to _____

MMDDYYYY MMDDYYYY

GR-67938 (10-18) R V

6. By signing below, I understand and agree:

- My PHI that I agree to share may be sensitive. It may include diagnosis and treatment information. It may cover chronic diseases, behavioral health conditions and alcohol or drug abuse. It may cover communicable diseases, sexually transmitted diseases such as HIV/AIDS, and genetic marker information.
- Whoever gets my PHI may share it with others. That means federal or state privacy laws may no longer protect my PHI.
- I can get a copy of this authorization form that I have signed by sending Aetna a signed request using the address at the bottom of this form.
- Aetna will not release my PHI to the individual(s) or company(ies) named in Section 2 unless I sign this form.
- I can cancel or change my decision any time. I can do this by writing to Aetna, using the address at the bottom of this form.
- If I do cancel my permission, it will not affect actions Aetna took before getting my request.
- My ability to enroll won't change if I do not sign this form.
- My eligibility for benefits and services won't change if I do not sign this form.

ATTENTION:

My signature is required if any of the below apply:

- I am 18 years of age or older
- I am a minor under the age of 18 and I am either married or I am emancipated
- The information being disclosed pertains to drug or alcohol treatment
- The information being disclosed pertains to one of the following conditions and my state allows me to be treated even if my parents or legal guardian do not agree with my decision:
 - Mental health
 - Sexually transmitted disease (including HIV/AIDS)
 - Reproductive health (including contraception, prenatal care and abortion)
 - General medical and dental health

7. My signature or my legal representative's signature

Signature	Date
Print name	

If a legal representative signed this form, describe the relationship: (parent, legal guardian, Power of Attorney, personal representative)

• If this request is being signed by the member's legal representative, you must provide legal documentation authorizing you to act on the member's behalf (legal guardianship, power of attorney, personal representative).

• If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Please sign and return this completed form to:

Aetna's HIPAA Member Rights Team
PO Box 14079
Lexington, KY 40512-4079

Or you can fax it to: **859-280-1272**

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TRS-Care Sample Card Content

aetna **TRSCare**

TRC-CARE STANDARD

GRP: 285740-020-00110
Issuer: (00040) S140060054 Choice POS II

ID W1234 56789

NAME
JENNIFER Q SAMPLE-TESTCARD

www.trscarestandarcaetna.com PAYER NUMBER 60054 0415

TALK TO A DOCTOR 24/7: 1-855-TELADOC OR TELADOC.COM/AETNA

24-hour Nurse Information Line: 1-800-556-1555

TRC Care benefits are administered by Aetna Life Insurance Company or affiliates. While coverage remains in force, covered participants are entitled to benefits as provided under the terms and conditions of TRS-Care.

This card does not guarantee coverage. For questions on mental health/substance abuse coverage call 1-800-424-4047 or call Teladoc. Referrals are not required. The plan describes what you need to precertify: 1-800-367-3636.

If you do not precertify, your benefits will be reduced.

Emergency: Call 911 or go to nearest emergency facility.

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

MEMBER SERVICES 1-800-367-3636

PROVIDERS CALL 1-888-632-3862

Aetna Authorization for Release of Protected Health Information

Visit **www.aetna.com/individuals-families-health-insurance** and go to "Find a Form".



GLOSSARY

The following definitions of certain words and phrases will help you better understand your benefits. Some definitions apply only to a specific benefit that appears in the benefit section. If a definition appears in a benefit section and also appears in the glossary, the definition in the benefit section will apply in lieu of the definition in the glossary.

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-Care participants.

ALCOHOLISM OR DRUG ABUSE. Physical and/or emotional dependence on alcohol, drugs, narcotics, or other addictive substances.

ALCOHOLISM OR DRUG ABUSE EFFECTIVE TREATMENT. A program of therapy that is prescribed and supervised by a physician meeting specific treatment criteria.

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.

ALLOWED AMOUNT. TRS-Care covers medical expenses at the allowed amount. If the provider is contracted and participating in a network, the allowed amount is determined by the contract. The contracted allowed amount is usually less than the billed amount. TRS-Care covers medical expenses at a lower fee schedule determined by TRS for out-of-network providers. In those instances, the allowed amount will be the lesser of the billed amount or the out-of-network fee. The out-of-network fee schedule usually represents fees that are similar to fees for network providers.

In areas where there is no network, TRS-Care pays covered medical expenses based on reasonable and customary charges. Reasonable and customary charges for each service are determined from claims from a large number of the same types of providers within a geographic region.

