IMPORTANT INFORMATION
TO REMEMBER

Later

2018 TRS-Care Standard Plan
for Participants without Medicare

TRS CARE
TEACHER RETIREMENT SYSTEM OF TEXAS

Your Guide to
Making the Most of
Your Health Benefits

This is your guide to making the most of your health care benefits. It equips you with everything you need to use your health plan and ensure you get the most value out of the health care dollars you spend.

Let's get started.

CONTENTS

The Basics

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

In addition, you can expect:

- ☑ No-cost preventive care for your annual wellness visit.
- ☑ The freedom to choose any doctor in the health plan's network, with no referral required.
- ☑ Prescription drug benefits through CVS Caremark, available at local retail pharmacies and by mail order, including no cost for certain generic medications classified as "preventive." See page 22 for more information.
- ☑ A telemedicine service called Teladoc that offers low-cost and convenient doctor visits by phone or computer, 24/7.

DON'T FORGET

The plan year is changing to a calendar year, with the new plan beginning on Jan. 1, 2018 (instead of Sept. 1, 2017), providing you an additional four months to prepare for the transition to your new health plan.

This also means that your deductibles and maximum out-of-pocket amounts will not start over until Jan. 1, 2018.

How the Plan Works

- You pay an annual in-network deductible of $1,500 (or $3,000 for family coverage) for medical care and prescription drug costs (including mental health, skilled home care and chemical dependency) before the plan begins to pay its share of your health care expenses.
- If you use in-network doctors and hospitals for your health care, you benefit from lower costs for the care you receive and the convenience of having your claims filed automatically on your behalf.
- Once you meet your annual in-network deductible, the plan pays 80 percent of your eligible in-network medical and prescription expenses (this is called coinsurance).
- Once you have met your plan maximum out-of-pocket for the year ($5,650 for individual coverage or $11,300 for family when you use in-network providers), the plan pays 100 percent of all your eligible medical and prescription drug expenses.
- **You have a separate deductible for care that you receive from doctors and hospitals that are not in the network.** So think carefully before you choose an out-of-network provider. It will take longer to meet your deductible, and you will not benefit from the plan's lower rates for health care services.

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

Out-of-Pocket Costs

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

Here's an example:

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

QUICK TIP

Take advantage of no-cost prescription drugs.

If you take certain generic medications classified as "preventive," such as a prescription drug used for hypertension, a heart condition or depression, you may receive your medication at no cost to you. It's an important way that TRS is investing in the health of retirees. See page 24 for more information.

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

1

PREMIUMS

This is the set amount you pay each month for your health insurance. Your premium costs do not apply toward your deductible or out-of-pocket maximum. See page 10 for your monthly premium costs.

2

DEDUCTIBLES

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

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

3

COINSURANCE

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

OUT-OF-POCKET MAXIMUM

The good news is that there is a limit on the amount you pay in a single year for health care costs, called your out-of-pocket maximum. After it has been met, the health plan pays 100 percent of your eligible medical and prescription drug costs and continues to pay 100 percent for the remainder of the calendar year. Your out-of-pocket maximum resets annually, just like your deductible.

Your Health Plan in Action

DEDUCTIBLE	COINSURANCE	OUT-OF-POCKET MAXIMUM
$1,500 for individual coverage (in-network)	**You pay 20 percent** (in-network)	**$5,650 for individual coverage** (in-network)
When you go to an in-network doctor or get a prescription drug, you pay the full cost of the service or prescription drug until your covered medical costs reach $1,500.	Once you've paid $1,500 for in-network medical and pharmacy costs, your health plan begins to pay 80 percent of the costs. You pay only 20 percent of your expenses.	Once you've paid $5,650 toward deductibles and coinsurance out of your pocket, the plan pays 100 percent of your costs for the rest of the calendar year.
Example: You visit an allergist and the cost is $150. You pay in full and that amount is subtracted from your deductible.	**Example:** You go in for that same allergist visit and have met your deductible. You pay 20 percent of that cost, or $30. Your TRS-Care plan pays the rest.	**Example:** The allergist says you need outpatient sinus surgery, which costs $30,000. You've already met your $1,500 individual deductible, which counts towards your out-of-pocket maximum. At this point, you'd have to pay the remaining $4,150 in order to meet your out-of-pocket maximum of $5,650, at which point your plan begins to pay 100 percent.
Visit cost: $150	**Visit cost:** $150	**Surgery cost:** $30,000
You pay: $150 **Your remaining deductible:** $1,350	**You pay:** $30 This amount goes towards meeting your out-of-pocket maximum.	**You pay:** $4,120 to meet your out-of-pocket maximum. The plan pays the rest.

