Important Notices

I. Initial Notice about Special Enrollment Rights and Pre-existing Condition Exclusion Rules in Your Group Health Plan

A federal law called Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. Second, this notice advises you of the plan's pre-existing condition exclusion rules that may temporarily exclude coverage for certain pre-existing conditions that you or a member of your family may have.

A. SPECIAL ENROLLMENT PROVISIONS

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program)
If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other available health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if you move out of an HMO service area, or the employer stops all contributions towards other coverage for you and your dependents). However, you must request enrollment, and Blue Cross and Blue Shield of Texas (BCBSTX) must receive your request, within 31 days after coverage ends for you or your dependents (or you move out of the prior plan's HMO service area, or after the employer stops all contributions toward the other coverage, including employer paid COBRA paid premiums).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under the Texas Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment, and BCBSTX must receive your request, within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

Loss of Coverage as a Result of a Lifetime Limit on All Benefits
You or your spouse or dependents may also have special enrollment rights in this plan at the time a claim is denied by another group health plan as a result of a lifetime limit on all benefits in the other group health plan. However, you must request enrollment, and BCBSTX must receive your request, within 31 days after the claim has been denied by the other group health plan.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption
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 in this plan. However, you must request enrollment, and BCBSTX must receive your request, within 31 days after the marriage, birth*, adoption, or placement for adoption.

*Special rules apply to newborns; refer to your TRS-ActiveCare Benefits Booklet or the HMO's Evidence of Coverage.

Eligibility for State Premium Assistance for Enrollees (HIPP) of Medicaid or a State Children's Health Insurance Program
If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment, and BCBSTX must receive your request, within 60 days after the determination is made concerning eligibility for such assistance for you or your dependents'.

Additional Information
To request special enrollment or obtain more information, call Customer Service at the phone number on the back of your TRS-ActiveCare ID card.

B. PRE-EXISTING CONDITION EXCLUSION RULES

Most health plans impose pre-existing condition exclusions. This means that if you have a medical condition before coming to our plan you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six- month period before your enrollment date. Generally, this six-month period ends the day before your coverage becomes effective. The pre-existing condition exclusion does not apply to pregnancy. Also, pre-existing condition exclusions do not apply to employees that initially enroll when a participating entity begins participating in TRS-ActiveCare or to new hires who enroll within 31 days after their actively-at-work date. However, 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 entity (or rehired by same participating entity), pre-existing limitation exclusions may apply. Finally, the pre-existing condition exclusion rule does not apply to an individual under the age of 19.

This pre-existing condition exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days you had prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage that you have. If you do not have a certificate, but you do have prior health coverage, you have a right to request one from your prior plan or issuers. There are also other ways that you can show that you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

For more information about the pre-existing condition exclusion and creditable coverage rules affecting your plan, call Customer Service at the phone number on the back of your TRS-ActiveCare ID card.

II. Additional Notice

Other federal laws require we notify you of additional provisions of your plan.

NOTICES OF RIGHT TO DESIGNATE A PRIMARY CARE PROVIDER (APPLIES TO PARTICIPATING TRS-ACTIVECARE HMO PLANS)
For plans that require or allow for the designation of primary care providers by participants or beneficiaries: If the plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the applicable network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, call Customer Service at the phone number on the back of your TRS-ActiveCare ID card.

For plans that require or allow for the designation of a primary care provider for a child: For children, you may designate a pediatrician as the primary care provider. For plans that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care

provider: You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following procedures for making referrals. For a list of participating health care professionals who specialize in pediatrics, obstetrics or gynecology, call Customer Service at the phone number on the back of your TRS-ActiveCare ID card.