AMBULANCE. 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.

ASSIGNMENT OF BENEFITS. The signed transfer of certain benefits by the participant to a health care provider. Benefits may be assigned only with the written consent of Aetna if Aetna receives proof from the provider that benefits have been assigned by the participant. Network providers automatically receive assignment of benefits.

BUNDLING OF CHARGES. A process that identifies a medical procedure (e.g., lab, radiology, surgery, anesthesiology, etc.) that is incidental to another billed procedure and is, therefore, included in that charge and not eligible for separate benefits. The process was developed in conjunction with physician specialists from across the country. When you use network providers, they must not bill separately for charges that bundle to other services; if a provider is out-of-network, the participant is responsible for these charges.

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 TRS-Care pays 80% and you pay 20% of the allowable amount for the eligible charges. Coinsurance is in addition to the deductible, charges for services not covered, precertification penalties and out-of-network charges, which are the patient's responsibility.

COINSURANCE LIMIT. The cumulative amount a participant must pay for covered medical expenses during a plan year before eligible benefits will be paid at 100%.

Services not covered, precertification penalties, out-of-network charges and amounts in excess of the maximum allowable fee do not apply.

Individual Coinsurance Limit

The coinsurance limit is the maximum accumulation of your 20% or 40% of covered expenses you must pay in a plan year, as your share of allowed amounts. Once the limit is met, TRS-Care pays 100% of the allowed amounts for that participant's covered medical expenses for the rest of that plan year. Precertification penalties, charges for services not covered and any payment for charges greater than the plan's allowable reimbursement do not apply to the individual coinsurance limit. After the participant has paid the coinsurance limit, he/she will still be responsible for any charges that are greater than the plan's allowable reimbursement for out-of-network service.

Family Coinsurance Limit

If there are two or more participants in a family unit covered under the TRS-Care Standard plan, the maximum coinsurance limit in a plan year will be two times the individual coinsurance limit. Precertification penalties, charges for services not covered and any payment for charges greater than the plan's allowable reimbursement do not apply to the family coinsurance limit.

When a family meets its coinsurance limit in a plan year, TRS-Care will pay a benefit equal to 100% of the allowed amounts of such covered medical expenses incurred by all family members for the rest of that plan year. After the family coinsurance limit is met, the family will still be responsible for any charges that are greater than the plan's allowable reimbursement for out-of-network services.

COMPASSIONATE CARE PROGRAM. The Aetna Compassionate Care Program is available for TRS-Care 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.

CONVALESCENT CARE/SKILLED NURSING CARE. Care requiring the skills of a licensed nurse in the form of intravenous medication or complex wound care and combined with other necessary physical restorative services that result in substantial improvement to the person's medical condition.

CONVALESCENT FACILITY/SKILLED NURSING FACILITY. An institution, or a distinct part of an institution, that meets the following criteria:

- It is licensed to provide and is providing, on an inpatient basis, for persons convalescing from injury or disease, professional nursing services rendered by an RN or an LVN directed by an RN, and physical restoration services to help patients reach a degree of body functioning to permit self-care in essential daily living activities.
Its services are provided for compensation from its patients and under the full-time supervision of a physician or RN.
- It keeps a complete medical record on each patient.
- It has a utilization review plan.
- It is not mainly a place for rest, the aged, drug addicts, alcoholics, mentally retarded, custodial or educational care, or care of mental disorders.

COVERED MEDICAL EXPENSES/COVERED CHARGES. Covered medical expenses are the expenses for medically necessary hospital services, other medical services and medical supplies incurred in connection with treatment of an injury or disease and for other preventive services as specified in this Benefits Booklet. The term "covered" refers to the fact that the medical service, supply or other item qualifies for benefits under the plan. The amount payable, for these covered medical expenses or the covered charges is based on allowed amounts for physicians and maximum reimbursement rates for hospital confinements. See page 20 for the basis of payment when medical services are provided or received out-of-state.

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 proportions.

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 each plan year before TRS-Care begins payment for eligible covered medical expenses. 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. If you have individual only coverage you will must meet the individual only deductible. If you have coverage for more than yourself, the family deductible must be met before the plan pays any benefits for any covered family member.

Family Deductible Limit. If you have family coverage, the family deductible must be met by one family member or a combination of family members before the plan pays benefits. However, no benefits are paid for any family member until the entire family deductible is met.

DENTIST. A person holding a Doctor of Dental Science or Doctor of Dental Medicine degree who is licensed in the State to do the dental work he or she performs.

