2021-2022 TRS-ActiveCare Plan Highlights

EFFECTIVE SEPTEMBER 1, 2021 THROUGH AUGUST 31, 2022 || NETWORK LEVEL OF BENEFITS UNLESS SPECIFIED

Type of Service	ActiveCare HD	ActiveCare Primary	ActiveCare Primary+	Scott & White Health Plan HMO
Provider Network	**BCBS POS / CVS Caremark**	**BCBS HMO / CVS Caremark**	**BCBS HMO / CVS Caremark**	**Scott & White HMO**
PCP/Referral Required	No	Yes	Yes	No
Coverage Area	Nationwide	Statewide	Statewide	Regional
Deductible (per plan year) In-Network Out-of-Network	**$3,000 individual / $6,000 family** $5,500 employee only / $11,000 family	$2,500 individual / $5,000 family N/A	$1,200 individual / $3,600 family N/A	**$1,150 individual / $3,450 family** N/A
Out-of-Pocket Maximum In-Network Out-of-Network (per plan year; includes medical and prescription drug deductibles, copays and	**$7,000 individual / $14,000** $20,250 individual / $40,500 family (the individual out-of-pocket max only includes covered expenses incurred by that individual)	$8,150 individual / $16,300 family N/A	$6,900 individual / $13,800 family N/A	$7,450 individual / $14,900 family N/A
Coinsurance Participant pays after deductible Out-of-Network	**30%** **50% of allowed amount**	30% N/A	20% N/A	20% N/A
Office Visit Copay Participant pays	**30% after ded**	$30 copay for primary $70 copay for specialist	$30 copay for primary $70 copay for specialist	$20 copay for primary ($0 copay for 1st visit and age 19 under) $70 copay for specialist
Diagnostic Lab Participant pays **(preauthorization may apply)**	**30% after ded**	$0 at Office/Independent Lab 30% after ded at outpatient facilities	$0 at Office/Independent Lab 20% after ded at outpatient facilities	$0 (X-ray, blood work) 20% after ded (Imaging)
Preventive Care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Virtual Health Care	$30 consultation fee (applies to ded and out-of-pocket max)	Plan pays 100%	Plan pays 100%	**Plan pays 100%**
High-Tech Radiology (CT scan, MRI, nuclear medicine) Participant pays	**30% after ded**	30% after ded	20% after ded	20% after ded
Inpatient Hospital In-Network Out-of-Network **(preauthorization required)** **(facility charges)**	**30% after ded** **50% after ded ($500 max per**	30% after ded N/A	20% after ded N/A	$150 copay per day + 20% after ded N/A
Urgent Care Centers	**30% after ded**	$50 copay per visit	$50 copay per visit	$50 copay per visit
Freestanding ER	**$500 copay + 30% after ded**	$500 copay + 30% after ded	$500 copay + 20% after ded	$250 copay + 20% after ded
Emergency Room (true emergency use) Participant pays	**30% after ded**	30% after ded	20% after ded	$500 copay + 20% after ded
Outpatient Surgery Participant pays	**30% after ded**	30% after ded	20% after ded	20% after ded
Bariatric Surgery Facility Professional Services	Not covered	30% after ded $5000 copay + 30% after ded Covered only if rendered at a BDC+	20% after ded $5000 copay + 20% after ded Covered only if rendered at a BDC+	Not covered
Vision Examination (one per plan year, performed by an ophthalmologist or optometrist)	**30% after ded**	$70 copay	$70 copay	Plan pays 100%
Hearing Examination (one per plan year)	**30% after ded**	$70 copay	$70 copay	$70 copay
Prescription Drugs Drug deductible (per plan year)	Subject to plan year ded	Subject to plan year ded	$0 for generic drugs $200 per person for brand-name drugs	$0 for generic drugs(ACA Preventive) **$200 per person for brand-name**
Retail Short-Term (up to 31 day supply) Participant pays · Tier 1-Generic · Tier 2-Preferred Brand · Tier 3-Non-Preferred Generic & Brand	 20% after ded[1] 25% after ded 50% after ded	 $15 copay[1] 30% coinsurance 50% coinsurance	 $15 copay 25% coinsurance 50% coinsurance	 (up to 30-day supply) **$10 copay** 30% after Rx ded 50% after Rx ded
Retail Maintenance (after first fill; up to a 31 day supply) Participant pays · Tier 1-Generic · Tier 2-Preferred Brand · Tier 3-Non-Preferred Brand	 20% coinsurance 25% coinsurance 50% coinsurance	 $30 copay[2] 30% coinsurance 50% coinsurance	 $30 copay[2] 25% coinsurance 50% coinsurance	 see below
Mail Order and Retail-Plus (60-90 day supply) Participant pays · Tier 1-Generic · Tier 2-Preferred Brand · Tier 3-Non-Preferred Brand	 20% after ded (ded and coinsurance waived for certain generic preventive drugs.) 25% after ded 50% after ded	 $45 copay 30% coinsurance 50% coinsurance	 $45 copay 25% after drug ded 50% coinsurance	BSWH Pharmacies only $12.50 30% after ded 50% after ded
Specialty Drugs Participant pays	20% after ded (30 day supply limit/fill)	30% after ded 31 day supply limit/fill	20% after ded 31 day supply limit/fill	15% after ded for Tier 1 & 2 25% after ded for Tier 3
Preventive Care Some examples of preventive care: (Covered services must be billed as preventive care. Non-network preventive care is not paid at 100%.)	Routine physicals (annually age 12+) **Mammograms (1/yr age 40+)** Smoking cessation counseling (8 visits/12 months)	Well-child care (unlimited up to age 12) **Colonoscopy (1/10yrs age 50+)** Healthy diet/Obesity counseling (unlimited to age 22; 26 visits/12 months age 22+)	Well woman exam & pap smear (annually age 18+) **Prostate cancer screening (1/yr age 45+)** Breastfeeding support (6 lactation counseling visits/12 months)	

Please visit **www.bcbstx.com/trsactivecare** for the latest list of covered services.

[1]Certain generic preventive drugs are covered at 100%. Check Caremark website for drug list. [2]On 2nd fill of a 1-31 day supply at a retail pharmacy, the participant will be charged a convenience fee. **Bold face type indicates changes from previous year.**