POP QUIZ

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

So your cost would be:

A. It's at no cost to you, because it falls under preventive care.

B. It's still $100.

C. It's $20 (20% of the full cost).

C is the right answer. It's not preventive care, because you went in for a specific condition. It's not $100, because you've met your deductible. The cost of this visit, or your share of the coinsurance for this visit would be $20. **Remember, we're talking in-network. Go out of network and you'll pay 40% of whatever that doctor charges (assuming you've met your out-of-network deductible).**

PREMIUMS

Monthly premiums for most non-Medicare retirees in 2018

Retiree only	$200*
Retiree + spouse	$689
Retiree + child(ren)	$408
Retiree + family	$999
Surviving child(ren)	$208

Non-Medicare retirees with disabled children (of any age)**

Retiree + child(ren)	$208
Retiree + family	$799

* For most participants, TRS-Care will no longer offer a $0 premium health plan option for retiree-only coverage. Most retirees will pay $200 for retiree-only coverage beginning Jan. 1, 2018.

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

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

QUICK TIP

Make every health care dollar you spend count.

Medical care can be expensive, with even simple diagnostic procedures costing thousands of dollars. For this reason, it's important that every eligible medical expense is applied to your deductible. The best way to make sure this happens is to use in-network doctors and hospitals because they will file your claim with Aetna, even if your deductible has not been met. In addition, Aetna's in-network doctors have lower, contracted rates—which translates into less money out of your pocket.

At **www.trscarestandardaetna.com**, you can use DocFind to learn if your doctor is in Aetna's network, or to find other providers.

IT PAYS TO STAY IN-NETWORK. REALLY.

If you go out of network, your individual deductible increases to $3,000. And your coinsurance doubles to 40 percent. Not only that, out-of-network expenses don't get applied to your in-network costs. In addition, you may be required to pay the difference between Aetna's discounted rate for the service and the amount the out-of-network hospital or doctor bills.

QUICK TIP

No matter what, it pays to comparison shop for your health care services. Log into Aetna Navigator® by visiting **www.trscarestandardaetna.com** and clicking the "Non-Medicare retiree" button.

PLANNING TO RETIRE DUE TO A DISABILITY?

If you are planning to retire due to a disability, you will pay the premiums listed in the chart on the previous page, depending on whether you cover yourself only or any dependents.

ALREADY RETIRED DUE TO A DISABILITY?

If you retired prior to Jan. 1, 2017, receive TRS disability benefits, and are not eligible for Medicare, you won't pay a premium for retiree-only coverage in the 2018 plan year (Jan. 1 - Dec. 31, 2018). Monthly premiums that cover a spouse or dependent will be reduced by $200. Refer to the "The Fine Print" section on page 30 for more information.

Because TRS has your disability status on file, you do not need to take additional action. Your premiums will be automatically adjusted.

Retiree only	$0
Retiree + spouse	$489
Retiree + child(ren)	$208
Retiree + family	$799

Choosing Your Doctor

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

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

1. Visit the TRS-Care Standard website at **www.trscarestandardaetna.com**.
2. Select **TRS-Care for Non-Medicare Retirees** and then click on **DocFind TRS-Care Provider Directory**.

You can also call TRS-Care Customer Service at **1-800-367-3636** Monday through Friday, 8 a.m. to 5 p.m. CST.

QUICK TIP

Not all doctors are created equal.

So when you're looking for one, take advantage of Aetna's DocFind tool. From cost and quality information for in-network providers to candid reviews from real patients, DocFind is a valuable online tool to help you find the right health care solutions. You can get there from TRS' website as described above or from Aetna's website at **www.trscarestandardaetna.com**.

KNOW YOUR NETWORK

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

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

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

Going to the Doctor

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

An annual wellness visit—provided to you at no cost under your preventive benefits—is a big part of that. This is the yearly opportunity for your doctor to see the big picture of how you're doing and ensure you're symptom-free. If you get a clean bill of health, great. You can then maintain, manage and even improve your health with regular check-ups, following your doctor's advice and taking advantage of complimentary tools and programs available through your health plan.

