PRESIDIO ISD
TRS ACTIVECARE
COST OF COVERAGE
2018-2019

TRS-ActiveCare Plan 1 HD

	Total Cost:	District Cost:	Employee Cost:	Biweekly*1 Deduction:
Employee	367.00	290.00	77.00	38.50
Emp/Spouse	1035.00	290.00	745.00	372.50
Emp/Child(ren)	701.00	290.00	411.00	205.50
Emp/Family	1374.00	290.00	1084.00	542.00

TRS-ActiveCare Select Plan

	Total Cost:	District Cost:	Employee Cost:	Biweekly*1 Deduction:
Employee	540.00	290.00	250.00	125.00
Emp/Spouse	1327.00	290.00	1037.00	518.50
Emp/Child(ren)	876.00	290.00	586.00	293.00
Emp/Family	1668.00	290.00	1378.00	689.00

TRS-ActiveCare Plan 2

	Total Cost:	District Cost:	Employee Cost:	Biweekly*1 Deduction:
Employee	782.00	290.00	492.00	246.00
Emp/Spouse	1855.00	290.00	1565.00	782.50
Emp/Child(ren)	1163.00	290.00	873.00	436.50
Emp/Family	2194.00	290.00	1904.00	952.00

***1 May be tax shelterd under cafeteria plan**

2018-19 TRS-ActiveCare Plan Highlights

Effective Sept. 1, 2018 through Aug. 31, 2019 | In-Network Level of Benefits

TRS ACTIVECARE
TEACHER RETIREMENT SYSTEM OF TEXAS

Medical Coverage	ActiveCare 1-HD	ActiveCare Select or ActiveCare Select Whole Health (Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance)	ActiveCare 2 NOTE: If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan. However, as of Sept. 1, 2018, TRS-ActiveCare 2 is closed to new enrollees.
Deductible (per plan year)			
In-Network	$2,750 employee only/$5,500 family	$1,200 individual/$3,600 family	$1,000 individual/$3,000 family
Out-of-Network	$5,500 employee only/$11,000 family	Not applicable. This plan does not cover out-of-network services except for emergencies.	$2,000 individual/$6,000 family
Out-of-Pocket Maximum (per plan year; medical and prescription drug deductibles, copays, and coinsurance count toward the out-of-pocket maximum)	The individual out-of-pocket maximum only includes covered expenses incurred by that individual.		
In-Network	$6,650 individual/$13,300 family	$7,350 individual/$14,700 family	$7,350 individual/$14,700 family
Out-of-Network	$13,300 individual/$26,600 family	Not applicable. This plan does not cover out-of-network services except for emergencies.	$14,700 individual/$29,400 family
Coinsurance			
In-Network Participant pays (after deductible)	20%	20%	20%
Out-of-Network Participant pays (after deductible)	40% of allowed amount	Not applicable. This plan does not cover out-of-network services except for emergencies.	40% of allowed amount
Office Visit Copay Participant pays	20% after deductible	$30 copay for primary $70 copay for specialist	$30 copay for primary $70 copay for specialist
Diagnostic Lab Participant pays	20% after deductible	20% after deductible	20% after deductible
Preventive Care See below for examples	Plan pays 100%	Plan pays 100%	Plan pays 100%
Teladoc® Physician Services	$40 consultation fee (counts toward deductible and out-of-pocket maximum)	Plan pays 100%	Plan pays 100%
High-Tech Radiology (CT scan, MRI, nuclear medicine) Participant pays	20% after deductible	$100 copay plus 20% after deductible	$100 copay plus 20% after deductible
Inpatient Hospital (preauthorization required) (facility charges) Participant pays	20% after deductible	$150 copay per day plus 20% after deductible ($750 maximum copay per admission)	$150 copay per day plus 20% after deductible ($750 maximum copay per admission; $2,250 maximum copay per plan year)
Freestanding Emergency Room Participant pays	$500 copay per visit plus 20% after deductible	$500 copay per visit plus 20% after deductible	$500 copay per visit plus 20% after deductible
Emergency Room (true emergency use) Participant pays	20% after deductible	$250 copay plus 20% after deductible (copay waived if admitted)	$250 copay plus 20% after deductible (copay waived if admitted)
Outpatient Surgery Participant pays	20% after deductible	$150 copay per visit plus 20% after deductible	$150 copay per visit plus 20% after deductible
Bariatric Surgery Physician charges (only covered if performed at an IOQ facility) Participant pays	$5,000 copay (does apply to out-of-pocket maximum) plus 20% after deductible	Not covered	$5,000 copay (does not apply to out-of-pocket maximum) plus 20% after deductible
Annual Vision Examination (one per plan year; performed by an ophthalmologist or optometrist using calibrated instruments) Participant pays	20% after deductible	$70 copay for specialist	$70 copay for specialist
Annual Hearing Examination Participant pays	20% after deductible	$30 copay for primary $70 copay for specialist	$30 copay for primary $70 copay for specialist