DURABLE MEDICAL EQUIPMENT (DME). Equipment able to withstand prolonged use for the therapeutic treatment of an active disease or injury.

EFFECTIVE DATE OF COVERAGE. The date an individual and/or dependent coverage begins under the plan.

ELIGIBILITY DATE. The date an individual and/or dependents become eligible for benefits under the plan.

ELIGIBILITY PERIOD. The period of time, 31 days from the qualifying event (e.g., retirement, active member or retiree death, acquiring a new dependent) when the eligible individual must enroll or be enrolled if coverage is desired.

EMERGENCY ADMISSION. One where the physician admits the person to the hospital or treatment facility right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition that:

- Requires immediate confinement as a full-time inpatient; and
- If immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
 - Placing the person's health in serious jeopardy;
 - Serious impairment to bodily function; or
 - Serious dysfunction of a body part or organ.

EMERGENCY. This means the sudden, and at that time, 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.

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 a retiree, surviving spouse or surviving dependent child by a health plan that includes the charges for services provided and benefits considered.

FORMULARY. A drug formulary is a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value. A committee of physicians, nurse practitioners, and pharmacists maintain the formulary.

HIPAA. The Health Insurance Portability and Accountability Act of 1996. (See page 88)

HOME HEALTH CARE. Medically necessary services provided in the patient's home by a licensed Home Health Care Agency or by others under arrangements made by the agency as an alternative to confinement in a hospital or convalescent facility. The care must be prescribed in writing by the attending physician.

HOME HEALTH CARE AGENCY. An agency or organization that meets fully all of the following requirements:

- It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
- It has policies established by a professional group associated with the agency or organization. This professional group must include at least one physician and at least one RN to govern the services provided, and it must provide for full-time supervision of such services by a physician or by an RN.
- It maintains a complete medical record on each patient.
- It has a full-time administrator.

HOME HEALTH CARE PLAN. This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be prescribed in writing by the attending physician and be an alternative to confinement in a hospital or convalescent facility.

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.

HOSPICE CARE AGENCY. An agency or organization that has hospice care available 24-hours-a-day, meets licensing or certification standards in its jurisdiction and provides specific services, staffing and policies. The Hospice Care Agency personnel must include at least one physician, one RN, one licensed or certified social worker employed by the agency and one pastoral or other counselor. A hospice care agency establishes policies governing the provision of hospice care, assesses and develops a Hospice Care Program to meet the patient's medical and social needs, provides an ongoing quality assurance program that includes reviews by physicians (other than those who own or direct the agency), permits all area medical personnel to utilize its services for their patients, keeps a medical record on each patient, utilizes volunteers trained in providing services for non- medical needs and has a full-time administrator.

HOSPICE CARE PROGRAM. A written plan of hospice care that includes an assessment of the person's medical and social needs and a description of the care to be rendered to meet those needs. The Program is established by and reviewed from time to time by a physician who is attending the person and by appropriate personnel of a Hospice Care Agency.

HOSPICE FACILITY. A facility, or a distinct part of a facility, that mainly provides inpatient hospice care and meets licensing or certification standards.

HOSPITAL. A legally constituted institution with organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis. Included are facilities for diagnosis and surgery under the supervision of a staff of one or more licensed physicians and that provide 24-hour nursing services by an RN on duty or on call. It is not a nursing home or mainly a place for rest, for the aged, for drug addicts or for alcoholics.

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-Care retirees, surviving spouses and surviving dependent children will receive two cards, one from Aetna for medical expense and one from CVS Caremark for pharmacy expenses.

Both the Aetna and CVS Caremark ID cards are issued using a "unique identification" number for the retiree/surviving spouse/surviving dependent children.

Due to concerns for privacy, the Social Security number is not used.

IDENTIFICATION NUMBER. A unique identification number will be assigned to the retiree or surviving spouse. The Aetna unique number will be different from the CVS Caremark unique number. Aetna cards will be issued in the name of the retiree or surviving spouse with the name of all individuals listed. CVS Caremark cards will be issued under the name of the retiree or surviving spouse. Both cards will have the retiree's or surviving spouse's unique identification number on them. When calling TRS or TRS-Care, however, you will still need to provide your Social Security number.

INCIDENTAL PROCEDURE. A procedure that is commonly performed at the same time as the primary procedure and is clinically an integral part of the total service.

It usually requires minimal additional physician resource and therefore, does not warrant separate reimbursement.

