
Coverage Requirements	Each ESC shall participate in the uniform group coverage program established under Insurance Code Chapter 1579 (TRS-ActiveCare). <i>Insurance Code 1579.151</i>
TRS-ActiveCare	The Teacher Retirement System (TRS) shall implement and administer the TRS-ActiveCare. TRS shall establish plans of group coverages for employees participating in the program and their dependents. <i>Insurance Code 1579.051, .101</i>
Employee Eligibility <i>Full-Time Employees</i>	Participation in TRS-ActiveCare is limited to full-time employees and to part-time employees who are participating members in TRS. A “full-time employee” is a participating TRS member who is currently employed by an ESC in a position that is eligible for membership in TRS and who is not receiving coverage as an employee or retiree from a uniform group insurance or health benefits program under Insurance Code Chapters 1551, 1601, or 1575 (TRS-Care). <i>Insurance Code 1579.202; 34 TAC 41.33(2)</i>
<i>Certain Part-Time Employees</i>	A part-time employee who is not a participating member in TRS is eligible to participate in TRS-ActiveCare only if the employee pays all of the premiums and other costs associated with the health coverage plan selected by the employee. For these purposes, a “part-time employee” is an individual who: <ol style="list-style-type: none">1. Is currently employed by an ESC for ten hours or more each week;2. Is employed in a position that is not eligible for membership in TRS or is not eligible for membership in TRS because of a service or disability retirement; and3. Is not receiving coverage as an employee or retiree from a uniform group insurance or health benefits program under Insurance Code Chapters 1551, 1601, or 1575 (TRS-Care). <i>Insurance Code 1579.204; 34 TAC 41.33(6)</i>
<i>Optional Coverages</i>	ESCs participating in TRS-ActiveCare may enter contracts to provide optional insurance coverages for ESC employees. <i>Education Code 22.004(j)</i>
Cost of Coverage	The cost of coverage under TRS-ActiveCare shall be shared by the state, the ESC, and the employees, as set forth below. <i>Education Code 22.004(c)</i>
State Contribution	The state shall assist employees of participating ESCs in the purchase of group health insurance coverage under Insurance Code 1579 by providing the employing ESC, for each covered employee,

	<p>the amount of \$900 each state fiscal year or an amount as provided by the General Appropriations Act. <i>Insurance Code 1579.251(b)</i></p>
Employee Contribution	<p>An employee covered by the program shall pay that portion of the cost of coverage selected by the employee that exceeds the amount of the state contribution and the ESC's contribution.</p> <p>The ESC may pay any portion of what otherwise would be the employee share of premiums and other costs associated with the coverage selected by the employee.</p> <p><i>Insurance Code 1579.253</i></p>
ESC Required Minimum Effort	<p>The ESC shall, for each fiscal year, pay an amount equal to the number of participating employees multiplied by \$1,800. <i>Insurance Code 1581.052(a)</i></p>
Designation of Compensation for Benefits	<p>An ESC employee who is covered by a cafeteria plan or who is eligible to pay health-care premiums through a premium conversion plan may elect to designate a portion of the employee's compensation to be used as health-care supplementation under Education Code Chapter 22. [See DEA(LEGAL)] <i>Education Code 22.103</i></p>
Use	<p>An employee may use compensation designated for health-care supplementation for any employee benefit, including depositing the designated amount into a cafeteria plan in which the employee is enrolled or using the designated amount for health-care premiums through a premium conversion plan. <i>Education Code 22.106</i></p>
Written Election	<p>Each year, an active employee must elect in writing whether to designate a portion of the employee's compensation to be used as health-care supplementation. An election must be made at the same time that the employee elects to participate in a cafeteria plan, if applicable. <i>Education Code 22.105</i></p>
	<hr/> <p>Note: The following section regarding instructional year only applies to an ESC that provides instruction to students or establishes an instructional year.</p> <hr/>
Continuation Coverage	<p>Notwithstanding any other law, an employee whose resignation is effective after the last day of an instructional year is entitled to participate or be enrolled in TRS ActiveCare or the ESC's group health coverage through the earlier of:</p>
After Resignation Instructional Year	<ol style="list-style-type: none">1. The first anniversary of the date participation in or coverage under TRS ActiveCare or the ESC's group health coverage

was first made available to ESC employees for the last instructional year in which the employee was employed by the ESC; or

2. The last calendar day before the first day of the instructional year immediately following the last instructional year in which the employee was employed by the ESC.

