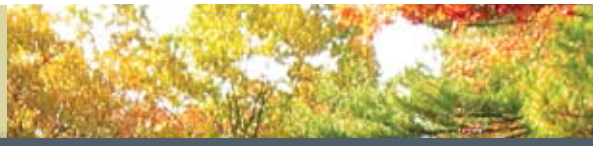
TRS-ActiveCare®

Teacher Retirement System of Texas

2010–2011 Health Plans

Enrollment Guide



This guide provides an overview of TRS-ActiveCare plan benefits. Your TRS-ActiveCare Benefits Booklet or your HMO's Evidence of Coverage provides a detailed description of your plan. The Benefits Booklet will be available online before September 1, 2010, and is the official TRS-ActiveCare statement on benefits. HMO Evidence of Coverage documents will be available online and printed copies may be available from your HMO. TRS-ActiveCare benefits will be paid according to the Benefits Booklet or HMO's Evidence of Coverage and other legal documents governing the plan.

This Enrollment Guide applies to the 2010–2011 TRS-ActiveCare plan year and supersedes any prior version of the Enrollment Guide. However, prior versions of the Enrollment Guides remain in effect for the plan year for which each one applies. In addition to TRS laws and regulations, the Enrollment Guide is TRS-ActiveCare's official statement about enrollment matters contained in the Guide and supersedes any other statement or representation made concerning TRS-ActiveCare enrollment, regardless of the source of that statement or representation. TRS-ActiveCare reserves the right to amend the Enrollment Guide at any time.

TRS-ActiveCare is administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. Prescription drug benefits for the ActiveCare 1-HD, 1, 2 and 3 plans are administered by Medco Health Solutions, Inc. HMO plans provided by: SHA, L.L.C. dba FirstCare Health Plans, Scott and White Health Plan and Valley Baptist Insurance Company dba Valley Baptist Health Plans.

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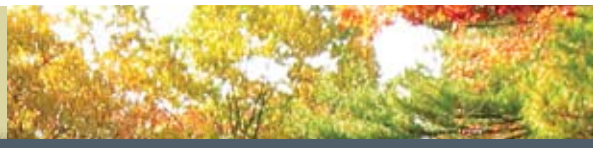
Questions? Call Customer Service

BlueCross BlueShield of Texas / medco ActiveCare 1-HD ActiveCare 1 ActiveCare 2 ActiveCare 3	866-355-5999 8–8 CT (Mon-Fri)
FirstCare Health Plans	800-884-4901 8–6 CT (Mon-Fri)
Scott & White Health Plan – Texas Friendly	800-321-7947 8–5 CT (Mon-Fri)
Valley Baptist Health Plans – An Affiliate of Valley Baptist Health System	800-829-6440 8–6 CT (Mon-Fri)

TDD Number (for the hearing impaired) 800-735-2989



Welcome

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

On September 1, 2002, TRS introduced TRS-ActiveCare, a new statewide health coverage program for public education employees established by the 77th Texas Legislature. Currently, TRS-ActiveCare provides medical and prescription drug benefits to over 1,100 districts/entities, representing almost 88 percent of the 1,257 entities in Texas eligible to participate in the program. More than 398,000 employees and dependents are enrolled for coverage.

Choosing the benefit plan that's right for you

This guide summarizes TRS-ActiveCare for the upcoming plan year, effective September 1, 2010. It provides details on all the health benefit plans offered through TRS-ActiveCare. The information will help you understand the different plans and give you the confidence to decide which option is best for you and your family. Throughout the guide, you'll find special sidebars with information to help you better understand your health care options. See Frequently Asked Questions on page 28 and Terms to Know on page 31 for additional information. If you still have questions, log in to the TRS-ActiveCare Web site or call the health plan's toll-free Customer Service number for assistance.

Pages 4 and 5 feature an overview of all plan options, followed by more detailed summaries of benefits for each plan. You should take the time to review the PPO and HMO Benefits Summaries and Plan Comparisons carefully. Rates and/or benefits for every TRS-ActiveCare plan option have changed. Think about which plan works best for you and your family. Before you make your choice, consider:

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

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

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

Example: Meeting a deductible and applying coinsurance and copays

Jim has PPO health coverage with a $500 deductible and 20 percent coinsurance. His health plan pays 80 percent after the deductible is satisfied. Jim didn't have any health care services until he began to experience severe pain in his lower back. He went to the ER for treatment. They found he had kidney stones and admitted him for surgery. Jim was in the hospital for three days. He used network providers for his care. His total hospital bill was $16,680, and the health plan covered $9,800.

Note: *The allowed amount for covered services is usually less than the billed charge. Network (contracted) providers will write off the difference. Non-network (non-contracted) providers may decide not to write off the difference and the member may be responsible for paying the difference in charges.*

For PPO Health Plan Using Network Providers	
Billed charge:	$16,680
Plan allowed amount for covered services:	$9,800
Jim is responsible for his $100 copay per day for his 3-day inpatient hospital stay:	$300
Jim must also meet his deductible. He is responsible for:	$500
Balance after deductible and copay:	$9,000
The plan pays 80% of Jim's hospital bill:	$7,200
Jim is responsible for 20% coinsurance:	$1,800
Jim's total responsibility for this claim is:	$500 +300 + $1,800 = $2,600 for his hospital stay

For example only. *Amounts are not real and do not reflect a total description of benefits.*

Comparing a PPO to an HMO

The following pages feature an overview of benefits for all TRS-ActiveCare health plan options. Not all health plan options are available in all areas of the state. See your benefits administrator or log in to the TRS-ActiveCare Web site to find out which options are available in your area.

The ActiveCare 1-HD, 1, 2 and 3 PPO plan options are available to districts/entities in all Texas counties. To be eligible for an HMO, you must live, work or reside within the HMO service area. HMO service areas are listed by county (or by ZIP code in some areas) on the specific HMO's Summary of Benefits and Plan Comparison pages.

If you have the opportunity to select between a PPO option and an HMO option, there are several factors you should consider when making a decision:

PPO Features

- No primary care physician (PCP) required; no referrals required to see a specialist
- Select any provider for care within the PPO network or outside the network
- When you receive care inside the network, you receive the highest level of benefits
- When you receive care outside the network, you still have coverage but you may pay more of the cost
- Worldwide coverage for emergency and non-emergency care

HMO Features

- Primary care physician (PCP) must coordinate care to receive benefits *(except for FirstCare, which does not require a PCP referral to see in-plan providers)*
- May choose a different PCP for each family member or select the same one for the entire family
- Females may choose a network OB/GYN and schedule appointments with that physician without a PCP referral
- Worldwide coverage for emergency care
- No preexisting condition exclusions apply

Plan options and preferred brand-name prescription drugs

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

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

4 Plan Options at a Glance

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

TRS-ActiveCare®
Teacher Retirement System of Texas

Plan Options and Benefits Highlights ▪ Effective September 1, 2010

	PPO Plans			
	ActiveCare 1-HD (Network)	**ActiveCare 1 (Network)**	**ActiveCare 2 (Network)**	**ActiveCare 3 (Network)**
Service Area	**Statewide**			
Primary Care Physician (PCP) required to direct care and for benefits to be paid?	No	No	No	No
Deductible *(per plan year; individual/family)*	$2,400/$2,400	$1,200/$3,000	$500/$1,500	None
Meets IRS definition of high deductible health plan?	Yes	Yes, for individual coverage only, not family	No	No
Out-of-Pocket Maximum *(per plan year; individual/family)*	$3,000/$5,000 *(does not include deductible or copays)*	$2,000/$6,000 *(does not include deductible or copays)*	$2,000/$6,000 *(does not include deductible or copays)*	$1,000 per individual *(does not include deductible or copays)*
Office Visit Copay	20% after deductible	20% after deductible	$30 for primary; $50 for specialist	$20 for primary; $30 for specialist
Preventive Care Copay	First $500, plan pays 100%	First $500, plan pays 100%	$30 for primary; $50 for specialist	$20 for primary; $30 for specialist
Inpatient Hospital	20% after deductible	20% after deductible	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year), plus 20% after deductible	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year), plus 20%
Emergency Room	20% after deductible	20% after deductible	$100 copay plus 20% after deductible *(copay waived if admitted)*	$100 copay **plus** 20% *(copay waived if admitted)*
Maximum Lifetime Benefits	Unlimited	Unlimited	Unlimited	Unlimited
Prescription Drug				
Drug Deductible *(per person, per plan year)*	Subject to plan year deductible	Subject to plan year deductible	$50	$50
Retail Short Term *(generic/ preferred/non-preferred)*	20% after deductible	20% after deductible	$10/$25/$45	$10/$25/$40
Retail Maintenance *(generic/ preferred/non-preferred)*	20% after deductible	20% after deductible	$15/$35/$60 *(after second fill)*	$15/$35/$55 *(after second fill)*
Mail Order *(generic/ preferred/non-preferred)*	20% after deductible	20% after deductible	$20/$62.50/$112.50	$20/$62.50/$100
Maximum Plan Year Prescription Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Cost of Coverage (per Month)				
Employee Only	$262.00	$297.00	$396.00	$533.00
Employee and Spouse	$642.00	$677.00	$901.00	$1,213.00
Employee and Child(ren)	$409.00	$474.00	$630.00	$850.00
Employee and Family	$840.00	$746.00	$991.00	$1,334.00
Customer Service	**866-355-5999 8-8 CT (Mon-Fri)**			

BlueCross BlueShield of Texas
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Plan Options and Benefits Highlights ▪ Effective September 1, 2010

	HMO Plans		
	FirstCare Health Plans	**Scott & White Health Plan**	**Valley Baptist Health Plans**
Service Area	93 counties *(Panhandle, West Texas and Central Texas)*	48 counties *(Central Texas)*	4 counties *(The Valley)*
Primary Care Physician (PCP) required to direct care and for benefits to be paid?	No (for in-plan providers)	Yes	Yes
Deductible *(per plan year; individual/family)*	$250/$500	None	$250/$500
Meets IRS definition of high deductible health plan?	No	No	No
Out-of-Pocket Maximum *(per plan year; individual/family)*	$3,000/$6,000 *(does not include deductible or copays)*	$2,000/$6,000 *(does not include pharmacy)*	$3,000/$6,000 *(does not include deductible or copays)*
Office Visit Copay	$25 for primary; $40 for specialist	$20	$25 for primary; $35 for specialist
Preventive Care Copay	No copay	No copay	$25 for primary; $35 for specialist
Inpatient Hospital	10% after deductible	$100 copay per day plus 20% *($500 maximum per admission)*	20% after deductible
Emergency Room	20% after deductible	$100 copay plus 20% *(copay waived if admitted within 24 hours)*	20% after deductible
Maximum Lifetime Benefits	$2,000,000	Unlimited	$2,000,000
Prescription Drug			
Drug Deductible *(per person, per plan year)*	$50	$50 *(does not apply to generic drugs)*	None
Retail Short Term *(generic/ preferred/non-preferred)*	$5/$25/$55	$5/30%/50%	$10/$30/$60
Retail Maintenance *(generic/ preferred/non-preferred)*	$10/$35/$70	$10/30%/50% *(in-plan pharmacies only)*	N/A
Mail Order *(generic/ preferred/non-preferred)*	$15/$75/$165	$10/30%/50%	$30/$90/$180
Maximum Plan Year Prescription Benefit	$10,000 per person	Unlimited	$10,000 per person
Cost of Coverage (per Month)			
Employee Only	$351.36	$456.70	$368.96
Employee and Spouse	$870.48	$1,077.58	$827.32
Employee and Child(ren)	$558.82	$722.39	$579.32
Employee and Family	$874.02	$1,122.36	$907.20
Customer Service	**800-884-4901 8-6 CT (Mon-Fri)**	**800-321-7947 8-5 CT (Mon-Fri)**	**800-829-6440 8-6 CT (Mon- Fri)**