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

QUICK TIP

TRS-Care coverage includes a no-cost annual wellness visit with your in-network primary care doctor, along with any immunizations and screenings that are appropriate for your age and gender. In addition, you're covered for a no-cost annual flu shot. Women can also get a no-cost well-woman exam with an in-network OB-GYN each year.

SERVICES COVERED AND CONSIDERED PREVENTIVE CARE

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

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

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

HEALTH SERVICES THAT ARE TYPICALLY AT NO COST TO YOU

- Blood pressure screening
- Cholesterol screening
- Annual preventive wellness visit
- Diabetes (Type 2) screening
- Depression screening
- Lung cancer screening
- Routine mammograms

Be sure to visit an in-network primary care provider for these services so that they are 100 percent covered and at no cost to you.

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

POP QUIZ

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

2. The same woman makes quarterly visits to her in-network doctor for blood tests to check her cholesterol level and to confirm the medication dosage level is appropriate.

Which one is preventive and at no cost?
Number one. The office visit and blood test are considered preventive because they're part of an overall wellness exam. The blood tests in option number two are not considered because they are treatment for an existing condition.

Getting Care When You Are Sick or Injured

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

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

GETTING CARE FROM HOME

Connect with a doctor by phone, iPad or computer via Teladoc.

- Call **1-855-Teladoc (1-855-835-2362)**.
- Teladoc doctors diagnose non-emergency medical problems, recommend treatment, call in a prescription to your pharmacy of choice and more.
- Pay a $40 consultation fee.

QUICK TIP

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

RETAIL CLINICS

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

URGENT CARE OR ACUTE CARE CLINICS

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

QUICK TIP

Get familiar with the urgent care and walk-in clinic in your neighborhood before you need one. Visit the TRS-Care Standard website to access the DocFind tool to find out what clinics are in your network.

EMERGENCY ROOM

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

FINDING URGENT CARE AND EMERGENCY ROOMS NEAR YOU

Visit the Aetna website or use the Aetna mobile app to find an urgent care center or emergency room near you. Here's how:

1. Visit **www.aetna.com** or download the **Aetna mobile app**.
2. Click on **Find a Doctor**.
3. Select **Urgent Care Facilities** or **Walk-In Clinics**.

Getting Lab, X-Ray or Other Diagnostic Tests

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

BE A GOOD HEALTH CARE SHOPPER: MRI TESTS

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

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

FROM CLAIMS TO COMPARISON SHOPPING, AETNA NAVIGATOR HAS YOU COVERED.

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

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

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

Staying in the Hospital

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

Hospital prices vary significantly, even when they are in-network. The cost that one hospital charges for a knee replacement may be 50 percent more than another hospital charges—with no difference in the quality of the care you receive. If your doctor practices at more than one hospital, use the Member Payment Estimator tool on Aetna Navigator to check prices first before agreeing on a facility.

Filling a Prescription

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

WHEN YOU NEED TO FILL A PRESCRIPTION

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

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

A. **For short-term prescriptions (up to a 31-day supply),** you can visit any pharmacy in the Caremark retail network (which includes non-CVS pharmacies). To find a network pharmacy,visit **info.caremark.com/trscarestandard**.

B. **You also may use out-of-network pharmacies,** but you may pay more out of your own pocket for your medication. And remember, the cost of your drugs will not apply towards your in-network deductible.

PRESCRIPTION ANSWERS AND INFORMATION ONLINE 24/7

Register with Caremark at **info.caremark.com/trscarestandard**. You can then log in any time to fill or refill long-term prescriptions, find drug coverage and price information, talk with a registered pharmacist, view your prescription history, download the Caremark mobile app and much more.

IF YOU NEED TO FILL AN ONGOING OR "MAINTENANCE" MEDICATION

Save time and energy with these convenient options:

1. **Use the mail-order service, Caremark Pharmacy.** You can order up to a 90-day supply of your medication and have it delivered to any address you provide. You can pay via credit card, check or money order. To learn more about the service, visit **info.caremark.com/trscarestandard**. If you use this option, you can also break up your costs for a 90-day supply into three monthly installments, which may help you manage costs.

