2022-2023 TRS-ActiveCare Plan Highlights

EFFECTIVE SEPTEMBER 1, 2022 THROUGH AUGUST 31, 2023 || NETWORK LEVEL OF BENEFITS UNLESS SPECIFIED

Type of Service	ActiveCare HD	ActiveCare Primary	ActiveCare Primary+	Baylor Scott & White Health Plan HMO	ActiveCare 2 (closed to new enrollees)
Provider Network	**BCBS POS / CVS Caremark**	**BCBS HMO / CVS Caremark**	**BCBS HMO / CVS Caremark**	**Scott & White HMO**	**BCBS POS / CVS Caremark**
PCP/Referral Required	No	Yes	Yes	No	No
Coverage Area	Nationwide	Statewide	Statewide	Regional	Nationwide
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	 **$1,900 individual / $4,750 family** N/A	 $1,000 individual / $3,000 family $2,000 individual / $6,000 family
Out-of-Pocket Maximum In-Network Out-of-Network (per plan year; includes medical and prescription drug deductibles, copays and	 $7,050 individual / $14,100 family $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	 **$8,000 individual / $15,000 family** N/A	 $7,900 individual / $15,800 family $23,700 individual / $47,400 family
Coinsurance Participant pays after deductible Out-of-Network	30% 50% of allowed amount	30% N/A	20% N/A	20% N/A	20% 40% of allowed amount
Office Visit Copay Participant pays	30% after ded	$30 copay for primary $70 copay for specialist	$30 copay for primary $70 copay for specialist	**$15 copay** for primary ($0 copay for 1st visit and age 19 under) $70 copay for specialist	$30 copay for primary $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)	$0 at Office/Independent Lab 20% after ded at outpatient facilities
Preventive Care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Virtual Health Care	**Teledoc: $42 consultation fee / RediMD: $30**	**Teledoc: $12 consultation fee** / RediMD: $0	**Teledoc: $12 consultation fee** / RediMD: $0	MyBSWHealth: $0 / MDLive: $0	**Teledoc: $12 consultation fee** / RediMD: $0
High-Tech Radiology (CT scan, MRI, nuclear medicine) Participant pays	30% after ded	30% after ded	20% after ded	20% after ded	$100 copay + 20% after ded
Inpatient Hospital In-Network Out-of-Network **(preauthorization required)** **(facility charges)**	 30% after ded 50% after ded	 30% after ded N/A	 20% after ded N/A	 $150 copay per day + 20% after ded N/A	 $150 copay per day + 20% after ded 40% after ded ($500/day max)
Urgent Care Centers	30% after ded	$50 copay per visit	$50 copay per visit	**$45 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	$500 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	$250 copay + 20% after ded
Outpatient Surgery Participant pays	30% after ded	30% after ded	20% after ded	20% after ded	$150 copay per visit + 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	 $150 copay per day + 20% after ded $5000 copay + 20% after ded Covered only if rendered at a BDC+
Vision Examination (one per plan year, performed by an ophthalmologist or optometrist)	30% after ded	$70 copay	$70 copay	Plan pays 100%	$70 copay
Hearing Examination (one per plan year)	30% after ded	$30 primary copay / $70 specialist copay	$30 primary copay / $70 specialist copay	$70 copay	$30 primary copay / $70 specialist 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	$0 for generic drugs $200 per person for brand-name drugs
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) **$12 copay** 30% after Rx ded 50% after Rx ded	 $20 copay 25% after drug ded (min $40, Max $80) 50% after ded (min $100, max $200)
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	 $45 copay[1,2] 30% coinsurance 50% coinsurance	 $45 copay[2] 25% coinsurance 50% coinsurance	 see below	 $45 copay 25% after drug ded **(min $105, Max $210)** 50% after ded **(min $205, max $430)**
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 **$30 copay** 30% after ded 50% after ded	 $45 $210) 50% after ded (min $215, max $430)
Specialty Drugs Eligible / Not Eligible thru PrudentRx	 20% after ded (PrudentRx not available)	 **$0 / 30% after ded**	 **$0 / 30% after ded**	**25% after ded for Tier 1 & 2** **35% after ded for Tier 3** (PrudentRx not available)	 $0 / 30% after ded (min $200, max $900

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 35+)** Smoking cessation counseling (8 visits/12 months)

Well-child care (unlimited up to age 12) **Colonoscopy (1/10yrs age 45+)** 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 indicates changes for upcoming year.**