FirstCare HEALTH PLANS

SCOTT&WHITE HEALTH PLAN Texas Friendly

Valley Baptist Health Plans AN AFFILIATE OF VALLEY BAPTIST HEALTH SYSTEM

What's new for 2010–2011? Benefit Changes Effective September 1, 2010

Plan Option	Benefit(s)	Change From	Change To
ActiveCare 1-HD *Meets IRS definition of high deductible health plan for all coverage categories*	Deductible (per plan year)	$2,300 "employee only" coverage $2,300 "employee and spouse," "employee and child(ren)" or "employee and family coverage"	$2,400 "employee only" coverage $2,400 "employee and spouse," "employee and child(ren)" or "employee and family" coverage
	Out-of-pocket maximum (per plan year)	Without deductibles: $3,000 "employee only" coverage $5,000 "employee and spouse," "employee and child(ren)" or "employee and family" coverage Including deductibles: $5,300 "employee only" coverage $7,300 "employee and spouse," "employee and child(ren)" or "employee and family" coverage	Without deductibles: $3,000 "employee only" coverage $5,000 "employee and spouse," "employee and child(ren)" or "employee and family" coverage Including deductibles: $5,400 "employee only" coverage $7,400 "employee and spouse," "employee and child(ren)" or "employee and family" coverage
ActiveCare 1	Deductible (per individual, per plan year)	$1,150	$1,200 (meets IRS definition of high deductible health plan for employee coverage only)
ActiveCare 2	Office visit	$25 copay for primary $35 copay for specialist	$30 copay for primary $50 copay for specialist
ActiveCare 1-HD, 1, 2 and 3 Plans	For dates of service on or after September 1, 2010, the allowable amount for non-contracting providers is calculated as 50 percent of billed charges. In compliance with SB 0704, 81 (R) Texas Legislature, TRS will make available through Medco Health Solutions, Inc., a retail maintenance network effective September 1, 2010. Retail pharmacies that choose to participate in this network will be able to dispense up to a 90-day supply of medication. Please contact Medco customer service for more information on pharmacies that may choose to participate in the retail maintenance network. **Separate ID cards for medical and prescription drug benefits:** Due to new legislative requirements for additional information on identification cards for prescription drug programs, plan participants enrolled in the PPO plans will receive two ID cards – one from Blue Cross and Blue Shield of Texas for medical benefits, and a separate card from Medco for pharmacy/prescription drug benefits. All cards will be reissued for the 2010–2011 plan year and be received before the effective date of coverage.		

What's the difference between ActiveCare 1-HD and ActiveCare 1?

The two plans are similar, but ActiveCare 1-HD features the highest deductible, the amount that must be met first before the plan pays benefits. Other key differences are highlighted below:

Feature	ActiveCare 1-HD	ActiveCare 1
Meets IRS definition of high deductible health plan and offers opportunity to contribute pretax dollars into a Health Savings Account (HSA)	Yes, for all coverage categories: "employee only," "employee and spouse," "employee and child(ren)" and "employee and family"	Yes, for "employee only" coverage No, for other coverage categories
Deductible (per plan year)	$2,400 for "employee only" $2,400 for "family" *The family deductible amount may be satisfied by one participant or a combination of two or more participants*	$1,200 per individual $3,000 per family *In this plan, the deductible applies to you and each covered person in your family individually; up to the maximum per family*
Maximum Coinsurance (per plan year)	$3,000 for "employee only" $5,000 for "family" *Coinsurance is the percentage of covered medical expenses that you and the plan share; once you and/or your family members have met your applicable deductible, the plan pays 80% of your benefits and you pay 20% up to the maximum amount shown*	$2,000 per individual $6,000 per family *After deductible, the plan pays 80% of your covered medical expenses and you pay 20% up to the maximum amount shown for individual/family*
Out-of-Pocket Maximum (per plan year; includes deductibles)	$5,400 for "employee only" $7,400 for "family" *When your or your family's combined deductible and coinsurance expenses satisfy the out-of-pocket maximum, the plan pays 100% of the allowable amount of covered medical expenses for the remainder of the plan year*	$3,200 per individual $9,000 per family *In this plan, the out-of-pocket maximum applies to you and each covered person in your family, up to the maximum per family. Once the out-of-pocket maximum is reached, the plan pays 100% of the allowable amount of covered medical expenses for the remainder of the plan year*
Preventive Services	Same as ActiveCare 1	When using network providers, plan pays 100% up to the first $500 per individual, per plan year; remaining charges will be subject to deductible and coinsurance
All Other Services and Prescription Drugs	Same as ActiveCare 1	After deductible, plan pays 80% and you pay 20% when using network providers (60%/40% for non-network)
Monthly Premium Costs (see page 33 for Cost of Coverage)	Less expensive than ActiveCare 1 in all coverage categories, **except** "employee and family" *"Employee and family" coverage is more expensive for this plan than ActiveCare 1 because the deductible and out-of-pocket maximum amounts for family are less and the plan may begin paying benefits sooner*	More expensive than ActiveCare 1-HD in all coverage categories, **except** "employee and family" *"Employee and family" coverage is less expensive for this plan than ActiveCare 1-HD because the deductible and out-of-pocket maximum amounts for family are greater and it will take longer to accumulate the medical expenses to satisfy these amounts*

Note: The amounts shown for "family" refer to the coverage categories for "employee and spouse," "employee and child(ren)" or "employee and family."

What is a Health Savings Account (HSA)?

An HSA is a special account owned by an individual used to pay for current and future medical expenses. It combines a high deductible health plan with a tax-free Health Savings Account that you and your covered family members can use to pay out-of-pocket expenses such as copays and deductibles, or leave unspent to grow as savings. Each year, the HSA can be funded up to the IRS maximum by you, your employer or both. You control the HSA, giving you the flexibility to decide how, when and where to spend your health care dollars. And the HSA is "portable," which means you keep the funds even if you change health plans, take a new job or retire.*

Who is eligible for an HSA?

Per IRS rules, any adult can contribute to an HSA if he/she:

- Has coverage under an HSA-qualified high deductible health plan
- Has no other first-dollar medical coverage (other types of insurance such as specific injury or accident, disability, dental, vision or long-term care are permitted)
- Is not enrolled in Medicare
- Cannot be claimed as a dependent on someone else's tax return

Does TRS-ActiveCare offer an HSA?

TRS-ActiveCare does **not** offer an HSA. However, ActiveCare 1-HD meets the IRS definition of a high deductible health plan for all coverage categories, and ActiveCare 1 meets the IRS definition of a high deductible health plan for "employee-only" coverage. You are not required to have an HSA to enroll in these plans, but if desired, you can seek an HSA administrator on your own to establish an account.

How do I learn more about an HSA?

The U.S. Treasury's Web site has additional information on HSAs, including answers to frequently asked questions, related IRS forms and publications, technical guidance, and links to other helpful Web sites. Visit the Treasury's Web site at **www.ustreas.gov** and click on "Health Savings Accounts."

***Important Note:** Health Savings Accounts (HSAs) have tax and legal ramifications. Neither the Teacher Retirement System of Texas nor Blue Cross and Blue Shield of Texas provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on, for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection to the matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax advisor regarding the tax consequences of specific health insurance plans or products.

Blue Distinction Centers for Bariatric Surgery

Blue Distinction® is a designation awarded by Blue Cross and Blue Shield to medical facilities that have demonstrated expertise in delivering quality health care, resulting in better overall outcomes for bariatric patients. All medically necessary bariatric surgical procedures for weight loss, such as lap band and gastric bypass, will be covered **only** if performed at one of the Blue Distinction Centers for Bariatric Surgery. Travel expenses to and from the Blue Distinction Centers will not be covered by the plan.

Blue Distinction Centers for Bariatric Surgery provide a full range of bariatric surgery care services, including inpatient care, post-operative care, outpatient follow-up care and patient education. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, and is subject to periodic reevaluation as criteria continue to evolve. **Note: The list of Blue Distinction Centers for Bariatric Surgery is subject to change without notice.** Refer to the Doctors and Hospitals section of the Web site, **www.bcbstx.com/trs** to search for current Blue Distinction Centers for Bariatric Surgery or contact Customer Service.

8 PPO Benefits Summaries and Plan Comparisons

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

Need to locate a network or ParPlan physician or hospital?

Log in to: **www.trs.state.tx.us/trs-activecare** or call Customer Service for assistance at **866-355-5999**.

Freedom of Choice

How the ActiveCare 1-HD, 1, 2 and 3 PPO Plans Work

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medco

Service Area
Statewide

Customer Service
866-355-5999
8 a.m. to 8 p.m. CT Monday through Friday

If you need to…	Network: You pay lower out-of-pocket costs if you choose network care	Non-Network: (Including ParPlan) You pay higher out-of-pocket costs if you choose non-network care Payment for non-network services is limited to the allowable amount as determined by Blue Cross and Blue Shield of Texas. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers that exceed the allowable amount.
Visit a doctor or specialist *A "specialist" is any physician other than a family practitioner, internist, OB/GYN or pediatrician*	• Visit any network doctor or specialist • Pay the office visit copay (*not applicable for ActiveCare 1-HD or ActiveCare 1*) • Pay any coinsurance and deductible • Your doctor cannot charge more than the allowable amounts for covered services	• Visit any licensed doctor or specialist • Pay for the office visit • File a claim and get reimbursed for the visit minus any coinsurance and deductible • Your costs will be based on allowable amounts; the non-network doctor you receive services from may require you to pay any charges over the allowable amounts determined by Blue Cross and Blue Shield of Texas
Receive preventive care	• Visit any network doctor or specialist • Pay the preventive care copay (*not applicable for ActiveCare 1-HD or ActiveCare 1*) • Pay any coinsurance and deductible • Your doctor cannot charge more than the allowable amounts for covered services	• Visit any licensed doctor or specialist • Pay for the preventive care visit • File a claim and get reimbursed for the visit minus any coinsurance and deductible • Your costs will be based on allowable amounts; the non-network doctor you receive services from may require you to pay any charges over the allowable amounts determined by Blue Cross and Blue Shield of Texas
Receive emergency care	• Call 911 or go to any hospital or doctor immediately; you will receive network benefits for emergency care • Pay any copay (waived if admitted) • Pay any coinsurance and deductible • Call the preauthorization number on your ID card within 48 hours	• Call 911 or go to any hospital or doctor immediately; you will receive network benefits for emergency care • Pay any copay (waived if admitted) • Pay any coinsurance and deductible • Call the preauthorization number on your ID card within 48 hours
Be admitted to the hospital	• Your network doctor will preauthorize your admission • Go to the network hospital • Pay any copays, coinsurance and deductible	• You, a family member, your doctor or the hospital must preauthorize your admission • Go to any licensed hospital • Pay any coinsurance and deductible each time you are admitted
Receive behavioral health or chemical dependency services	• Call the behavioral health number on your ID card first to authorize all care • See a network doctor or health care professional, or go to any network hospital or facility • Pay any coinsurance and deductible	• Call the behavioral health number on your ID card first to authorize all care • See any licensed doctor or health care professional, or go to any licensed hospital or facility • Pay any coinsurance and deductible
File a claim	Claims will be filed for you	You may need to file the claim yourself
Get prescription drugs	ActiveCare 1-HD and ActiveCare 1: • Take prescription to a network retail pharmacy or use Medco's mail order service • Pay the required coinsurance and deductible ActiveCare 2 and ActiveCare 3: • Take prescription to a network retail pharmacy or use Medco's mail order service • Pay the required prescription drug deductible and copay	ActiveCare 1-HD and ActiveCare 1: • Take prescription to any licensed pharmacy • Pay the total cost of the drug • File a claim with Medco and get reimbursed the amount that would have been charged by a network pharmacy *less* any coinsurance and deductible ActiveCare 2 and ActiveCare 3: • Take prescription to any licensed pharmacy • Pay the total cost of the drug • File a claim with Medco and get reimbursed the amount that would have been charged by a network pharmacy *less* the required prescription drug deductible and copay

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

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

Note: Non-contracting providers (non-network/ non-ParPlan providers) may bill you for amounts exceeding the allowable amount. **For dates of service on or after September 1, 2010, the allowable amount for non-contracting providers is calculated as 50 percent of billed charges.**

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Online resources for your health – www.bcbstx.com/trs

Through Blue Access for Members, you and your family have access to online resources where you will find practical and useful information. For example, you can research specific health conditions and get advice on how to start a program for exercise, smoking cessation or weight loss. With Blue Access for Members, you can also:

- Check the status of a claim and print your Explanation of Benefits (EOB)
- Confirm who is covered under your plan
- Locate a physician in your network that meets your needs
- Sign up to receive e-mail notifications of new claim activity
- Request a new or replacement ID card or print a temporary ID card
- Access the Personal Health Manager and earn Blue Points℠
- Take a confidential Health Risk Assessment
- E-mail and gain immediate access to Customer Service with questions about your ActiveCare 1-HD, 1, 2 and 3 benefits and claims through **Live Chat**

To register for Blue Access for Members, you'll need your group and member identification number, found on your TRS-ActiveCare ID card. Upon authentication, you'll be asked to create a user name and password that you'll use for all future visits to Blue Access for Members.