2. **Visit a Caremark Retail-Plus pharmacy.** Retail pharmacies that participate in the Retail-Plus network can dispense a 60- to 90-day supply of medication. To find Retail-Plus pharmacies near you, visit **info.caremark.com/trscarestandard** or call CVS Caremark Customer Service at **1-844-345-4577 (TTY: 711)**.

IF YOU NEED TO FILL A SPECIALTY MEDICATION

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

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

Take Advantage of No-Cost Prescription Drugs to Protect Your Health

Your TRS-Care health plan includes full coverage for certain generic drugs classified as "preventive medications." These are drugs that are used to prevent a condition, not treat an existing one. If you are prescribed a medication in one of the classes on the following page, your medication may be on the list and you may be eligible to receive the drug at no cost to you. Be sure and check the list of drugs classified as "preventive" at **info.caremark.com/trscarestandard** to see if your drug is on the list and make the most of this valuable benefit.

QUICK TIP

Find Out If Your Specialty Medication Qualifies For a Discount

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

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

Cardiovascular
Antiarrhythmic agents

Antianginal agents

Coronary artery disease

Antihyperlipidemics and combinations

Diabetes
Antidiabetics

Diabetic diagnostic products and supplies

Hematologic agents
Coagulation factors

Hypertension
ACE inhibitors, ARBs, CCBs

Beta blockers

Diuretics

Antihypertensives and combinations

Immunizing Agents
Vaccines, toxoids, passive

Immunizing agents and biologicals

Mental Health
Antidepressants

Antipsychotics

Osteoporosis
Calcium regulators

Hormone receptor modulators

Preventive Care
Anti-obesity agents

Smoking deterrents

Agents for chemical dependency

Bowel preparations

Respiratory Disorders
Antiasthmatics

Seizure Disorders
Anticonvulsants

Stroke
Anticoagulants

Platelet aggregation inhibitors

Women's Health
Aromatase inhibitors and antiestrogens

Contraceptives

Prenatal vitamins

Various Conditions
Anti-malarial agents

Dental caries prevention

Hereditary angioedema (HAE) agents

Immunosuppressive MS agents

Antiretroviral agents

TOP 4 DRUGS FROM CVS CAREMARK

1. Generic Crestor (rosuvastatin)
2. Generic Benicar (olmesartan)
3. Generic Zetia (ezetimibe)
4. Generic Vytorin (ezetimibe/simvastatin)

Avoiding Unexpected and Unnecessary Expenses

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

TRY TO ALWAYS STAY IN NETWORK

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

SHOP FOR DIAGNOSTIC SERVICES

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

CONSIDER ALTERNATIVES

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

USE GENERIC

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

TRUST. BUT VERIFY.

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

QUICK TIP

When in doubt, call 911 or go to the nearest emergency room. Don't worry. The TRS-Care plan treats all hospitals as in-network when it comes to emergencies.

MEDIATION

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

Saving Money with a Health Savings Account

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

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

PLEASE NOTE

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

HOW AN HSA WORKS

If you decide to open a health savings account, you will need to visit a financial institution that offers HSAs. You will own the account and make all deposits to it. You can make deposits to your HSA account, up to a maximum of $3,450 a year for an individual and $6,900 for a family in 2018 (be aware that the limit changes each year). You can then use the money you deposit to help pay your health care deductible and for most other health care expenses, including dental and vision services. However, because you will likely deduct those deposits from your income taxes and because the money grows tax-free, be certain that you spend these funds only on approved medical costs. If you spend them on other things, you will have to pay both taxes and penalties. For a complete list, go to **www.IRS.gov** and search for Publication 502.

Using the funds in your HSA couldn't be easier. You can either:

A. **Transfer the money from your health savings account to your checking account** to cover the cost of a health care service

B. **Open an account with a bank that offers debit cards with their health savings accounts** and use the HSA debit card to pay for the health care service

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

Another important feature of an HSA—you own the HSA and the money deposited in the account is yours. Unlike a flexible spending account, any money and interest earned that you do not spend will remain in the account and roll over into the next plan year.

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

Who can enroll in TRS-Care?

SERVICE RETIREES

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

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

-OR-

B. you have 30 or more years of service credit in the TRS pension (including purchased service).

Note: Combined service credit under the Proportionate Retirement Program may not be used to establish eligibility for TRS-Care or any type of benefits other than service retirement benefits.