The ESC may not diminish or eliminate its contribution [see ESC Required Minimum Effort, above] before the last date on which the employee is entitled to participation or enrollment.

Education Code 22.004(k), (l), 34 TAC 41.38

Note: The remaining sections apply to all ESCs.

During Military
Leave

An employee who is absent from a position of employment by reason of service in the uniformed services may elect to continue coverage under a health plan. The maximum period of coverage of such a person and the person's dependents shall be the lesser of:

1. The 24-month period beginning on the date on which the person's absence begins; or
2. The day after the date on which the person fails to apply for or return to a position of employment. [See DEBB]

38 U.S.C. 4317(a)

During Family and
Medical Leave

During any period of leave under the Family and Medical Leave Act (FMLA), the ESC shall maintain coverage under any group health plan for the duration of the leave at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of the leave. [See also DEBA] *29 U.S.C. 2614(c); 29 C.F.R. 825.209, .210, .213*

Upon Termination
or Other Qualifying
Event (COBRA)

In accordance with regulations that the Secretary of Health and Human Services shall prescribe, each group health plan that is maintained by any state that receives funds under 42 U.S.C. Chapter 6A, by any political subdivision of such a state, or by any agency or instrumentality of such a state or political subdivision, shall provide, in accordance with 42 U.S.C. Chapter 6A, Subchapter XX, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan

with respect to whom a qualifying event has not occurred. If coverage is modified under the plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan in connection with such group. *42 U.S.C. 300bb-1(a), 300bb-2(1)*

Qualifying Event

“Qualifying event” means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under 42 U.S.C. Chapter 6A, Subchapter XX, would result in the loss of coverage of a qualified beneficiary:

1. The death of the covered employee.
2. The termination, other than by reason of such employee’s gross misconduct, or reduction of hours, of the covered employee’s employment.
3. The divorce or legal separation of the covered employee from the employee’s spouse.
4. The covered employee becoming entitled to benefits under Medicare, 42 U.S.C. 1395 et seq.
5. A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

42 U.S.C. 300bb-3

Period of Coverage

The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

1. In the case of the termination or reduction of hours of a covered employee as described at item 2 at “Qualifying Event” above, the date which is 18 months after the date of the termination or reduction of hours.
2. If a qualifying event occurs during the 18 months after the date of the termination or reduction of hours, the date which is 36 months after the date of the termination or reduction of hours.
3. In the case of a qualifying event other than termination or reduction of hours, the date which is 36 months after the date of the qualifying event.
4. In the case of the termination or reduction of hours of a covered employee as described at item 2 at “Qualifying Event” that occurs less than 18 months after the date the covered employee became entitled to benefits under Medicare, 42

U.S.C. 1395 et seq., the period of coverage for qualified beneficiaries other than the covered employee shall not terminate under this provision before the close of the 36-month period beginning on the date the covered employee became so entitled.

5. In the case of a qualified beneficiary who is determined, under Title II or XVI of the Social Security Act, 42 U.S.C. 401 et seq., 1381 et seq. (the Social Security Act), to have been disabled at any time during the first 60 days of continuation coverage, any reference in item 1 or 2, above, to 18 months is deemed a reference to 29 months with respect to all qualified beneficiaries, but only if the qualified beneficiary has provided notice of such determination under 42 U.S.C. 300bb-6(3) before the end of such 18 months.
6. The date on which the employer ceases to provide any group health plan to any employee.
7. The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.
8. The date on which the qualified beneficiary first becomes, after the date of the election, covered under any other group health plan that satisfies 42 U.S.C. 300bb-2(2)(D)(i), or entitled to benefits under Title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].
9. In the case of a qualified beneficiary who is disabled at any time during the first 60 days of continuation coverage under this subchapter, the month that begins more than 30 days after the date of the final determination under the Social Security Act that the qualified beneficiary is no longer disabled.