PERSONAL HEALTH MANAGER

If you want to learn more about your health and making healthy changes to your lifestyle, the Personal Health Manager can help you. Use this online wellness resource to:

- Make healthier choices about food, start a fitness program, quit smoking and keep track of your results
- Get health and wellness questions answered by nurses, dietitians, fitness trainers and life coaches
- Take a Health Risk Assessment and learn more about your health, health risks and what you can do to improve your well-being
- Stay motivated to reach your goals! When you use many of the features of the Personal Health Manager, you automatically earn Blue Points that can be redeemed for reward items

24/7 Nurseline

- Call 24 hours a day, seven days a week for answers to health related questions, **800-581-0368**
- Talk to registered nurses for free advice on health conditions such as high fevers, earaches, rashes, cuts and bruises, and more
- Access audio library, featuring more than 1,200 pre-recorded health messages, including:
  - Kicking the smoking habit
  - Managing high blood pressure
  - Ways to get a good night's rest
  - Getting a grip on stress

Having a baby?

Special Beginnings® can help you better understand and manage your pregnancy. Available at no additional cost, this maternity program supports you from early pregnancy until six weeks after delivery through prenatal and postnatal health education, pregnancy risk assessment, and assistance in managing high-risk conditions such as gestational diabetes and preeclampsia. Be sure to enroll in the program as soon as you find out you are pregnant. Enrollment is easy and confidential. Just call **888-421-7781**, 8 a.m. – 6:30 p.m. CT.

Condition Management

Voluntary, no-cost health improvement programs that can help members with: congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, asthma, diabetes and other health conditions

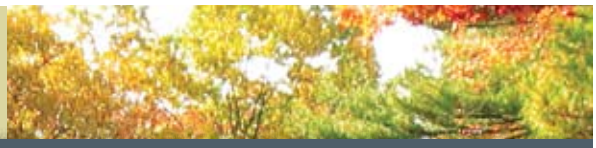
Obesity/Weight Management and Tobacco Cessation Programs

Behavioral coaching, clinical coaching, education and condition management to help those who want to lose weight or stop smoking

Enroll Today

To enroll or ask questions about the voluntary health and wellness programs available to you at no additional cost, please call toll-free at **800-462-3275**.

10 PPO Benefits Summaries and Plan Comparisons



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

Type of Service	ActiveCare 1-HD		ActiveCare 1	
General Provisions	**Network**	**Non-Network**	**Network**	**Non-Network**
	No primary care physician required		No primary care physician required	
Deductible (per plan year)				
Individual—You pay	$2,400 for employee only (meets IRS definition of a high deductible health plan)		$1,200 (meets IRS definition of a high deductible health plan)	
Family—You pay	$2,400 (meets IRS definition of a high deductible health plan)		$3,000 (does not meet IRS definition of a high deductible health plan)	
Out-of-pocket maximum (per plan year)				
Individual—You pay	$3,000 plus deductible for employee only		$2,000 plus deductible	
Family—You pay	$5,000 plus deductible		$6,000 plus deductible	
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Doctor and Lab Services				
Doctor office visits—You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Allergy injections—You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Office surgery—You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient surgery—You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges)—You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Inpatient doctor visits—You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Contraceptive devices—You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Preventive Care				
Doctor office visits Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams, routine mammograms, and eye exams. Other services include well-baby exams, immunizations, hearing exams, and PSA, colorectal cancer, osteoporosis screenings	Plan pays 100% up to the first $500 per individual, per plan year; remaining charges will be subject to deductible and coinsurance	40% after deductible	Plan pays 100% up to the first $500 per individual, per plan year; remaining charges will be subject to deductible and coinsurance	40% after deductible
Hospital/Facility Services				
Inpatient hospital and other inpatient charges—You pay	20% after deductible (preauthorization required)	40% after deductible (preauthorization required)	20% after deductible (preauthorization required)	40% after deductible (preauthorization required)
Outpatient surgery—You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient hospital/facility—You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency room care—You pay	20% after deductible		20% after deductible	

Note: Non-contracting providers (non-network/ non-ParPlan providers) may bill you for amounts exceeding the allowable amount. **For dates of service on or after September 1, 2010, the allowable amount for non-contracting providers is calculated as 50 percent of billed charges.** For example, if the billed charge is $1,000, the allowable amount when using a non-contracting provider would be $500. Assuming the deductible has been met, the plan would pay $300 ($500 x .60) and the participant would pay $200 ($500 x .40), plus any costs exceeding the $500 allowable amount.

Service Area
Statewide

Customer Service
866-355-5999
8 a.m. to 8 p.m. CT Monday through Friday

ActiveCare 2		ActiveCare 3	
Network	**Non-Network**	**Network**	**Non-Network**
No primary care physician required		No primary care physician required	
$500		None	$500
$1,500		None	$1,500
$2,000 plus deductible and copays		$1,000 plus copays	$3,000 plus deductible and copays
$6,000 plus deductible and copays		N/A	N/A
Unlimited	Unlimited	Unlimited	$1,000,000
$30 copay for primary $50 copay for specialist	40% after deductible	$20 copay for primary $30 copay for specialist	40% after deductible
20% after deductible (when no office visit is billed)	40% after deductible	20% (when no office visit is billed)	40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
$30 copay for primary $50 copay for specialist (for initial visit only; 20% after deductible for delivery)	40% after deductible	$20 copay for primary $30 copay for specialist (for initial visit only; 20% for delivery)	40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
$30 copay for primary $50 copay for specialist (includes all preventive care services billed with an office visit by a network doctor; coinsurance applies when no office visit is billed or services are performed outside the office – deductible waived)	40% after deductible	$20 copay for primary $30 copay for specialist (includes all preventive care services billed with an office visit by a network doctor; coinsurance applies when no office visit is billed or services are performed outside the office)	40% after deductible
$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 20% after deductible	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 40% after deductible	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 20%	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 40% after deductible
$100 copay per visit, plus 20% after deductible	$100 copay per visit, plus 40% after deductible	$100 copay per visit, plus 20%	$100 copay per visit, plus 40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
$100 copay plus 20% after deductible (copay waived if admitted)		$100 copay plus 20% (copay waived if admitted)	

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

12 PPO Benefits Summaries and Plan Comparisons

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

Type of Service	ActiveCare 1-HD		ActiveCare 1	
General Provisions	**Network**	**Non-Network**	**Network**	**Non-Network**
	No primary care physician required		No primary care physician required	
Behavioral Health (Mental Health and Chemical Dependency)				
Mental Health	Preauthorization required	Preauthorization required	Preauthorization required	Preauthorization required
Inpatient facility–You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Inpatient physician charges–You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient/office visit	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Serious Mental Illness				
Inpatient facility–You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Inpatient physician charges–You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient–You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Office visit–You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Serious Mental Illness				
	Preauthorization required	Preauthorization required	Preauthorization required	Preauthorization required
Inpatient facility–You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Inpatient physician charges–You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient/office visit–You pay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Prescription Drugs				
Drug deductible	Subject to plan year deductible		Subject to plan year deductible	
Retail Short-Term	Up to 30-day supply	Up to 30-day supply	Up to 30-day supply	Up to 30-day supply
Generic–You pay Preferred Brand–You pay Non-preferred Brand–You pay	20% after deductible	You will be reimbursed the amount that would have been charged by a network pharmacy less the required deductible and coinsurance	20% after deductible	You will be reimbursed the amount that would have been charged by a network pharmacy less the required deductible and coinsurance
Retail Maintenance (after second fill)	Up to 30-day supply	Up to 30-day supply	Up to 30-day supply	Up to 30-day supply
Generic–You pay Preferred Brand–You pay Non-preferred Brand–You pay	20% after deductible	You will be reimbursed the amount that would have been charged by a network pharmacy less the required deductible and coinsurance	20% after deductible	You will be reimbursed the amount that would have been charged by a network pharmacy less the required deductible and coinsurance
Medco by Mail	Up to 90-day supply	N/A	Up to 90-day supply	N/A
Generic–You pay Preferred Brand–You pay Non-preferred Brand–You pay	20% after deductible	N/A	20% after deductible	N/A
Maximum Plan Year Prescription Benefit	Unlimited	Unlimited	Unlimited	Unlimited

Note: Non-contracting providers (non-network/ non-ParPlan providers) may bill you for amounts exceeding the allowable amount. **For dates of service on or after September 1, 2010, the allowable amount for non-contracting providers is calculated as 50 percent of billed charges.** For example, if the billed charge is $1,000, the allowable amount when using a non-contracting provider would be $500. Assuming the deductible has been met, the plan would pay $300 ($500 x .60) and the participant would pay $200 ($500 x .40), plus any costs exceeding the $500 allowable amount.

Service Area
Statewide

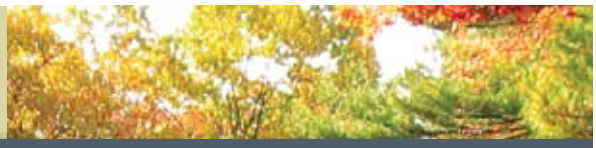
Customer Service
866-355-5999
8 a.m. to 8 p.m. CT Monday through Friday

ActiveCare 2		ActiveCare 3	
Network	**Non-Network**	**Network**	**Non-Network**
No primary care physician required		No primary care physician required	
Preauthorization required	Preauthorization required	Preauthorization required	Preauthorization required
$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 20% after deductible	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 40% after deductible	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 20%	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 20% after deductible	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 40% after deductible	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 20%	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
$30 copay for primary $50 copay for specialist	40% after deductible	$20 copay for primary $30 copay for specialist	40% after deductible
Preauthorization required	Preauthorization required	Preauthorization required	Preauthorization required
$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 20% after deductible	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 40% after deductible	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 20%	$100 copay per day ($500 maximum copay per admission; $1,500 maximum copay per plan year; preauthorization required), plus 40% after deductible
20% after deductible	40% after deductible	20%	40% after deductible
$30 copay for primary $50 copay for specialist (for other services, 20% after deductible)	40% after deductible	$20 copay for primary $30 copay for specialist (20% for other services)	40% after deductible
$50 per person, per plan year		$50 per person, per plan year	
Up to 30-day supply	Up to 30-day supply	Up to 30-day supply	Up to 30-day supply
$10 copay $25 copay* $45 copay*	You will be reimbursed the amount that would have been charged by a network pharmacy less the required copay	$10 copay $25 copay* $40 copay*	You will be reimbursed the amount that would have been charged by a network pharmacy less the required copay
Up to 30-day supply	Up to 30-day supply	Up to 30-day supply	Up to 30-day supply
$15 copay $35 copay* $60 copay*	You will be reimbursed the amount that would have been charged by a network pharmacy less the required copay	$15 copay $35 copay* $55 copay*	You will be reimbursed the amount that would have been charged by a network pharmacy less the required copay
Up to 90-day supply	N/A	Up to 90-day supply	N/A
$20 copay $62.50 copay* $112.50 copay*	N/A	$20 copay $62.50 copay* $100 copay*	N/A
Unlimited	Unlimited	Unlimited	Unlimited

*If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug.