A service retiree is not eligible to enroll in the TRS-Care program if they are eligible for ERS, UT System or A&M System health benefit program coverage.

DISABILITY RETIREES

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

Note: Coverage for a disability retiree with fewer than 10 years of service credit in the TRS pension only continues up to the total amount of service credit. Consequently, coverage for such a disability retiree will end when disability retirement benefits under the TRS pension end.

A disability retiree is eligible to enroll in TRS-Care even if they are eligible for ERS, UT System or A&M System health benefit program coverage.

DEPENDENTS

The following types of dependents are eligible for coverage under your TRS-Care health plan:

A. Your spouse (including a common-law spouse).

B. A child under the age of 26 who is also:
- a natural child;
- an adopted child, or one lawfully placed for adoption;
- a foster child;
- a stepchild; or
- a grandchild who lives with you, depends on you for support, and who you claim for federal income tax purposes.

C. Children (regardless of age) who have a mental disability or physical incapacity to such an extent to be dependent on the retiree or surviving spouse for care and support, as determined by TRS.

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

OTHER SCENARIOS

I am already enrolled in TRS-ActiveCare
TRS-Care (for retirees) is a separate and distinct program from TRS-ActiveCare (for working school employees). When you retire, you must submit an application that tells TRS if you'd like to enroll yourself and your dependents in, or defer enrollment in, TRS-Care. Also be sure to contact your school official to verify your TRS-ActiveCare termination date.

Both spouses are TRS pension retirees
If both spouses are TRS pension retirees, and each meet the TRS-Care eligibility requirements individually, it is okay for each to enroll separately in TRS-Care as individuals, which may be financially advantageous. Feel free to call **1-888-237-6762** for additional information.

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

How to Enroll

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

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

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

When You May Enroll: Initial Enrollment Period

If you are a service retiree, your Initial Enrollment period is the later of:

A. the period that begins on the effective date of your retirement and expires at the end of the last day of the month that is 3 consecutive calendar months, but in no event less than 90 days, after your effective retirement date;

-OR-

B. the period that begins on the last day of the month in which your election to retire is received by TRS and expires at the end of the last day of the month that is 3 consecutive calendar months, but in no event less than 90 days, following the last day of the month in which your election to retire is received by TRS.

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

INITIAL ENROLLMENT PERIOD FOR TRS-CARE

3 consecutive months but no less than 90 days

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

If you are a disability retiree, your Initial Enrollment period begins on the date that your disability retirement is approved by the TRS Medical Board and expires at the end of the last day of the month that is 3 consecutive calendar months, but in no event less than 90 days, after the date that your disability retirement is approved by the TRS Medical Board.

When is my coverage effective?

EFFECTIVE DATE OF COVERAGE

The effective date of coverage will be (1) the first day of the month following your effective date of retirement if TRS receives your TRS-Care Enrollment application (Form TRS 700A) on or before your effective retirement date; or (2) the first day of the month following the receipt of the application for coverage by TRS-Care if your Form TRS 700A is received after your effective retirement date but within your Initial Enrollment period. If you want your coverage to take effect the first of the month after your retirement date, TRS must receive the application before the retirement date.

The same applies for disability retirees.

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

DEFERRING COVERAGE

During your Initial Enrollment period, you may postpone the effective date of your TRS-Care coverage to the first of any of the three months immediately following the month after your retirement date. For example, if your retirement date is May 31, the TRS-Care coverage effective date (normally June 1) may be deferred to July 1, Aug. 1, or Sept. 1. For a deferred effective date, you must write the coverage effective date in the space provided on the Initial Enrollment application (TRS Form 700A). If you have questions about deferring your effective date, please call **1-888-237-6762**.

Special Enrollment Events

Special enrollment events are opportunities to enroll in TRS-Care outside of your Initial Enrollment period. There are two general categories of special enrollment events:

LOSS OF ELIGIBILITY FOR OTHER COVERAGE

If a retiree or surviving spouse loses coverage

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

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

Should you lose coverage with another plan, it will be important to keep your notice of termination letter in order to demonstrate to TRS that the loss of coverage was for a qualifying reason.