42 U.S.C. 300bb-2(2)

Premium

The plan may require payments of a premium for any period of continuation coverage, except that such premium shall not exceed 102 percent applicable premium for such period, and may, at the election of the payor, be made in monthly installments. Individuals entitled to 29 months of continuation coverage may be required to pay premiums not to exceed 150 percent of the usual cost for any month after the 18th month. In no event may the plan require payment of any premium before the day that is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage. *42 U.S.C. 300bb-2(3)*

Notice	The employer of an employee under a group health plan must notify the plan administrator of an employee's death, termination, reduction of hours, or eligibility for Medicare payments within 30 days of the date of the qualifying event. <i>42 U.S.C. 300bb-6(2)(3)</i>
Coverage of Preexisting Conditions	Notwithstanding any other law, group health benefit coverage provided by or offered through the ESC to its employees under any law other than TRS-ActiveCare is subject to the requirements of Insurance Code Sections 1501.102-.105, which limits exclusion for preexisting conditions. This provision applies to all group health benefit coverage provided by or offered through the ESC to its employees, including a standard health benefit plan issued under Insurance Code Chapter 1507 and health and accident coverage provided through a risk pool established under Local Government Code Chapter 172. <i>Education Code 22.004(m)</i>
TRS-ActiveCare	Coverage provided under TRS-ActiveCare may not be made subject to a preexisting condition limitation during the initial period of eligibility. <i>Insurance Code 1579.105</i>
Federal Law	A group health plan may not impose a preexisting condition exclusion. <i>42 U.S.C. 300gg-3(a), 45 C.F.R. 146.111, 147.108</i>
Health Insurance Portability and Accountability Act (HIPAA)	The Public Health Service Act (PHS Act) requirements are the following: <ol style="list-style-type: none">1. Limitations on preexisting condition exclusion periods in accordance with Section 2701 of the PHS Act as codified before enactment of the Affordable Care Act;2. Special enrollment periods for individuals and dependents described under Section 2704(f) of the PHS Act;3. Prohibitions against discriminating against individual participants and beneficiaries based on health status under Section 2705 of the PHS Act, except that the sponsor of a self-funded non-federal governmental plan cannot elect to exempt its plan from requirements under Section 2705(a)(6) and 2705(c) through (f) that prohibit discrimination with respect to genetic information;4. Standards relating to benefits for mothers and newborns under Section 2725 of the PHS Act;5. Parity in mental health and substance use disorder benefits under Section 2726 of the PHS Act;6. Required coverage for reconstructive surgery following mastectomies under Section 2727 of the PHS Act; and