In compliance with SB 0704, 81 (R) Texas Legislature, TRS will make available through Medco Health Solutions, Inc. a retail maintenance network effective September 1, 2010. Retail pharmacies that choose to participate in this network will be able to dispense up to a 90-day supply of medication. Please contact Medco customer service for more information on pharmacies that may choose to participate in the retail maintenance network.

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



FirstCare HEALTH PLANS

Service Area

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

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

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

New county/service area appears in bold.

What's New for 2010–2011? Benefits Changes Effective September 1, 2010

Plan Option	Benefit(s)	Change From	Change To
FirstCare Health Plans	Deductible (medical; per plan year)	$100 per individual	$250 per individual $500 per family
	Out-of-pocket maximum *(does not include deductible)*	$3,500 per individual	$3,000 per individual $6,000 per family
	Maximum lifetime benefit	Unlimited	$2,000,000
	Physician office services	$20 copay for primary care $40 copay for specialists $50 copay per surgical procedure after deductible	$25 copay for primary care $40 copay for specialists 20% after deductible for diagnostic tests 20% after deductible for surgical procedures
	Preventive care	$20 copay	No copay, except $50 copay for colorectal cancer screening/procedure
	Inpatient hospital/facility	$150 copay per day ($750 maximum) after deductible	10% after deductible
	Outpatient services (facility charges, surgical procedures, physician services and diagnostic tests)	$150 copay after deductible	20% after deductible
	Emergency room	$100 copay after deductible (waived if admitted)	20% after deductible (waived if admitted)
	Ambulance	$100 copay after deductible	20% after deductible
	Minor emergency/urgent care	$40 copay after deductible	$75 copay–deductible waived

Other minor benefit changes will be included in the HMO's Evidence of Coverage. For additional information, contact customer service for the HMO.

General Provisions	Primary care physician required to direct care and for benefits to be paid
Deductible (per plan year)	
Individual–You pay	$250
Family–You pay	$500
Out-of-pocket maximum (per plan year; does not include prescription drugs or deductible)	
Individual–You pay	$3,000
Family–You pay	$6,000
Maximum Lifetime Benefit	$2,000,000
Doctor and Lab Services	
Doctor office visits–You pay	$25 for primary care physician; $40 for specialist–deductible waived
Allergy injections–You pay	50% for serum after deductible; 50% for administration after deductible
Office surgery–You pay	20% after deductible
Outpatient surgery–You pay	20% after deductible
Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges)–You pay	$0 physician copay for pre- and post-natal care and delivery
Inpatient doctor visits–You pay	10% after deductible
Contraceptive devices–You pay	20% after deductible
Preventive Care	
Doctor office visits–You pay	No copay–deductible waived Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams and routine mammograms. Other services include well-baby exams, immunizations, hearing exams, and PSA and osteoporosis screenings

FirstCare HEALTH PLANS

Customer Service

800-884-4901

8 a.m. to 6 p.m. CT

Monday through Friday

Online resources from FirstCare Health Plans

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

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

General Provisions	Primary care physician required to direct care and for benefits to be paid
Hospital/Facility Service	
Inpatient hospital and other inpatient charges–You pay	10% after deductible
Outpatient hospital/facilities–You pay	20% after deductible
Emergency room care–You pay	20% (waived if admitted) after deductible
Urgent care services/facility–You pay	$75 per visit–deductible waived
Behavioral Health (Mental Health and Chemical Dependency)	
Mental health	
Inpatient facility–You pay	10% after deductible
Inpatient physician charges–You pay	10% after deductible
Outpatient/office visit–You pay	$40 copay–deductible waived
Chemical dependency	Maximum of three series per lifetime
Inpatient facility–You pay	10% after deductible
Inpatient physician charges–You pay	10% after deductible
Outpatient–You pay	$40 copay–deductible waived
Office visit–You pay	$40 copay–deductible waived
Serious Mental Illness	
Inpatient facility–You pay	10% after deductible
Inpatient physician charges–You pay	10% after deductible
Outpatient/office visit–You pay	$40 copay–deductible waived
Prescription Drugs	
Prescription Drug Deductible (per person, per plan year)	$50
Retail Non-Maintenance Drug	Up to 30-day supply
Generic–You pay Preferred Brand–You pay Non-Preferred Brand–You pay Self-injectable and high technology Preferred–You pay Non-preferred–You pay	$5 copay* $25 copay* $55 copay* 15% 35%
Retail Maintenance Drug (after second fill)	Up to 30-day supply
Generic–You pay Preferred Brand–You pay Non-Preferred Brand–You pay Self-injectable and high technology Preferred–You pay Non-preferred–You pay	$10 copay* $35 copay* $70 copay* 15% 35%
Mail Order	Up to 90-day supply
Generic–You pay Preferred Brand–You pay Non-preferred Brand–You pay Self-injectable and high technology Preferred–You pay Non-preferred–You pay	$15 copay* $75 copay* $165 copay* 15% 35%
Maximum Plan Year Prescription Benefit (*Self-injectable and high technology medications are not subject to this maximum*)	$10,000 per person

*If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug.

SCOTT & WHITE HEALTH PLAN

Texas Friendly

Service Area

48 Texas Counties

(Central Texas)

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

Austin°
Bastrop
Bell
Blanco
Bosque
Brazos
Burleson
Burnet
Caldwell°
Coke°
Coleman°
Concho
Coryell
Crockett
Erath°
Falls
Grimes°
Hamilton
Hays°
Hill
Irion
Kimble°
Lampasas
Lee°
Leon°
Limestone°
Llano°
Madison
Mason°
McCulloch
McLennan
Menard
Milam
Mills
Reagan°
Robertson
Runnels°
San Saba°
Schleicher
Somervell°
Sterling°
Sutton
Tom Green
Travis
Walker°
Waller°
Washington°
Williamson

° **Partial counties covered as follows:**

Austin – All of 77452, 77833, 78931 and 78944. Portions of ZIP codes 77418, 78940 and 78950
Caldwell – All of 78610, 78616, 78622, 78640, 78644, 78655, 78656, 78661 and 78953. Portions of ZIP codes 78648 and 78666
Coke – All of 76905, 76933, 76945, 76949 and 76953. Portions of ZIP code 76506
Coleman – All of 76828, 76834, 76873, 76878, 76882, 76884, 76888, 79519 and 79538. Portions of ZIP codes 76443, 76801, 76823, 76827 and 79510
Erath – All of 76436, 76457 and 76690. Portions of ZIP codes 76401, 76433 and 76446
Grimes – All of 77363, 77830, 77831, 77861, 77868, 77869, 77875 and 77876. Portions of ZIP codes 77356 and 77873
Hays – All of 78610, 78619, 78620, 78640, 78652, 78667, 78676, 78736, 78737 and 78738. Portions of ZIP code 78666
Kimble – All of 76841, 76849, 76854, 76856, 76859 and 76874. Portions of ZIP codes 76883, 78058 and 78631
Lee – All of 76578, 77853, 78621, 78659, 78942, 78947 and 78948. Portions of ZIP code 78946
Leon – All of 77855 and 77871. Portions of ZIP codes 75833, 75850 and 77865
Limestone – All of 76624, 76635, 76642, 76648, 76653, 76664, 76667, 76673, 76678, 76686, 76687 and 75846. Portions of ZIP codes 76693 and 75838
Llano – All of 76831, 76885, 78607, 78609, 78639, 78643, 78657 and 78672. Portions of ZIP code 78624
Mason – All of 76820, 76825, 76842, 76856 and 76869. Portions of ZIP code 78624
Reagan – All of 76932. Portions of ZIP codes 79739 and 79755
Runnels – All of 76821, 76861, 76865, 76875, 76882, 76933, 79519, 79538, 79566 and 79567. Portions of ZIP code 79530
San Saba – All of 76824, 76832, 76871 and 76877. Portions of ZIP code 76872
Somervell – All of 76033, 76043, 76048, 76070, 76077 and 76690. Portions of ZIP code 76433
Sterling – All of 76951. Portions of ZIP code 79720
Walker – All of 77334, 77340, 77341, 77342, 77343, 77344, 77348, 77349 and 77367. Portions of ZIP codes 75862, 77320, 77358 and 77873
Waller – All of 77445 and 77446. Portions of ZIP codes 77423 and 77484
Washington – All of 77426, 77833, 77834, 77835 and 77880. Portions of ZIP codes 77423 and 78946

What's New for 2010–2011? Benefits Changes Effective September 1, 2010

Plan Option	Benefit(s)	Change From	Change To
Scott & White Health Plan	Out-of-pocket maximum	$3,000	$2,000 per individual $6,000 per family
	Office visit	$25 copay for primary care	$20 copay for primary care
	Allergy serum	$25 per vial	20% of charges
	Outpatient surgery	20% of charges	$100 copay plus 20% of charges
	Eye exams, speech/hearing/ physical therapy, education and nutrition counseling	$25 copay	$35 copay
	Outpatient mental health, serious mental illness and alcohol/drug dependency	$25 copay	$35 copay
	Home health services	$25 copay	$35 copay
	Maximum plan year prescription benefit	$4,000 per person	Unlimited

Other minor benefit changes will be included in the HMO's Evidence of Coverage. For additional information, contact customer service for the HMO.

General Provisions	Primary care physician required to direct care and for benefits to be paid
Deductible (per plan year)	
Individual–You pay	None
Family–You pay	None
Out-of-pocket maximum (per plan year)	
Individual–You pay	$2,000 per individual per plan year (does not include pharmacy)
Family–You pay	$6,000 (does not include pharmacy)
Maximum Lifetime Benefit	Unlimited
Doctor and Lab Services	
Primary care office visits–You pay	$20 copay
Specialist office visits–You pay	$35 copay
Allergy injections–You pay	20% of charges
Office surgery–You pay	$100 copay plus 20% of charges
Outpatient surgery–You pay	$100 copay plus 20% of charges
Maternity care (doctor charges)	$20 per primary care visit (maximum $240)/ $35 per specialist visit (maximum $420)
Hospital/facility services for inpatient charges–You pay	$100 copay per day limited to $500 per admission, plus 20% of charges
Inpatient doctor visits–You pay	20% of charges
Contraceptive devices–You pay	20% of charges
Preventive Care	
Doctor office visits–You pay	No copay. Well-baby exams and immunizations (age appropriate). Services limited to one per person per plan year: OB/GYN well-woman exams, screening mammograms, annual physicals, osteoporosis screenings, screening PSA tests and colorectal cancer screenings.