Preventive Care

Some examples of preventive care frequency and services:

- **Routine physicals** – annually age 12 and over
- **Mammograms** – one every year age 35 and over
- **Smoking cessation counseling** – eight visits per 12 months
- **Well-child care** – unlimited up to age 12
- **Colonoscopy** – one every 10 years age 50 and over
- **Healthy diet/obesity counseling** – unlimited to age 22; age 22 and over – 26 visits per 12 months
- **Well woman exam & pap smear** – annually age 18 and over
- **Prostate cancer screening** – one per year age 50 and over
- **Breastfeeding support** – six lactation counseling visits per 12 months

Note: Covered services under this benefit must be billed by the provider as "preventive care." Non-network preventive care is not paid at 100%. If you receive preventive services from a non-network provider, you will be responsible for any applicable deductible and coinsurance under the ActiveCare 1-HD and ActiveCare 2. There is no coverage for non-network services under the ActiveCare Select plan or ActiveCare Select Whole Health.

For a listing of preventive care services, please view the Benefits Booklet at **www.trsactivecareaetna.com** for the latest list of covered services.

TRS-ActiveCare is administered by Aetna Life Insurance Company. Aetna provides claims payment services only and does not assume any financial risk or obligation with respect to claims. Prescription drug benefits are administered by Caremark.

2018-19 TRS-ActiveCare Plan Highlights

Prescription Coverage	ActiveCare 1-HD	ActiveCare Select or ActiveCare Select Whole Health (Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance)	ActiveCare 2 NOTE: If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan. However, as of Sept. 1, 2018, TRS-ActiveCare 2 is closed to new enrollees.
Drug Deductible (per person, per plan year)	Must meet plan-year deductible before plan pays.[2]	$0 generic; $200 brand	$0 generic; $200 brand
Short-Term Supply at a Retail Location (up to a 31-day supply)			
Tier 1 – Generic	20% coinsurance after deductible, except for certain generic preventive drugs that are covered at 100%.[2]	$20 for a 1- to 31-day supply	$20 for a 1- to 31-day supply
Tier 2 – Preferred Brand	20% coinsurance after deductible	$40 for a 1- to 31-day supply[3]	$40 for a 1- to 31-day supply[3]
Tier 3 – Non-Preferred Brand	50% coinsurance after deductible	50% coinsurance for a 1- to 31-day supply[3]	50% coinsurance for a 1- to 31-day supply (Min. $65[4]; Max. $130)[3]
Extended-Day Supply at Mail Order or Retail-Plus Pharmacy Location (60- to 90-day supply)[5]			
Tier 1 – Generic	20% coinsurance after deductible	$45 for a 60- to 90-day supply	$45 for a 60- to 90-day supply
Tier 2 – Preferred Brand	20% coinsurance after deductible	$105 for a 60- to 90-day supply[3]	$105 for a 60- to 90-day supply[3]
Tier 3 – Non-Preferred Brand	50% coinsurance after deductible	50% coinsurance for a 60- to 90-day supply[3]	50% coinsurance for a 60- to 90-day supply (Min. $180[4]; Max. $360)[3]
Specialty Medications (up to a 31-day supply)	20% coinsurance after deductible	20% coinsurance	20% coinsurance (Min. $200[4]; Max. $900)
Short-Term Supply of a Maintenance Medication at Retail Location (up to a 31-day supply) The second time a participant fills a short-term supply of a maintenance medication at a retail pharmacy, they will pay a convenience fee. They will be charged the coinsurance and copays in the row below the second time they fill a short-term supply of a maintenance medication. Participants can avoid paying the convenience fee by filling a larger day supply of a maintenance medication through mail order or at a Retail-*Plus* location.			
Tier 1 – Generic	20% coinsurance after deductible	$35 for a 1- to 31-day supply	$35 for a 1- to 31-day supply
Tier 2 – Preferred Brand	20% coinsurance after deductible	$60 for a 1- to 31-day supply[3]	$60 for a 1- to 31-day supply[3]
Tier 3 – Non-Preferred Brand	50% coinsurance after deductible	50% coinsurance for a 1- to 31-day supply[3]	50% coinsurance for a 1- to 31-day supply (Min. $90[4]; Max. $180)[3]

What is a maintenance medication?
Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

When does the convenience fee apply?
For example, if you are covered under TRS-ActiveCare Select, the first time you fill a 31-day supply of a generic maintenance drug at a retail pharmacy you will pay $20, then you will pay $35 each month that you fill a 31-day supply of that generic maintenance drug at a retail pharmacy. A 90-day supply of that same generic maintenance medication would cost $45, and you would save $225 over the year by filling a 90-day supply.

