

TRS-ActiveCare 2020-2021 Summary of Benefits

Fully Covered Healthcare Services	
Preventive Services	No Charge
Standard Lab and X-Ray	No Charge
Disease Management and Complex Case Management	No Charge
Well Child Care Annual Exams	No Charge
Immunizations (age appropriate)	No Charge
Nurse Advice Line	1-877-505-7947
Telehealth (MyBSWHealth and MDLIVE)	\$0 copay go to trs.swhp.org
Plan Provisions	
Annual Deductible	\$950 Individual/ \$2,850 Family
Annual out-of-pocket maximum (including medical and prescription co-pays and co-insurance)	\$7,450 Individual/ \$14,900 Family (includes combined Medical and Rx copays, deductibles and coinsurance)
Lifetime Paid Benefit Maximum	None
Outpatient Services	
Primary Care ¹	\$20 Copay First Primary Care Visit for Illness - \$0 Copay ²
Primary Care Dependents ¹ (under age 19)	\$0 Copay ²
After-Hours Primary Care Clinics	\$20 copay
Specialty Care	\$70 copay
Other Outpatient Services	20% after deductible ³
Diagnostic/Radiology Procedures	20% after deductible
Eye Exam (one annually)	No Charge
Allergy Serum & Injections	20% after deductible
Inpatient Services	
Overnight hospital stay; includes all medical services including semi-private room or intensive care	\$150 per day ⁴ and 20% of charges after deductible
Maternity Care	
Prenatal Care	No Charge
Inpatient Delivery	\$150 per day ⁴ and 20% of charges after deductible
Expecting the Best [®] Maternity Program ⁷	No Charge
Equipment and Supplies	
Preferred Diabetic Supplies and Equipment - Rx only	\$5/\$12.50 copay; no deductible
Non-Preferred Diabetic Supplies and Equipment - Rx only	30% after Rx deductible
Durable Medical Equipment/Prosthetics	20% after deductible

Home Health Services											
Home Health Care Visit	\$70 copay										
Worldwide Emergency Care											
Ambulance and Helicopter	\$40 copay and 20% of charges after deductible										
Emergency Room ⁶	\$500 copay after deductible										
Urgent Care Facility	\$50 copay										
Prescription Drugs											
Annual Benefit Maximum	Unlimited										
Rx Deductible per Individual Does not apply to preferred generic drugs	\$150										
Ask an SWHP Pharmacy representative how to save money on your prescriptions.	<table border="1"> <thead> <tr> <th>Retail Quantity (Up to a 30-day supply)</th> <th>Maintenance Quantity (Up to a 90-day supply)</th> </tr> </thead> <tbody> <tr> <td>ACA Preventive*</td> <td>\$0 copay</td> </tr> <tr> <td>Preferred Generic</td> <td>\$5 copay</td> </tr> <tr> <td>Preferred Brand</td> <td>30% after Rx deductible</td> </tr> <tr> <td>Non-Preferred</td> <td>50% after Rx deductible</td> </tr> </tbody> </table> Available at BSW Pharmacies, in-network retail pharmacies and mail order	Retail Quantity (Up to a 30-day supply)	Maintenance Quantity (Up to a 90-day supply)	ACA Preventive*	\$0 copay	Preferred Generic	\$5 copay	Preferred Brand	30% after Rx deductible	Non-Preferred	50% after Rx deductible
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ACA Preventive*	\$0 copay										
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Non-Preferred	50% after Rx deductible										
Online Refills	trs.swhp.org										
Mail Order	BSWH: 1-855-388-3090 OptumRx: 1-855-205-9182										
Specialty Medications (up to a 30-day supply)											
Tier 1	15% after Rx deductible										
Tier 2	15% after Rx deductible										
Tier 3	25% after Rx deductible										
Diagnostic & Therapeutic Services											
Physical and Speech Therapy	\$70 copay										
Manipulative Therapy ⁵	20% without office visit \$40 plus 20% with office visit										
Wellness											
Naturally Slim ⁷	No Charge										
Well-Being Assessment ⁷	No Charge										
Digital Health Coaching ⁷	No Charge										

¹Including all services billed with office visit

²Does not apply to wellness or preventive visits

³Includes other services, treatments, or procedures received at time of office visit

⁴\$750 maximum copay per admission and 20% after deductible

⁵35 visits per year maximum

⁶Copay waived if admitted within 24 hours

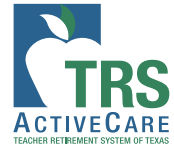
⁷See member guide for additional information

*See list of ACA preventive drugs on the Pharmacy Benefits page at trs.swhp.org.



2020-21 HMO Rates and Benefit Changes

Changes effective September 1, 2020



Coverage Tier/Benefit	2019-2020	2020-2021
Employee Only	\$558.54	\$551.10*
Employee and Spouse	\$1,306.58	\$1,382.06*
Employee and Child(ren)	\$876.76	\$883.50*
Employee and Family	\$1,457.28	\$1,478.56*
Deductible	\$950	\$950
Out-of-Pocket Maximum	Individual - \$7,450 Family - \$14,900	Individual - \$7,450 Family - \$14,900
Copays	Primary care office visit copay \$20; copay for first visit for illness waived, does not apply to wellness or preventive visits; \$0 copay for dependents under 19 for primary care. Specialist copay \$70	Primary care office visit copay \$20; copay for first visit for illness waived, does not apply to wellness or preventive visits; \$0 copay for dependents under 19 for primary care. Specialist copay \$70
Emergency and Urgent Care	Emergency \$500 copay after the deductible. Urgent Care \$50	Emergency \$500 copay after the deductible. Urgent Care \$50
Pharmacy	Group Value Formulary 3-Tier coverage	Group Value Formulary 3-Tier coverage
Telehealth (MyBSWHealth and MDLIVE)	n/a	\$0 copay go to trs.swhp.org

*Full monthly premium represented above do not include district and TRS contributions. Please check with your district for monthly contributions.



Central Texas Region