SCOTT & WHITE HEALTH PLAN

Texas Friendly

Customer Service

800-321-7947 or

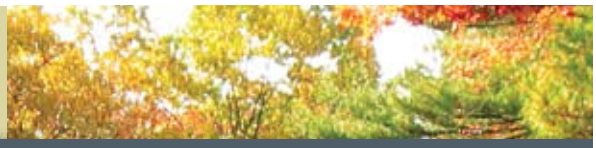
254-298-3000

8 a.m. to 5 p.m. CT

Monday through Friday

General Provisions	Primary care physician required to direct care and for benefits to be paid
Hospital/Facility Service	
Inpatient hospital and other inpatient charges–You pay	$100 copay per day limited to $500 per admission, plus 20% of charges
Outpatient hospital/facilities–You pay	20% of charges
Emergency room care–You pay	$100 copay per visit plus 20% of charges ($100 copay waived if admitted within 24 hours)
Urgent care services/facility–You pay	$40 copay per visit plus 20% of charges
Behavioral Health (Mental Health and Chemical Dependency)	
Mental health	
Inpatient facility–You pay	$100 copay per day limited to $500 per admission, plus 20% of charges
Inpatient physician charges–You pay	20% of charges
Outpatient/office visit–You pay	$35 copay
Chemical dependency	Covered as any other illness
Inpatient facility–You pay	$100 copay per day limited to $500 per admission, plus 20% of charges
Inpatient physician charges–You pay	20% of charges
Outpatient–You pay	20% of charges
Office visit–You pay	$35 copay
Serious Mental Illness	
Inpatient facility–You pay	$100 copay per day limited to $500 per admission, plus 20% of charges
Inpatient physician charges–You pay	20% of charges
Outpatient/office visit–You pay	$35 copay
Prescription Drugs	
Drug deductible (per person, per plan year); applies to brand, non-preferred and non-formulary	$50
Retail	Up to 34-day supply
Generic–You pay Preferred Brand–You pay Non-preferred Brand–You pay Non-Formulary	$5 copay 30% after deductible 50% after deductible Greater of $50 or 50% after deductible
Retail Maintenance (in-plan pharmacies only)	Up to a 90-day supply
Generic–You pay Preferred Brand–You pay Non-preferred Brand–You pay Non-Formulary	$10 copay 30% after deductible 50% after deductible Not available
Mail Order	Up to a 90-day supply
Generic–You pay Preferred Brand–You pay Non-preferred Brand–You pay Non-Formulary	$10 copay 30% after deductible 50% after deductible Not available
Outpatient Specialty Drugs	
Level 1 Level 2 (preferred) Level 3 (premium preferred) Level 4 (non-preferred)	10% of charges 20% of charges 30% of charges 50% of charges; does not count toward out-of-pocket maximum
Maximum Plan Year Prescription Benefit	Unlimited

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



Valley Baptist Health Plans
AN AFFILIATE OF VALLEY BAPTIST HEALTH SYSTEM

Service Area

4 Texas Counties (The Valley)

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

Cameron
Hidalgo
Starr°
Willacy

° **Partial counties covered as follows:**

Starr – All of 78536, 78547, 78548

What's New for 2010–2011? Benefits Changes Effective September 1, 2010

Plan Option	Benefit(s)	Change From	Change To
Valley Baptist Health Plans	Deductible (medical; per plan year)	None	$250 per individual $500 per family
	Out-of-pocket maximum *(does not include deductible)*	$3,000 per individual (hospital only) $6,000 per family (hospital only)	$3,000 per individual $6,000 per family
	Maximum lifetime benefit	Unlimited	$2,000,000 per member
	Inpatient hospital/facility	$300 copay per day ($1,500 maximum)	20% after deductible
	Outpatient services (facility charges, surgical procedures, physician services and diagnostic tests)	$250 copay	20% after deductible
	Emergency room	$150 copay per visit	20% after deductible
	Ambulance	$25 copay per trip	20% after deductible
	Minor emergency/urgent care	$25 copay	$75 copay–deductible waived
	Maximum plan year prescription benefit	Unlimited	$10,000 per individual

Other minor benefit changes will be included in the HMO's Evidence of Coverage. For additional information, contact customer service for the HMO.

General Provisions	Primary care physician required to direct care and for benefits to be paid
Deductible (per plan year)	
Individual–You pay	$250
Family–You pay	$500
Out-of-pocket maximum (per plan year)	
Individual–You pay	$3,000 per member
Family–You pay	$6,000 per member
Maximum Lifetime Benefit	$2,000,000 per member
Doctor and Lab Services	
Doctor office visits–You pay	$25 copay for primary care physician; $35 for specialist
Allergy injections–You pay	50% after deductible
Office surgery–You pay	20% after deductible
Outpatient surgery–You pay	20% after deductible
Maternity care (doctor charges only; see Hospital/Facility Services for inpatient charges)–You pay	$0 copay
Inpatient doctor visits–You pay	20% after deductible
Contraceptive devices–You pay	20% after deductible

Valley Baptist Health Plans
AN AFFILIATE OF VALLEY BAPTIST HEALTH SYSTEM

Customer Service
800-829-6440
8 a.m. to 6 p.m. CT
Monday through Friday

General Provisions	Primary care physician required to direct care and for benefits to be paid
Preventive Care	
Doctor office visits–You pay	$25 for primary care physician office visit copay; $35 for specialist office visit copay (includes all preventive care services billed with an office visit by a network doctor) Services limited to one per person per plan year: routine physicals, OB/GYN well-woman exams, routine mammograms ($0 copay), and eye exams. Other services include well-baby exams, immunizations ($0 copay), hearing exams, and PSA, colorectal cancer, osteoporosis screenings
Hospital/Facility Service	
Inpatient hospital and other inpatient charges–You pay	20% after deductible
Outpatient hospital/facilities–You pay	20% after deductible
Emergency room care–You pay	20% after deductible
Urgent care services/facility–You pay	$75 copay–deductible waived
Behavioral Health (Mental Health and Chemical Dependency)	
Mental health	
Inpatient facility–You pay	20% after deductible
Inpatient physician charges–You pay	20% after deductible
Outpatient/office visit–You pay	$35 copay
Serious Mental Illness	
Inpatient facility–You pay	20% after deductible
Inpatient physician charges–You pay	20% after deductible
Outpatient/office visit–You pay	$35 copay
Prescription Drugs	
Retail	Up to 30-day supply
Generic–You pay Preferred brand–You pay Non-preferred brand–You pay	$10 copay $30 copay* $60 copay*
Mail Order	Up to 90-day supply
Generic–You pay Preferred brand–You pay Non-preferred brand–You pay	$30 copay $60 copay* $180 copay*
Maximum Plan Year Prescription Benefit	$10,000

* If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug.

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

Who can enroll in TRS-ActiveCare?

To be eligible for TRS-ActiveCare, you must be employed by a participating district/entity and be *either* an active, contributing TRS member *or* employed 10 or more regularly scheduled hours each week.

You are **not** eligible for TRS-ActiveCare coverage if you are:

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

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

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

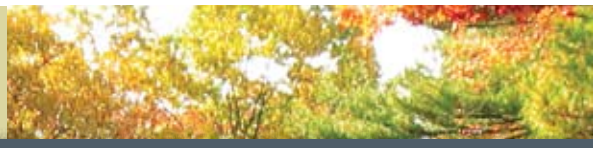
Under Section 22.004, Texas Education Code, an employee who is participating in TRS-ActiveCare is entitled to continue participating in TRS-ActiveCare if the employee resigns after the end of the instructional year. TRS Rule 41.38, Texas Administrative Code, will be applied by TRS-ActiveCare in determining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

Eligible dependents include:

- Your spouse (including a common law spouse)
- An unmarried (including divorced) child under the age of 25, such as:
  - A natural or adopted child
  - A stepchild
  - A foster child
  - A child under the legal guardianship of the employee
  - Another child in a regular parent-child relationship with the employee, meaning:
    - The child's primary residence is the household of the employee;
    - The employee provides at least 50 percent of the child's support;
    - Neither of the child's natural parents resides in that household; and
    - The employee has the legal right to make decisions regarding the child's medical care
- An unmarried grandchild whose primary residence is the household of the employee and who is a dependent of the employee for federal income tax purposes
- An unmarried child of a covered employee, regardless of age, may be eligible for dependent coverage, provided that the child is either mentally or physically incapacitated to such an extent to be dependent on the employee on a regular basis as determined by TRS, and meets other requirements as determined by TRS. Siblings over age 25 or parents are not the children of an employee and do not meet the definition of an eligible dependent.

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

TRS-ActiveCare eligibility audits may be conducted periodically. Audit notifications will be mailed to TRS-ActiveCare plan participants when TRS-ActiveCare needs to verify that participants or their covered dependents meet plan eligibility requirements. Please contact your benefits administrator immediately to submit an *Enrollment Change Form* if you have an ineligible person enrolled in TRS-ActiveCare. During an eligibility audit, you may be asked to provide proof of eligibility for yourself or your covered dependents and, if unsatisfactory, you will have a limited time to cancel coverage for the ineligible person(s) without incurring penalties that may include expulsion under TRS Rules published in the Texas Administrative Code and recovery of paid claims.



Who is eligible for TRS-ActiveCare coverage?

Teachers, administrative personnel, permanent substitutes, bus drivers, librarians, crossing guards, cafeteria workers, and high school or college students are all eligible for coverage, provided no exception applies, if they are employees of the participating district/entity, not volunteers, and are either active contributing TRS members or are employed by a participating district/entity for 10 or more regularly scheduled hours each week. True on-call substitutes, independent contractors, and volunteers are **not** employees and are therefore **not** eligible for TRS-ActiveCare coverage.

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

What is CHIP and is it available to my family?

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

To apply, call TexCare Partnership at 800-647-6558 or log in to **www.texcarepartnership.com**.

Note: A child cannot receive coverage under both TRS-ActiveCare and CHIP.

How to Enroll

Follow these steps to enroll:

1 Choose the health plan option that's right for you.

2 Complete the *Enrollment Application and Change Form* (if required), available from your benefits administrator or on the TRS-ActiveCare Web site. Even if you are not accepting available coverage through TRS-ActiveCare, please complete sections 2 and 9 of the *Enrollment Application and Change Form* and note that you are declining health coverage for yourself and/or your dependents.

3 Submit the completed, signed and dated form to your benefits administrator within the required enrollment period(s).

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

Enroll Now!

The plan enrollment periods for the 2010-2011 plan year are:

- April 19 - May 21 (Spring Enrollment)
- August 1- August 31 (Summer Enrollment)

During the plan enrollment periods, you may select a plan option, make plan changes, and add or delete dependents from your health coverage without a special enrollment event.

Note: You should choose your plan carefully. You may not change plans during a plan year, and there may be restrictions to making plan changes in future plan years.

- If you plan to keep the same TRS-ActiveCare coverage, you do not need to submit an application form, unless you are transferring to a new participating district/entity. *However, a form must be submitted to decline coverage, even if you declined TRS-ActiveCare coverage in 2009-2010.*
- No preexisting exclusions apply for plan or coverage changes you make *unless you previously declined coverage.* (Preexisting condition exclusions do not apply to HMO coverage.)

Enrollment Application Available Online

Type your application online by visiting www.trs.state.tx.us/trs-activecare and completing three steps:

1 Enter your information in the application file

2 Print the application

3 Sign, date and submit the form to your benefits administrator

Who needs to submit an Enrollment Application and Change Form?

- New hires
- Employees already enrolled, but making changes such as:
  - Changing to a different TRS-ActiveCare plan option
  - Adding or dropping dependents
  - Choosing to cancel and/or decline coverage under TRS-ActiveCare
  - Enrolling for TRS-ActiveCare coverage with a different participating district/entity
  - Changing name or address and/or correcting date of birth or Social Security number

Remember, you must submit an *Enrollment Application and Change Form* if you change employment during the plan year and enroll for TRS-ActiveCare coverage with another participating district/entity.

Forms should be returned to your benefits administrator. If you do not return your enrollment form, you will automatically be enrolled in the same plan you elected for 2009-2010 at the same level of coverage. Please pay close attention to any benefit changes from last year as you make your plan choices. Your premium will be adjusted to reflect any rate change that becomes effective on September 1, 2010.

What do I need to do to enroll in TRS-ActiveCare for the first time?

You will need to sign and submit an *Enrollment Application and Change Form* to your benefits administrator before the later of:

- The end of the plan enrollment period
- 31 calendar days after your actively-at-work date
- 31 calendar days after a special enrollment event *(Special rules apply to adding newborns; see page 25 for more information)*

If you are a new hire, you may choose your actively-at-work date (the date you start to work) or the first of the month following your actively-at-work date as your effective date of coverage. If choosing the actively-at-work date, full premium for the month will be due; premiums are not prorated.