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

[1] Illustrates benefits when in-network providers are used. For some plans non-network benefits are also available; there is no coverage for non-network benefits under the ActiveCare Select or ActiveCare Select Whole Health Plan; see Enrollment Guide for more information. Non-contracting providers may bill for amounts exceeding the allowable amount for covered services. Participants will be responsible for this balance bill amount, which maybe considerable.

[2] For ActiveCare 1-HD, certain generic preventive drugs are covered at 100%. Participants do not have to meet the deductible ($2,750 – individual, $5,500 – family) and they pay nothing out of pocket for these drugs. Find the list of drugs at **info.caremark.com/trsactivecare**.

[3] If a participant obtains a brand-name drug when a generic equivalent is available, they are responsible for the generic copay plus the cost difference between the brand-name drug and the generic drug.

[4] If the cost of the drug is less than the minimum, you will pay the cost of the drug.

[5] Participants can fill 32-day to 90-day supply through mail order.

Monthly Premiums

TRS-ActiveCare Monthly Premium	TRS-ActiveCare 1-HD			TRS-ActiveCare Select/ ActiveCare Select Whole Health			TRS-ActiveCare 2		
	Full monthly premium*	Premium with min. state/district contribution**	Your monthly premium***	Full monthly premium*	Premium with min. state/district contribution**	Your monthly premium***	Full monthly premium*	Premium with min. state/district contribution**	Your monthly premium***
Individual	$367	$142		$540	$315		$782	$557	
+Spouse	$1,035	$810		$1,327	$1,102		$1,855	$1,630	
+Children	$701	$476		$876	$651		$1,163	$938	
+Family	$1,374	$1,149		$1,668	$1,443		$2,194	$1,969	

* If you are not eligible for the state/district subsidy, you will pay the full monthly premium. Please contact your Benefits Administrator for your monthly premium.

** **The premium after state, $75 and district, $150 contribution is the maximum you may pay per month. Ask your Benefits Administrator for your monthly cost.** (This is the amount you will owe each month after all available subsidies are applied to your premium.)

*** Completed by your benefits administrator. The state/district contribution may be greater than $225.

TRS ActiveCare

Enrollment, Change and Declination Form

ELIGIBILTY:	Are you an active employee and making monthly contributions to TRS? ☐ Yes ☐ No If no, are you regularly scheduled to work 10 or more hours per week? ☐ Yes ☐ No	(If no to both, you are not eligible for TRS ActiveCare coverage)

SECTION 1: ENROLLMENT/CHANGE TRANSACTION TYPE

☐ Annual Enrollment ☐ New Employee ☐ Add Dependent ☐ Special Enrollment

☐ **For New Employee** (check one): ☐ Effective on Actively at Work ☐ Effective 1st day of month following

Life Event Date: __/__/____ ☐ Marriage ☐ Court Order ☐ Birth/Adoption ☐ Loss of Coverage ☐ Other:

Change Only:
☐ Name
☐ Address
☐ Plan/Coverage

Decline Coverage:
☐ Yes (Complete Section 6)
☐ N/A

Effective Date of Change/Cancel
____/____/_____

Cancel Employee
☐ Death
☐ Loss of Eligibility
☐ Retirement/Terminated
☐ Non-Payment
☐ Other: _____

Cancel Dependent
☐ Divorce
☐ Death
☐ Loss of Eligibility
☐ Dropped Coverage
☐ Other: _____

For District Use Only

TRS District #

Actively at Work Date:

Effective/Change Date:

Employer Approval:

_____

Were you covered by another district? ☐ Yes ☐ No

If so, which: _____

SECTION 2: EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	Social Security #:
Mailing Address:	City:	State:	Zip:
Alternative Address:	City:	State:	Zip:
Home Phone Number:	Work Phone Number:	Work Email:	
Date of Birth:	Sex: ☐M ☐F	Language: ☐ English ☐Spanish	Tobacco user: ☐Yes ☐No

Do you have a disability affecting your ability to communicate or read? ☐Yes (Please complete Section 8) ☐ No

Is the Employee Covered By Other Insurance? ☐Yes Carrier/Plan: ☐No

Is the Employee Covered by Medicare? ☐Yes ☐Part A ☐Part B ☐Part C ☐Part D Effective: ☐No

Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐End Stage Renal Disease (ESRD)