	<p>7. Coverage of dependent students on a medically necessary leave of absence under Section 2728 of the PHS Act.</p>
Exemption Election	<p>A sponsor of a non-federal governmental plan may elect to exempt its plan, to the extent the plan is not provided through health insurance coverage (that is, it is self-funded), from one or more of the requirements described in items 4 through 7, above.</p> <p><i>42 U.S.C. 300gg-21(a)(2); 45 C.F.R. 146.180(a)</i></p>
Form of Election	<p>The election must meet the following requirements:</p> <ol style="list-style-type: none">1. Be made in an electronic format in a form and manner as described by the U.S. Secretary of Health and Human Services in guidance.2. Be made in conformance with all of the plan sponsor's rules, including any public hearing requirements.3. Specify the beginning and ending dates of the period to which the election is to apply. This period is a single specified plan year, as defined in 45 C.F.R. 144.103.4. Specify the name of the plan and the name and address of the plan administrator, and include the name and telephone number of a person the Centers for Medicare and Medicaid Services (CMS) may contact regarding the election.5. State that the plan does not include health insurance coverage, or identify which portion of the plan is not funded through health insurance coverage.6. Specify each requirement described in 45 C.F.R. 146.180(a)(1) of this section from which the plan sponsor elects to exempt the plan.7. Certify that the person signing the election document, including, if applicable, a third-party plan administrator, is legally authorized to do so by the plan sponsor.8. Include, as an attachment, a copy of the notice described in 45 C.F.R. 146.180(f). <p><i>42 U.S.C. 300gg-21(a)(2); 45 C.F.R. 146.180(b)</i></p>
Timing of Election	<p>Absent an extension by the U.S. Department of Health and Human Services CMS for good cause, a plan sponsor or entity acting on behalf of a plan sponsor must file an election with CMS before the first day of the plan year.</p> <p>A plan sponsor may renew an election through subsequent elections.</p> <p><i>42 U.S.C. 300gg-21(a)(2); 45 C.F.R. 146.180(c), (f)</i></p>

Contents of Notice	A plan that makes the election described in these provisions must notify each affected enrollee of the election, and explain the consequences of the election. The notice must be in writing and must be provided to each enrollee at the time of enrollment under the plan, and on an annual basis no later than the last day of each plan year for which there is an election. A plan may meet the notification requirements by prominently printing the notice in a summary plan description, or equivalent description, that it provides to each enrollee at the time of enrollment, and annually. Also, when a plan provides a notice to an enrollee at the time of enrollment, that notice may serve as the initial annual notice for that enrollee. <i>42 U.S.C. 300gg-21(a)(2)(C); 45 C.F.R. 146.180(e)(1)</i>
Privacy of Health Information	To the extent the ESC is a covered entity under the Administrative Simplification provisions of HIPAA, the ESC must maintain the privacy of protected health information in accordance with the Privacy Rule, 45 C.F.R. Part 164, Subpart E. <i>42 U.S.C. Chapter 7, Subchapter XI, Part C.</i>
Definitions	“Covered entity” means:
<i>Covered Entity</i>	<ol style="list-style-type: none">1. A health plan;2. A health-care clearinghouse; or3. A health-care provider who transmits any health information in electronic form in connection with a transaction covered by 45 C.F.R. Chapter A, Subchapter C. <p><i>45 C.F.R. 160.103</i></p>
<i>Protected Health Information</i>	“Protected health information” means individually identifiable health information that is transmitted by electronic media, maintained by electronic media, or transmitted or maintained in any form or medium. “Protected health information” excludes individually identifiable health information in: <ol style="list-style-type: none">1. Education records covered by the Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. 1232g.2. Medical treatment records, as described at 20 U.S.C. 1232g(a)(4)(B)(iv), on a student who is at least 18 years of age.3. Employment records held by a covered entity in its role as employer. <p><i>20 U.S.C. 1232g; 45 C.F.R. 160.103 [See FA]</i></p>

<i>Plan Sponsor</i>	The term “plan sponsor” includes the employer in the case of an employee benefit plan established or maintained by a single employer. <i>29 U.S.C. 1002(16)(B)</i>
Sponsors of Group Health Plans	<p>A group health plan, to disclose protected health information to the plan sponsor or to provide for or permit the disclosure of protected health information to the plan sponsor by a health insurance issuer or health maintenance organization (HMO) with respect to the group health plan, must ensure that the plan documents restrict uses and disclosures of such information by the plan sponsor are consistent with the requirements of the Privacy Rule.</p> <p>The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose summary health information to the plan sponsor, if the plan sponsor requests the summary health information for the purpose of:</p> <ol style="list-style-type: none">1. Obtaining premium bids from health plans for providing health insurance coverage under the group health plan; or2. Modifying, amending, or terminating the group health plan. <p>The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose to the plan sponsor information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the plan.</p> <p><i>45 C.F.R. 164.504(f)</i></p>