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

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

To decline coverage: Complete sections 1, 2 and 9 of the *Enrollment Application and Change Form* to voluntarily decline coverage for yourself and any of your dependents and to provide the reason for declining. Submit the form to your benefits administrator. If you are currently covered by TRS-ActiveCare but want to decline coverage for 2010-2011, you must sign and submit an *Enrollment Application and Change Form* during the plan enrollment period to terminate coverage at the end of the 2009-2010 plan year by checking the boxes for Cancel Enrollee and Decline Coverage for the new plan year.

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

Any decision you make, including the decision not to enroll, stays in effect for the entire plan year, unless you have a special enrollment event.

Making Changes/Special Enrollment Events

The plan options and coverage levels you select during the 2010–2011 plan enrollment periods will remain in effect from September 1, 2010, through August 31, 2011. You cannot add or change covered persons during the year unless you have a special enrollment event (family status change) such as:

- You marry (a common law marriage is not considered a special enrollment event unless there is a certificate of common law marriage filed with an authorized government agency)
- You divorce (if the divorce results in a loss of other coverage)
- A child is born, adopted, or is placed with you for adoption
- A court orders you to provide health coverage for your child (does not apply to court-ordered coverage for a spouse)
- Your school district receives an insurance enrollment notification letter from the Texas Health and Human Services agency, stating that you and/or your dependent(s) qualify for the Health Insurance Premium Reimbursement program (HIPP), available for Medicaid recipients (the type of coverage and premium amount must match the information provided in the notification letter)
- You **involuntarily** lose other health insurance coverage (and you originally declined TRS-ActiveCare coverage in writing because of coverage under another health benefit plan)
- Your eligible dependent **involuntarily** loses other health insurance coverage (and you originally declined TRS-ActiveCare dependent coverage in writing for the individual(s) losing other coverage because of coverage under another health benefit plan). **Note:** You can add the dependent only if you are already covered by ActiveCare 1-HD, 1, 2 or 3. If you live, work or reside in an HMO service area, you and your dependent can enroll in HMO coverage.

TRS-ActiveCare participants may drop TRS-ActiveCare coverage during a plan year, unless restricted from doing so by their district/entity's Section 125 cafeteria plan's rules. Voluntary terminations of other coverage, such as dropping other coverage due to premium or benefit changes, including spousal surcharges or coverage restrictions, are **not** special enrollment events. **Call Customer Service before you make any changes to other coverage you may have.**

The change in coverage must be consistent with the family status change for special enrollment events as defined by TRS-ActiveCare plan rules.

Changes in employee and/or dependent coverage must be made within 31 calendar days after the special enrollment event. *(Special rules apply to adding newborns; see below for more information.)* **It is YOUR responsibility to meet any such deadlines.** If you do not request the appropriate changes during the applicable special enrollment period, the changes cannot be made until the next plan enrollment period or, if applicable, another special enrollment event. A preexisting condition waiting period may apply at that time.

For most special enrollment events, the effective date of coverage will be the first of the month after the event date.

Note: Even if you have a special enrollment event, change employment to another participating district/entity or leave and become re-employed by your same district/entity, **you may not make plan changes** during a plan year unless specifically permitted by TRS Rules. An employee may not add dependents during the plan year unless there is a special enrollment event.

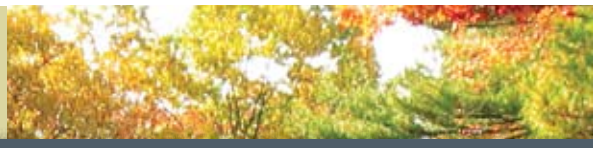
Can coverage be dropped throughout the plan year? Unless restricted due to participation in an Internal Revenue Code Section 125 cafeteria plan, an employee can drop all coverage or drop dependent coverage. If coverage is dropped during the plan year, the individual will not be eligible to re-enroll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

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

How are newborns covered by TRS-ActiveCare?

TRS-ActiveCare automatically provides coverage for a newborn child of a covered employee for the first 31 days after the date of birth. To add coverage for the newborn, you must sign, date and submit an *Enrollment Application and Change Form* to your benefits administrator **within 60 days after the date of birth.** *However, you have up to one year after the newborn's date of birth to add the newborn to coverage if you have employee and family or employee and child(ren) coverage with TRS-ActiveCare at the time of the newborn's birth and at enrollment.* The effective date of coverage is the date of birth. **If the application is submitted after the enrollment period for the newborn child, the request to add coverage will be denied**—even if there would be no change in premium. **Note:** It is not necessary to wait for the newborn's Social Security number. You should submit an *Enrollment Application and Change Form* without the newborn's Social Security number to add coverage and re-submit another form once the number has been issued.

26 Cost for Coverage



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

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

Pooling Funds/Split Premium

Married employees who are both active contributing TRS members may "pool" their local district and state funding to use toward the cost of TRS-ActiveCare coverage.

If a husband and wife both work for a participating entity, funds may be pooled when:

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

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

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

Gross Monthly Cost • 2010–2011 Plan Year Effective September 1, 2010 through August 31, 2011				
PPO Plans	**ActiveCare 1-HD**	**ActiveCare 1**	**ActiveCare 2**	**ActiveCare 3**
Coverage Category	Total Cost*	Total Cost*	Total Cost*	Total Cost*
Employee Only	$262.00	$297.00	$396.00	$533.00
Employee and Spouse	$642.00	$677.00	$901.00	$1,213.00
Employee and Child(ren)	$409.00	$474.00	$630.00	$850.00
Employee and Family	$840.00	$746.00	$991.00	$1,334.00

HMO Plans	FirstCare Health Plans	Scott & White Health Plan	Valley Baptist Health Plans
Coverage Category	Total Cost*	Total Cost*	Total Cost*
Employee Only	$351.36	$456.70	$368.96
Employee and Spouse	$870.48	$1,077.58	$827.32
Employee and Child(ren)	$558.82	$722.39	$579.32
Employee and Family	$874.02	$1,122.36	$907.20

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

Note: *New hires may choose their actively-at-work date (the date they start to work) or the first of the month following their actively-at-work date as their effective date of coverage. If choosing the actively-at-work date, the full premium for the month will be due; premiums are not prorated.*

ActiveCare 1-HD vs. ActiveCare 1

The cost of "employee and family" coverage for ActiveCare 1-HD is correct as shown. "Employee and family" coverage is more expensive for ActiveCare 1-HD than ActiveCare 1 because the deductible and out-of-pocket maximum amounts for family are less and the plan may begin paying benefits sooner. For ActiveCare 1, "employee and family" coverage is less expensive than ActiveCare 1-HD because the deductible and out-of-pocket maximum amounts for family are greater, and it will take longer to accumulate the medical and prescription drug expenses to satisfy these amounts.

ActiveCare 1-HD is not for everyone. Employees should look beyond the premium to ensure the plan's higher deductible and out-of-pocket maximums will meet the employee (and/or family's) needs for health care coverage. For example, there is a $35 cost difference between the premium for "employee only" coverage for ActiveCare 1-HD and ActiveCare 1. The annual savings would be $420, yet the additional deductible amount would be $1,200 and the additional out-of-pocket maximum would be $1,000.

28 Frequently Asked Questions

Enrollment

When does TRS-ActiveCare coverage begin?
The plan options and dependent coverage levels you select during the spring and summer enrollment periods will remain in effect from September 1, 2010, through August 31, 2011. However, for employees of districts/entities who elect to come into TRS-ActiveCare after September 1, 2010, the selected coverage will not go into effect until the district/entity enters TRS-ActiveCare. For example, if your district/entity decides to keep its present health benefit plan coverage until December 31, 2010, your plan options under TRS-ActiveCare will not go into effect until January 1, 2011, and will remain in effect until August 31, 2011.

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

How will TRS-ActiveCare enrollment be handled?
Each participating district/entity will be responsible for enrolling its employees. Your benefits administrator can provide you with information on the location and dates of enrollment meetings, but enrollment is ultimately your responsibility.

Can I enroll my spouse in one plan and myself in another?
No. All dependents must be covered under the same plan option as the employee.

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

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

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

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

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

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

Medical

If my district/entity is new to TRS-ActiveCare and if I have already satisfied my deductible this year with my present health coverage carrier, will I have to satisfy another deductible under my TRS-ActiveCare health plan option?
Deductible and out-of-pocket expense accumulations from your prior health plan will not carry over to your TRS-ActiveCare plan option. This also applies to any expenses accumulated toward the lifetime maximum.

Are there any preexisting condition exclusions?
For ActiveCare 1-HD, 1, 2 and 3, preexisting condition exclusions do not apply to employees that initially enroll when the district/entity begins participating in TRS-ActiveCare or to new hires who enroll within 31 days after their actively-at-work date. **Exception:** If you were covered by TRS-ActiveCare at any point in time since the program's inception in 2002, and have been hired by a different participating district/entity (or rehired by same participating district/entity), preexisting limitation exclusions may apply. Prior creditable coverage may be used to offset a preexisting condition waiting period, unless followed by a gap in coverage of 63 or more consecutive days. A 12-month preexisting condition waiting period may apply to employees or dependents enrolling in ActiveCare 1-HD, 1, 2 or 3 due to:

- A special enrollment event
- A future plan enrollment period as determined by TRS
- A transfer to another participating district/entity (or rehired by same participating district/entity) if the employee or any covered dependent has any remaining preexisting waiting period or a gap in coverage of 63 or more consecutive days.

To receive credit for a preexisting condition waiting period, you must provide information about prior creditable coverage for you

and/or any dependents. If you have a certificate of creditable coverage, attach a copy to your *Enrollment Application and Change Form*. (HMO coverage does not contain preexisting condition exclusions.)

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

If your district/entity is participating in TRS-ActiveCare for the first time in the 2010-2011 plan year, transitional care benefits may be available when you enroll in a health plan option. If you are pregnant or receiving treatment for a serious illness, you may still be able to see your non-network provider for a period of time and receive network benefits for covered services. Log in to the TRS-ActiveCare Web site for information on transitional care for your specific health plan.

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

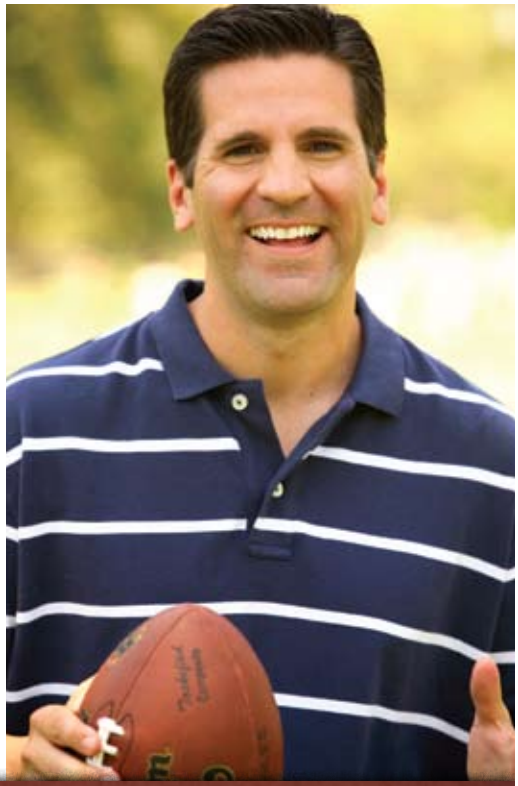
A PCP will be assigned for you. You will be required to use this PCP until the health plan receives a PCP change request from you.

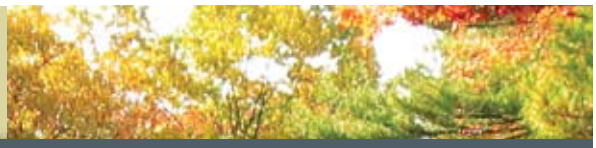
How will my child be covered if he or she is going to college in another city?