SECTION 3: COVERAGE SELECTION (Please select a Plan of Coverage – Plan or HMO - and Coverage Type)

Plan Selection: ☐ActiveCare 1-HD ☐ActiveCare Select ☐ActiveCare Kelsey Select

HMO Selection: ☐FirstCare Health Plans ☐Scott & White Health Plan ☐Blue Essentials Access Plan (formerly Allegian Health Plans)

Coverage Type Selected: ☐Employee Only ☐Employee + Spouse ☐Employee + Child(ren) ☐Employee + Family

SECTION 4: DEPENDENT INFORMATION (Use additional form for additional dependents)

SPOUSE Last Name:	First Name:		MI:
Street Address:			☐Same as Employee
City:	State:	Zip:	Phone Number:
Sex: ☐M ☐F	Date of Birth:	Social Security #:	Tobacco user: ☐Yes ☐No
Other Insurance: ☐Yes. Carrier/Plan	☐No	☐Medicare: ☐Part A ☐Part B ☐Part C	☐Part D
CHILD Last Name:	First Name:		MI:
☐Child ☐Grandchild ☐Disabled	Tobacco user: ☐Yes ☐No	* required for children 18 and older	
Street Address:			☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F	
Other Insurance: ☐Yes. Carrier/Plan	☐No	☐Medicare: ☐Part A ☐Part B ☐Part C	☐Part D
CHILD Last Name:	First Name:		MI:
☐Child ☐Grandchild ☐Disabled	Tobacco user: ☐Yes ☐No	* required for children 18 and older	
Street Address:			☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F	
Other Insurance: ☐Yes. Carrier/Plan	☐No	☐Medicare: ☐Part A ☐Part B ☐Part C	☐Part D

PLEASE CONTINUE ON NEXT PAGE

CHILD Last Name:	First Name:	MI:
☐Child ☐Grandchild ☐Disabled	Tobacco user: ☐ Yes ☐ No	* required for children 18 and older
Street Address:		☐Same as Employee
City: State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F
Other Insurance: ☐Yes. Carrier/Plan	☐No ☐Medicare: ☐Part A ☐Part B	☐Part C ☐Part D
CHILD Last Name:	First Name:	MI:
☐Child ☐Grandchild ☐Disabled	Tobacco user: ☐ Yes ☐ No	* required for children 18 and older
Street Address:		☐Same as Employee
City: State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F:
Other Insurance: ☐Yes. Carrier/Plan	☐No ☐Medicare: ☐Part A ☐Part B	☐Part C ☐Part D

SECTION 5: DISABLED DEPENDENTS OVER AGE 26

☐Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement

Please note that a Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement are required for coverage of a disabled child over age 26. See your Benefits Administrator for the forms, which must be completed in full and submitted to your Benefits Administrator.

SECTION 6: DECLINATION OF COVERAGE

This is to certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage available to me and my dependents and have voluntarily elected to decline the coverage as elected below.

Name:	SSN:	☐Employee	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Spouse	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee

SECTION 7: COVERAGE CONDITIONS

- I am employed by the Employer named in this Enrollment Application and Change Form. I am eligible to participate in the coverage(s) offered by the TRS-ActiveCare program which is administered by Aetna, with HMO benefits provided by SHA, L.L.C. dba FirstCare Health Plan, Scott and White Health Plan, and Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation Health Plans. On behalf of myself and any dependents listed on their Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.
  - If I am enrolling a grandchild in Section 4, I certify that my household is the grandchild's primary residence and the grandchild is my dependent for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.
  - If I am enrolling a child as an "other Child" in Section 4, I certify that my household is the child's primary residence, that I provide at least 50% of the child support, that neither of the children's natural parents reside in my household, and that I have the legal right to make decisions regarding the child's medical care.
- Only those coverage(s) and amount for which I am eligible will be available to me. I understand that if this Enrollment Application and Change Form is accepted, the coverage(s) will become effective in accordance with the provisions or the TRS-ActiveCare program.
- I understand that by enrolling for coverage with Employer named in the Enrollment Application and Change Form that any TRS-ActiveCare coverage I previously elected under another TRS-ActiveCare participating district/entity will be terminated under TRS Rules.
- I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.
- I understand that by declining TRS-ActiveCare coverage now or by terminating TRS-ActiveCare coverage during the plan year, I am not eligible to re-enroll in TRS-ActiveCare until the next plan year, unless I experience a special enrollment event.
- I state that the information given on the Enrollment Application and Change Form is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).

Applicant Signature: ______________________________ Date: ______________

SECTION 8: SPECIAL NOTES REGARDING MY ENROLLMENT **(Please indicate any special information regarding my enrollment for Aetna, Caremark or my selected HMO)**