INCURRED CHARGE. The charge for a service or supply on the date the service and/or supply is furnished.

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.

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 U.S. 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.

In no event will the following be considered to be necessary:

- Those services rendered by a provider that do not require the technical skills of such a 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.

MEDICARE CONTRACTED HMO. A Medicare Contracted HMO is an HMO that has been federally approved to provide services to Medicare beneficiaries and meets Medicare contracting requirements. Medicare Contracted HMOs provide, at a minimum, all Medicare-covered services.

MEDICARE DIRECT/MEDICARE CROSSOVER. A program that electronically transmits claims filed with Medicare under Part B to Aetna.

MENTAL OR NERVOUS DISORDER OR CONDITION. A disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional.

MENTAL OR NERVOUS DISORDER OR CONDITION TREATMENT FACILITY. A licensed institution or a distinct part of an institution that provides diagnosis, evaluation and effective treatment of mental or nervous disorders and meets specific criteria regarding staffing and medical documentation.

NETWORK-ALLOWED REIMBURSEMENT. A reimbursement arrangement based on a prospective payment system or discount agreements with certain hospitals and physicians.

NETWORK CARE. Covered medical expenses for health care services or supplies that are furnished by a network provider or for emergency conditions.

NETWORK HOSPITAL. A licensed hospital that has contracted to participate in the Aetna network within the 50 states.

NETWORK PHYSICIAN. A licensed physician in the state in which he or she practices who has contracted to participate in the Aetna network within the 50 states.

NETWORK PROVIDER. A licensed provider in the state in which they practice and who has contracted to participate in the Aetna network within the 50 states.

NIGHT CARE TREATMENT. A partial confinement treatment program provided to a person with a mental health disorder who is confined during the night. A room charge is made by the hospital or treatment facility. A private room is considered at a semiprivate room rate. A night care program must be available at least four hours but not more than eight hours in any one 24-hour period.

NON-OCCUPATIONAL DISEASE/INJURY. A disease or injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Results from a disease/injury that arises out of (or in the course of) any work for pay or profit. However, a disease shall be considered "non- occupational" if proof is furnished to Aetna that a person:
 - Is not covered under a Workers' Compensation Law; or
 - Is not covered for that disease under such law.

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).

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.

OUT-OF-NETWORK CARE. Health care services and supplies that are provided by an out-of-network provider.

OUT-OF-NETWORK FEE SCHEDULE. A reduced schedule of allowed amounts for services performed by out-of-network providers that has been uniquely formulated for the TRS-Care Program.

OUT-OF-NETWORK HOSPITAL. An appropriately licensed hospital that has not contracted to participate in an Aetna network.

OUT-OF-NETWORK PHYSICIAN. A licensed physician who has not contracted to participate in an Aetna network.

OUT-OF-NETWORK PROVIDER. A provider (including, but not limited to pathology laboratories, radiology centers, psychologists, master social workers, physical therapists and certified nurse anesthetists) who is appropriately licensed, but has not contracted to participate in an Aetna network.

OUT-OF-POCKET LIMIT. Maximum amount the participant will have to pay for covered medical expenses in a plan year. (Precertification penalties, services not covered and amounts in excess of the maximum allowable amount do not apply.)

OUTPATIENT EXPENSES. Charges incurred for hospital services and supplies that are furnished to a participant while not confined as a full-time inpatient.

PARTICIPANT. A retiree, spouse, dependent child, surviving spouse, and a surviving dependent child enrolled in TRS-Care.

PHYSICAL RESTORATIVE SERVICES. Physical restorative services (i.e., physical therapy, occupational therapy, and speech therapy) are those which, after disease or injury, improve functional skills and increase independence within the time frame of the treatment plan.

PHYSICIAN. Legally qualified physicians include but are not limited to MDs (Medical Doctors), DOs (Doctors of Osteopathy), DPMs (Podiatrists), Oral Maxillary Surgeons, and DCs (Doctors of Chiropractic Care). If applicable law requires the recognition of a specific practitioner, the term “physician” will include that practitioner to the extent required by law.

PLAN. Texas Public School Retired Employees Group Benefit Program known as TRS-Care 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 Retired Employees Group Benefits Program.

PLAN YEAR. The plan year is the 12-month calendar year. (January 1 through December 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-Care/Aetna Service Center before the procedure and/or service is performed.

PRIVATE CONTRACTING. A contract with an individual physician that would allow the physician to opt out of Medicare and bill the patient directly for any services provided that would normally be covered by Medicare. If a physician enters into this type of agreement with only one of his Medicare beneficiaries, that physician cannot bill Medicare for any of his or her other Medicare beneficiaries for a period of two years.