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

Do I have health coverage when traveling out of state?

The answer depends on whether you are enrolled in a PPO or HMO plan. **PPO:** If enrolled in ActiveCare 1-HD, 1, 2 or 3, you will receive network benefits when you use Blue Cross and Blue Shield (BCBS) PPO network providers. Although you may choose to use any provider, you will receive benefits at the non-network level if you use a non-network provider. To locate network providers outside of Texas, contact Customer Service. **HMO:** You have worldwide coverage for emergency care. All non-emergency care must be provided by or referred by your primary care physician.





Pharmacy

Do I need a new prescription from my doctor when using the mail order pharmacy service offered by my health plan or will my existing refills be honored?
You will be required to get a new prescription from your doctor before filling your prescription through the mail order service. Additional information on using your mail order (and retail) pharmacy benefits will be provided to you by your health plan prior to your effective date of coverage.

How do I find out if my medication is on the preferred drug list?
You can locate the preferred drug list for the health plan you select on the Web site or by calling Customer Service.

Can I have the brand-name medication my doctor prescribed even if a generic is available?
Yes, you can get the brand-name medication if your doctor specifies "brand necessary" or "brand medically necessary" on the prescription. However, you may pay the generic copayment plus, depending on the plan option you select, a portion of (or all of) the cost difference between the generic and the brand-name drug. See the Benefits Summaries and Plan Comparisons on pages 6 to 19 of this guide for more information.

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

Will I be charged a lower copay for mail service if my prescription order is for less than a 90-day supply?
No, the same copay applies at mail service regardless of day supply. For example, a person who sends in a prescription for a 60-day supply will pay the same copayment as a person who sends in a prescription for a 90-day supply, provided that the cost of the medication is not less than the copay. Be sure to tell your doctor if you will be using mail service so he/she will know to write your prescription for a 90-day supply.

Learn more about the prescription drug benefits administered by Medco for the ActiveCare 1-HD, 1, 2 and 3 PPO plans

How can I find out if my medication is covered?
You can find drug coverage and pricing information at www.trs.state.tx.us/trs-activecare or, once you are enrolled in TRS-ActiveCare, by registering online at www.medco.com to compare prices of medications with the help of My Rx Choices.

How long does it take to get my medications when I use mail order?
First-time orders arrive within eight to 11 days. Refills usually arrive in less time – seven to nine days. At **www.medco.com,** you can review detailed information about when your order will be processed and shipped. The best time to reorder is when you have about a 14-day supply of your medication remaining. This will help ensure that you receive the medication you need, when you need it.

I have seen several $4 and $5 generic medication offerings. How does this coordinate with my prescription benefit?
Medco's claims processing looks at both the Medco discount and what a cash-paying customer would pay at that pharmacy. The lesser of those two amounts is then applied. That being the case, plan participants are encouraged to present their cards as both a safety and cost savings measure. Once the card is presented, the prescription is assessed for possible drug-to-drug interactions, excessive quantity, etc. The amount paid will also be applied to the participant's deductible, if any. If the plan participant fails to show his or hercard, neither of these will happen. Of course, as is the case with any product, consumers are encouraged to shop for the best value for their dollar.

Why is my pill a different color/shape?
Often several manufacturers will offer a generic version of a drug. Medco and retail pharmacies may choose to purchase their generic drugs from different manufacturers. Medco By Mail continually monitors the quality and prices on the drugs being dispensed in order to provide the highest quality, lowest cost version to plan sponsors and their membership. Since pricing and the manufacturers' ability to supply adequate volume may change, Medco has been known to switch generic manufacturers to obtain greater savings. If you have a question about your medication, you should always contact a Medco pharmacist.

Can Medco transfer my prescriptions from a retail pharmacy to Medco By Mail?
You must ask your doctor to provide a new prescription when you request mail order. By law, a 30-day prescription cannot be converted to a 90-day prescription. A new prescription is needed. By asking for a 90-day prescription, this enables your doctor to prescribe the maximum days' supply for your mail order, which is typically 90 days for long-term drugs. That likely is more than your maximum supply at a retail pharmacy. It also gives your doctor an opportunity to review your prescription and make any necessary adjustments.

What if I need to speak with a pharmacist?
Registered Medco pharmacists are available 24 hours a day, seven days a week to answer any questions about your medications. Call the toll-free number located on your TRS-ActiveCare ID card. You can also contact one of our registered pharmacists online at **www.medco.com**.

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

Allowable Amount: The maximum amount that will be allowed for a medical service or supply under ActiveCare 1-HD, 1, 2 and 3 plans (not applicable to HMO plans). The allowable amount is determined by Blue Cross and Blue Shield of Texas based on either charges made for the same service by providers in the same geographic area with similar training, experience, and facilities, or negotiated rates with providers who have contracted with Blue Cross and Blue Shield of Texas. Non-contracting providers (non-network, non-ParPlan providers) may bill you for amounts exceeding the allowable amount. **For dates of service on or after September 1, 2010,** the allowable amount for non-contracting providers is calculated as 50 percent of billed charges.

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

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

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

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

Copayment (Copay): The set amount you pay for certain medical services and prescription drugs at the time of service. Copays do not apply to deductibles or out-of-pocket maximums for the ActiveCare 1-HD, 1, 2 and 3 plans. Copays do apply to the out-of-pocket maximums for the HMO plans, with the exception of pharmacy copays.

Coinsurance: The percentage of medical expenses that you and the plan share. For example, if the network coinsurance amount is "80/20" that means that the plan pays 80% and you pay 20% of the allowable amount for the eligible charges.

Creditable Coverage: Prior health coverage under various plans including, but not limited to, group health plans, individual health policies, Medicare, and Medicaid. Any prior coverage preceding a gap of 63 or more consecutive days without coverage will not be considered to be creditable coverage.

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

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

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

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

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

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

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

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

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

32 Terms to Know

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

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

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

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

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

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

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

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

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

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

Special Enrollment Event: An event as defined by the TRS-ActiveCare or applicable state law that may provide a special enrollment period for individuals and dependents when there is an involuntary loss of other coverage or a gain of additional dependents. See the online Benefits Booklet or the HMO's Evidence of Coverage for details regarding your rights in the event you experience a special enrollment event.

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

Important: This list does not contain all of the limitations and exclusions. The TRS-ActiveCare Benefits Booklet will be available online by September 1, 2010. If you choose an HMO, their Evidence of Coverage will have a complete list and description of plan coverage, limitations and exclusions. For additional information, call your plan's Customer Service number.

What the Plans Do Not Cover

ActiveCare 1-HD, 1, 2 and 3

- As determined by Blue Cross and Blue Shield of Texas, services or supplies that are not medically necessary or any experimental/investigational or unproven services or supplies.
- Charges resulting from the failure to keep a scheduled visit with a physician or other professional provider, for the completion of any insurance forms, or for the acquisition of medical records.
- Vision services or supplies, including but not limited to, orthoptics, vision training, vision therapy, radial keratotomy, contact lenses or the fitting of contact lenses, eyeglasses, photoreflective keratotomy, and LASIK, and INTACS.
- Cosmetic (including reduction mammoplasty), reconstructive, or plastic surgery except as listed in the Benefits Booklet.
- General dental services, including dental appliances (except for appliances as allowed for accidental injury under covered oral surgery).
- Any items of medical/surgical expense incurred for dental surgery except as described in the Benefits Booklet.
- Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease.
- Any services or supplies in connection with foot care for flat feet, fallen arches and chronic foot strain.
- Services or supplies provided for obesity or weight reduction, except for medically necessary treatment of morbid obesity as determined by Blue Cross and Blue Shield of Texas. This exclusion does not apply to condition management or wellness programs provided through Blue Care Connection.
- Services or supplies provided for bariatric surgery except for medically necessary bariatric procedures performed at designated Blue Distinction Centers for Bariatric Surgery.
- Services or supplies provided for injuries sustained as a result of war, declared or undeclared, or any act of war or while on active or reserve duty in the armed forces of any country or international authority.
- Services or supplies provided for treatment or related services to the temporomandibular joint (TMJ), except for medically necessary diagnostic/surgical treatment.
- Services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment, whether or not benefits are or could be provided under Workers' Compensation.
- Items for patient convenience or comfort as determined by Blue Cross and Blue Shield of Texas.
- Any charge for room and board in a private room over the semi-private room rate is not covered unless medically necessary, as determined by Blue Cross and Blue Shield of Texas.
- Dietary and nutritional services or supplies *except* for (1) an inpatient nutritional assessment program provided in and by a hospital and approved by Blue Cross and Blue Shield of Texas, (2) diabetic management services that are provided by a physician and approved by Blue Cross and Blue Shield of Texas, (3) medically necessary dietary supplements required for the treatment of Phenylketonuria (PKU or other heritable diseases, or (4) amino acid-based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins; severe food protein-induced enterocolitis syndromes; eosinophilic disorders, as evidenced by the results of biopsy; and disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract (a prescription order is required).
- Services or supplies provided before the participant's effective date of coverage or after the expiration date of coverage.
- Charges that would not be made if you did not have health insurance or charges that you are not legally required to pay.
- Services or supplies provided by a person, entity, facility or hospital that has not been approved as a network or non-network provider by Blue Cross and Blue Shield of Texas.
- Room and board charges during a hospital admission for diagnostic or evaluative procedures, unless Blue Cross and Blue Shield of Texas determines that inpatient status is medically necessary.
- Marriage and family therapy/counseling, self-therapy, or therapy as a part of training.
- Travel services and accommodations, whether or not recommended or prescribed, except ambulance services.
- Services or supplies provided for, in preparation for, or in conjunction with: sterilization reversal (male or female); transsexual surgery; sexual dysfunction, in vitro fertilization; or promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, transuterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.
- Abortion, unless the participant's life would be endangered by continuing the pregnancy, or there is a diagnosed fetal anomaly, or unless the pregnancy is caused by a criminal act such as rape or incest.
- Transplant procedures which Blue Cross and Blue Shield of Texas considers experimental and/or investigational in nature.

34 Limitations and Exclusions

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Important: This list does not contain all of the limitations and exclusions. The TRS-ActiveCare Benefits Booklet will be available online by September 1, 2010. If you choose an HMO, their Evidence of Coverage will have a complete list and description of plan coverage, limitations and exclusions. For additional information, call your plan's Customer Service number.

ActiveCare 1-HD, 1, 2 and 3 (continued)

- Medical social services, bereavement counseling (except as part of a preauthorized hospice treatment plan), or vocational counseling.
- Environmental sensitivity, clinical ecology, or inpatient allergy testing or treatment.
- Chelation therapy except for treatment of acute metal poisoning.
- Prescription drugs or medicines that are covered under a separate prescription drug program with its own limitations and exclusions. The following are examples of, but is not a complete listing of, categories that are excluded: non-federal legend drugs; ostomy supplies; allergy serums; blood or blood plasma products; implantable contraceptives; experimental drugs; drugs whose sole purpose are to promote or stimulate hair growth (e.g., Rogaine, Propecia) or for cosmetic purposes only (e.g., Renova, Vaniqua); Retin-A/Avita for use by individuals age 35 and over.
- Over-the-counter products, which do not require a prescription.
- Acupuncture, intersegmental traction, surface EMGs, spinal manipulation under anesthesia, and muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph, and Dynatron.
- Any occupational therapy services that do not consist of traditional physical therapy modalities and are not part of a rehabilitation program designed to restore lost or impaired body functions.
- Any portion of a charge for a service or supply that is in excess of the allowable amount as determined by Blue Cross and Blue Shield of Texas, except for emergency services provided by a non-network provider in a network facility within 48 hours of an accident or medical emergency.
- Any services or supplies not specifically defined as eligible expenses, unless pre-approved through case management by Blue Cross and Blue Shield of Texas.
- Services or supplies for custodial care as determined by Blue Cross and Blue Shield of Texas.
- Telemedicine services provided by telephone or fax machine.
- Services or supplies provided by a person who is related to the participant by blood or marriage, such as, but not limited to spouse, child, sibling or self.
- Any services or supplies provided for treatment of adolescent (up to age 18) behavior disorders, including conduct disorders and opposition disorders.
- Services for smoking cessation or nicotine addiction. This exclusion does not apply to condition management or wellness programs provided through Blue Care Connection. (Supplies may be covered through the prescription drug benefit.)
- Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county of municipality, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjuntion with any automobile casualty insurance policy.