Among other possible events, the following do not qualify for a Special Enrollment Event:

- Dropping other coverage because premiums increase
- Termination of coverage for failure to pay your premiums
- Termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the coverage)

If a spouse or other eligible dependent loses coverage

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

NEW DEPENDENTS

A retiree or surviving spouse (enrolled or otherwise eligible for TRS-Care) who acquires an eligible dependent through marriage, birth, adoption, placement for adoption, or guardianship, must notify TRS in writing within 31 days of the date they acquire the eligible dependent, in order for the enrollment to be valid. For example, if an otherwise eligible retiree is not currently enrolled in TRS-Care at the time they get married, the retiree may enroll himself or herself, along with any eligible dependents, during a special enrollment period. However, a surviving spouse may not enroll a new spouse if the surviving spouse remarries. Enrollment will take effect the first of the month after TRS-Care receives the request for enrollment in writing. Documentation is required to establish the eligibility for all new dependents. A common law marriage is not considered a special enrollment event unless there is a Declaration of Common Law Marriage filed with an authorized government agency.

Turning Age 65: A New Enrollment Opportunity

If you're a retiree or surviving spouse who isn't yet 65, and you either terminated TRS-Care or didn't enroll during your Initial Enrollment opportunity, you can enroll in TRS-Care when you turn 65. You may also add eligible dependents at that time. Prior to your 65th birthday, TRS will send a postcard with instructions on how to enroll. To enroll in TRS-Care at 65, you must request an application for TRS-Care (Form 700EO) and submit your application for coverage no later than 31 days from the end of the month in which you turn 65. Call TRS Health and Insurance Benefits at **1-888-237-6762** to request an application.

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

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

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

WHAT SHOULD YOU KNOW?

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

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

WHEN AM I ELIGIBLE FOR MEDICARE?

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

MEDICARE ELIGIBILITY AT AGE 65

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

Keep in mind, **the period for enrolling in the TRS-Care program is shorter than the enrollment period for Medicare**. The enrollment period for Medicare extends for three months after the month of your 65th birthday, but you must submit an application for enrollment in the TRS-Care program (TRS Form 700EO) no later than 31 days from the end of the month in which you turn 65.

MEDICARE ELIGIBILITY DUE TO END STAGE RENAL DISEASE (ESRD)

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

SO WHAT ACTIONS DO YOU NEED TO TAKE?

TRS urges you to:

- ☑ If you're eligible for premium-free Medicare Part A (hospitalization), sign up for it. Likewise, you have the option to purchase Medicare Part A.
- ☑ Purchase Medicare Part B as soon as you can enroll.
- ☑ As soon as you enroll in Medicare, call TRS Health and Insurance Benefits at 1-888-237-6762 to provide your Medicare information. TRS can't enroll you in TRS-Care coverage without your Medicare information.
- ☑ Review the materials in the enrollment kit you receive from TRS.
- ☑ Complete and submit the application for TRS-Care (TRS Form 700EO) no later than 31 days from the end of the month in which you turn 65.

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

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Multi-language Interpreter Services

DISCRIMINATION IS AGAINST THE LAW

The Teacher Retirement System of Texas (TRS) complies with applicable Federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex. TRS provides free aids and services, such as: written information in other formats (large print, audio, accessible electronic formats, other formats), qualified interpreters (including sign language interpreters), and written information in other languages.

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

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

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

FAX: 512-542-6575

EMAIL: section1557coordinator@trs.texas.gov

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

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

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

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

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

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

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

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

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

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

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. اتصل بالرقم 888-237-6762-1 (رقم هاتف الصم والبكم: 711).

اردو: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ 1-888-237-6762 (TTY: 711) پر کال کریں۔

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

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

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

توجه: اگر به فارسی صحبت می‌کنید، تسهیلات زبانی رایگان برای شما فراهم است. با 1-888-237-6762 (TTY: 711) تماس بگیرید.

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

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

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

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-237-6762 (TTY: 711).

Visit us at
www.trs.texas.gov

The TRS-Care program may be changed in the future to provide coverage levels that are different from the levels described in this booklet, or the TRS-Care program may be discontinued. The cost to participants in the TRS-Care program may be changed with the approval of the TRS Board of Trustees. To the extent that any information in this Enrollment Guide is not consistent with or contradicts TRS laws and rules, the TRS laws and rules control. The TRS-Care Benefits Booklet will always control over information in this Enrollment Guide. TRS-Care reserves the right to amend the Benefits Booklet at any time. Generally, such amendments will be reflected in an updated online version of the Benefits Booklet appearing on the TRS website.