PROVIDER. A person, facility, or vendor (e.g., physician, hospital, laboratory, home health care agency, etc.) that provides health care services.

PSYCHIATRIC PHYSICIAN. A legally qualified physician who specializes in psychiatry and has the training or experience in the field of psychiatric medicine sufficient to perform the required evaluation and treatment of mental illness.

REASONABLE (AND CUSTOMARY) CHARGES. The reasonable charge for a service or supply is based upon fees reported to Aetna for the same service by other similar providers. Only that part of a charge that is reasonable is covered. In determining the reasonable charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, Aetna may take into account factors, such as:

- The complexity of service provided;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

RESIDENTIAL TREATMENT CENTER. An institution accredited by the Council on Accreditation, Joint Commission on Accreditation of Hospitals, or American Association of Psychiatric Services for Children that provides residential care and treatment for emotionally disturbed children and adolescents.

RESPIRE CARE. Care furnished during a period of time when the person’s family or usual caretaker cannot or will not attend to the family member’s needs.

ROOM AND BOARD CHARGES. An institution’s (hospital’s or facility’s) charge for room and board.

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

SEMIPRIVATE ROOM RATE. The room and board charge that an institution applies to its rooms with two or more beds. If there are no such rooms, the semiprivate room rate will be the rate most commonly charged by similar institutions in the same geographic area. The term “area” means a city, a county, or any greater area necessary to obtain a representative cross section of similar institutions.

SKILLED NURSING FACILITY/CONVALESCENT CARE. Care that is deemed medically necessary (See page 104) and requires the skills of a licensed nurse. Custodial care is not covered (See page 101).

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 RN;
- 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.

SURGICAL PROCEDURE. The designation of "type of service" and procedure codes (i.e., CPT codes) are determined by the American Medical Association. Any procedure in the following categories:

- Incision of any part of the body;
- Excision or electrocauterization of any part of the body;
- Manipulative reduction of a fracture or dislocation;
- Suturing of a wound; or
- Endoscopic removal of a stone or foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder, or ureter.

SURVIVING DEPENDENT CHILDREN. The term used for eligible dependents who have survived the deceased active employee or retiree and the deceased active employee or retiree's spouse. (Eligible dependent children can be covered only if the surviving spouse elects coverage.)

SURVIVING SPOUSE. The spouse of an active member or retiree at the time of the member/retiree's death.

TERMINAL ILLNESS. A medical prognosis of six months or less to live.



If you have any questions, please feel free to call the TRS-care Customer Service line at 1-800-367-3636 or refer to the website at www.trscarestandardaetna.com

**TRS Health & Insurance Benefits
Teacher Retirement System of Texas
1000 Red River Street
Austin, TX 78701-2698
1-888-237-6762
www.trs.texas.gov**

Claims Processing, Customer Service and
Patient Management Services Provided by:

**Aetna
PO Box 981106
El Paso, TX 79998-1106
1-800-367-3636
www.aetna.com**

Prescription Drug Benefits Provided by:

**Caremark, L.L.C.
2211 Sanders Road
Northbrook, IL 60062
1-844-345-4577
info.caremark.com/trscarestandard**

The TRS-Care program may be changed in the future to provide coverage levels that are different from the levels described in this booklet, 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 benefits booklet 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 the TRS-Care Plan 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.

www.trscarestandardaetna.com

TRSCARE-0040 (01/20)

DISCRIMINATION IS AGAINST THE LAW

The Teacher Retirement System of Texas (TRS) complies with applicable Federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex. TRS provides free aids and services, such as: written information in other formats (large print, audio, accessible electronic formats, other formats), qualified interpreters (including sign language interpreters), and written information 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 Street, 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. Department of Health and Human Services,
200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
PHONE: 1-800-368-1019, 800-537-7697 (TDD)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

यान दः यद्द आप ह दी बोलते ह तो आपके ललए मु त म भाषा सहायता सेवाएं उपल ध ह।

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

સચુ ના: જો તમે ગજુ રાતી બોલતા હો, તો નન:શુ ક ભાષા સહાય સેવાઓ તમારા માટે ઉ પ લ ધ છે.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

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。

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ.

1-888-237-6762 (TTY: 711)

TRS-Care Benefits Booklet

**TRS-Care Standard Plan Participants
under Age 65 without Medicare**

Effective January 1, 2020