Important: This list does not contain all of the limitations and exclusions. The TRS-ActiveCare Benefits Booklet will be available online by September 1, 2010. If you choose an HMO, their Evidence of Coverage will have a complete list and description of plan coverage, limitations and exclusions. For additional information, call your plan's Customer Service number.

FirstCare Health Plans

- Additional expenses incurred as a result of the plan participant's failure to follow a plan provider's medical orders.
- Acupuncture, naturopathy, hypnotherapy or hypnotic anesthesia, Christian Science Practitioner Services or biofeedback; for or in connection with marriage, family, child, career, social adjustment, finances, or medical social services; psychiatric therapy on court order or as a condition of parole or probation; nutritional counseling, except for the treatment and self-management of diabetes; Lifestyle Eating and Performance (LEAP) program.
- Amniocentesis, except when medically necessary.
- Biofeedback services, except for the treatment of acquired brain injury and for rehabilitation of acquired brain injury.
- Comfort or convenience items in a hospital or other inpatient facility.
- Cosmetic, plastic, medical or surgical procedures, and cosmetic therapy and related services or supplies. Any procedure that does not repair a functional disorder; and rhinoplasty and associated surgery.
- Respite or domiciliary care and inpatient or outpatient custodial care.
- Dental treatments, diagnostics, services, appliances, and supplies.
- Charges for the normal delivery of a baby outside our plan's service area if the delivery is within thirty days of your due date.
- Educational testing and therapy, motor or language skills, or services that are educational in nature or are for vocational testing or training.
- Electron beam tomography (EBT).
- Treatments, services or supplies for non-emergency care at an emergency room.
- Non-emergency confinement, treatment, services, or supplies received outside the United States.
- Equine or hippo therapy.
- Experimental or investigational drugs, devices, treatments, or procedures.
- Eyeglasses, contract lenses, except for treatment of keratoconus, and any other items or services for the correction of your eyesight unless specifically covered in the Evidence of Coverage. Vision care services for refractive care.
- Routine foot care.
- Genetic counseling and testing.
- Growth hormone treatment, unless prior authorized.
- All charges for inpatient hospital days that exceed the medically recommended length of stay for the diagnosis.
- Charges for services received as a result of injury or sickness caused by or contributed to by the covered person engaging in an illegal act or occupation; by committing or attempting to commit a crime, criminal act, assault or other felonious behavior; or by a participating in a riot or public disturbance.
- Any services or items for which you have no legal obligation to pay, or for which no charge would ordinarily be made, unless FirstCare has authorized such services in advance, or the care provided was of an emergent or urgent nature.
- Appearance at court hearings and other legal proceedings.
- Massage therapy, unless associated with a physical therapy modality provided by a licensed physical therapist.
- Mastectomy for relief of pain, to prevent breast cancer (except when you have been previously diagnosed with breast cancer), or due to any disease or illness other than for the treatment of breast cancer.
- Inpatient and outpatient treatment, surgery, service, procedures or supplies that are not medically necessary.
- Mental health services for specific conditions. Marriage counseling, court ordered evaluation, diagnosis, and treatment for mental conditions are excluded unless this Evidence of Coverage would otherwise cover such services.
- Implanted neurological stimulators.
- If a service is not covered under the plan, FirstCare will not cover any services that are related to it.
- Nutritional counseling, testing and diet planning.
- Services intended primarily to treat obesity, such as gastric bypasses and balloons, stomach stapling, jaw wire, vertical banding or other treatments for obesity.
- Orthotic devices, except for the treatment of diabetes.
- Orthotripsy and related procedures.
- Intradiscal electrothermal annuloplasty (IDET) procedures for pain management.
- Reduction mammoplasty, except for surgical reconstruction related to treatment of breast cancer.
- Treatment, implanted devices or prosthetics, or surgery related to sexual dysfunction. Sex-change or sex change related services.
- Anti-smoking treatments and programs.
- All surgical procedures for snoring and sleep apnea.
- Sports cords and TENS units.
- Reversal of voluntary sterilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF).

36 Limitations and Exclusions

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

Important: This list does not contain all of the limitations and exclusions. The TRS-ActiveCare Benefits Booklet will be available online by September 1, 2010. If you choose an HMO, their Evidence of Coverage will have a complete list and description of plan coverage, limitations and exclusions. For additional information, call your plan's Customer Service number.

FirstCare Health Plans (continued)

- Temporomandibular joint (TMJ) syndrome.
- Any and all transplants of organs, cells, and other tissues, except for those specifically list in the Evidence of Coverage.
- Services for any work-related injury or illness.
- Circumcision in any male other than a newborn, unless medically necessary.
- PolarCare™ devices for cryotherapy.
- Charges that exceed the non-participating provider reimbursement (NPPR).
- Eyeglasses , contact lenses, orthoptics, vision training, vision therapy, radial keratotomy (RK), automated lamellar keratoplasty (ALK or LK), astigmatic keratotomy (AK), laser vision corrective surgery and photo refractive keratectomy (PRK-laser).
- Long-term rehabilitative services. Long-term is defined as more than two months.
- Elective, non-therapeutic termination of pregnancy, including any abortion medication, except where the life of the mother would be endangered if the fetus were to be carried to term.
- Medications prescribed for non-FDA approved indications, referred to as off-label use.
- Certain medications are subject to dispensing limitations.
- Certain medications are subject to prior authorization.
- Brand-name prescription drugs will not be covered as preferred drugs when a generic equivalent prescription drug is available.
- Prescriptions written in connection with any treatment or service that is not a covered benefit are excluded.
- Appetite suppressants, anti-smoking aids, medications used for cosmetic improvement, uncomplicated nail fungus and hair loss are excluded.
- Any prescription drug for which the actual cost is less than the required copayment is not covered.
- Prescriptions or refills that replace lost, stolen, spoiled, expired, spilled or are otherwise misplaced or mishandled are excluded.
- Prescriptions written for the treatment of infertility are excluded.

Important: This list does not contain all of the limitations and exclusions. The TRS-ActiveCare Benefits Booklet will be available online by September 1, 2010. If you choose an HMO, their Evidence of Coverage will have a complete list and description of plan coverage, limitations and exclusions. For additional information, call your plan's Customer Service number.

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Scott & White Health Plan

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

Valley Baptist Health Plans

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

Important: This list does not contain all of the limitations and exclusions. The TRS-ActiveCare Benefits Booklet will be available online by September 1, 2010. If you choose an HMO, their Evidence of Coverage will have a complete list and description of plan coverage, limitations and exclusions. For additional information, call your plan's Customer Service number.

Valley Baptist Health Plans (continued)

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

Notices

General Notice of Special Enrollment Rights and Preexisting Condition Exclusion

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

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

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

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

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

For further information, contact your benefits administrator.

Special rules apply to newborns; see page 25.

HIPAA Notice of Election of Exemption

Under Title 1 of a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below:

1. Limitations on a preexisting condition exclusion period.
2. Special enrollment periods.
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status.
4. Standards relating to benefits for mothers and newborns.
5. Parity in the application of certain limits to mental health benefits.
6. Required coverage for reconstructive surgery following mastectomies.

However, HIPAA also permits certain self-funded, governmental group health plans to elect to exempt a plan from these requirements for any port of the plan that is "self-funded," rather than provided through a health insurance policy. For the 2010–2011 plan year beginning September 1, 2010, and ending August 31, 2011, the Teacher Retirement System of Texas (TRS) has elected to exempt TRS-ActiveCare 1-HD, TRS-ActiveCare 1, TRS-ActiveCare 2 and TRS-ActiveCare 3 plans from HIPAA provisions 2 and 3 listed above. The election may be renewed for subsequent plan years.

Special enrollment events will be defined by TRS-ActiveCare plan documents rather than HIPAA for the 2010–2011 plan year. This will allow TRS-ActiveCare to continue to apply the same rules and practices as in the past.

TRS-ActiveCare does not currently require health status information in order to enroll in TRS-ActiveCare, with the exception of enrolling an incapacitated child over the age of 25.

This election by TRS to opt TRS-ActiveCare Plans 1-HD, 1, 2 and 3 out of certain HIPAA provisions does not apply to the three insured health maintenance organizations (HMO) participating in TRS-ActiveCare for the 2010-2011 plan year. These HMOs will continue to comply with all the provisions of HIPAA, including those listed in this notice.

HIPAA also requires TRS-ActiveCare 1-HD, TRS-ActiveCare 1, TRS-ActiveCare 2 and TRS-ActiveCare 3 to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under TRS-ActiveCare 1-HD, TRS-ActiveCare 1, TRS-ActiveCare 2 or TRS-ActiveCare 3. There is no exemption from this requirement. The certificate provides evidence that you were covered under TRS-ActiveCare 1-HD, TRS-ActiveCare 1, TRS-ActiveCare 2 or TRS-ActiveCare 3, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another health plan, or if you wish to purchase an individual health insurance policy.

If you have any questions, please contact TRS-ActiveCare at 1000 Red River Street, Austin, Texas 78701-2698 or at **800-223-8778 ext. 6735**.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Federal law requires the Teacher Retirement System of Texas (TRS) to protect the privacy of your health information. Please refer to the Notice of Privacy Practices within the online Benefits Booklet for the PPO plans or within the HMO's Evidence of Coverage documents (also available online) for more information.

Medicare Beneficiaries and Medicare Part D

Effective January 1, 2006, a new Medicare prescription drug plan, called Medicare Part D, now provides Medicare benefits for prescription drugs to those Medicare beneficiaries who enroll in Part D. Medicare Part D is an optional benefit and is available only to individuals who have Medicare Part A and/or Part B. TRS-ActiveCare coverage will not be affected by enrollment in Medicare Part D for these individuals. That is, your TRS-ActiveCare coverage will continue to be your primary coverage; Medicare Part D will be secondary. However, the TRS-ActiveCare plan you have may influence your decision on whether or not to enroll in Medicare Part D. The Centers for Medicare & Medicaid Services (CMS) administers Medicare and a link to their Web site is available on the TRS-ActiveCare page of the TRS Web site: **www.trs.state.tx.us**. If you or your dependent is covered by TRS-ActiveCare and is at least age 65, you will receive additional information on Medicare Part D from TRS (if covered by ActiveCare 1-HD, 1, 2 and 3) or from your HMO plan before the end of the calendar year 2010.

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

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

TRS Group Long Term Care Insurance Program

Did you know 42 percent of people receiving long term care services are under age 65?*

Many people think a long term health event would be covered by their health or disability insurance. Generally, plans like TRS-ActiveCare are not designed to cover long term custodial care costs.

Only long term care insurance is primarily designed to help pay for many of the care services you may need in your own home, in an assisted living or nursing facility.

With the right long term care insurance in place, you can:

- Help protect your family's financial security;
- Have more control over decisions about your custodial care;
- Take comfort knowing that you're confidently moving toward a more secure and independent future.

TRS' group long term care insurance program, underwritten by Genworth Life Insurance Company, can help get you there.

* "Long Term Care Financing Policy Options for the Future." Page 7. Feder, Komisar & Friedland, June 2007; Health Policy Institute, Georgetown University.

Genworth® Financial

To learn more details about this program, including eligibility, costs, benefits and any restrictions that apply:

- Go to **www.genworth.com/trsactivemember**
- Or call **866-659-1970**