Scott and White Health Plan
TRS-ActiveCare 2017-2018 Summary of Benefits

Fully Covered Health Care 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
Plan Provisions	
Annual Deductible	**$1,000 Individual/ $3,000 Family**
Annual out-of-pocket maximum (including medical and prescription co-pays and co-insurance)	**$6,550 Individual/ $13,100 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])**
Specialty Care	$50 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
Outpatient Surgery	$150 copay and 20% of charges after deductible
Maternity Care	
Prenatal Care	No Charge
Inpatient Delivery	$150 per day[4] and 20% of charges 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
Diagnostic & Therapeutic Services	
Physical and Speech Therapy	$50 copay
Manipulative Therapy[5]	**20% without office visit $40 plus 20% with office visit**
Equipment and Supplies	
Preferred Diabetic Supplies and Equipment	$5/$10 copay; no deductible
Non-Preferred Diabetic Supplies and Equipment	30% after Rx deductible
Durable Medical Equipment/ Prosthetics	20% after deductible

Home Health Services	
Home Health Care Visit	$50 copay
Worldwide Emergency Care	
Nurse Advice Line	1-877-505-7947
Online Services	No Charge — go to trs.swhp.org
After-Hours Primary Care Clinics	$20 copay
Ambulance and Helicopter	$40 copay and 20% of charges after deductible
Emergency Room[6]	$150 copay and 20% of charges after deductible
Urgent Care Facility	$55 copay
Prescription Drugs	
Annual Benefit Maximum	Unlimited
Rx Deductible Does not apply to preferred generic drugs	$150

Ask an SWHP Pharmacy representative how to save money on your prescriptions.	Retail Quantity (Up to a 30-day supply)	Maintenance Quantity (Up to a 90-day supply) Only at BSW Pharmacies, including Mail Order
Preferred Generic[7]	$5 copay	$10 copay
Preferred Brand[7]	30% after Rx deductible	30% after Rx deductible
Non-Preferred	50% after Rx deductible	50% after Rx deductible
Non-Formulary	Greater of $50 or 50% after Rx deductible	Not available
Online Refills	trs.swhp.org	
Mail Order	1-800-707-3477 or 1-855-388-3090	
Specialty Medications		
(up to a 30-day supply)	20% after Rx deductible	

The SWHP MOMS Program provides you with specialized nurses who are notified of the delivery of your baby. These licensed professionals will contact you after you return home and help you with everything from the general well-being of both you and your baby, to breast/bottle feeding, to information on how to add your baby to your health plan.

[1]Including all services billed with office visit

[2]Does not apply to wellness or preventive visits

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

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

[5]5 visits max per month, 35 max visits per year

[6]Copay waived if admitted within 24 hours

[7]If a brand name drug is dispensed when a generic is available, 50% copay applies

Scott&White HEALTH PLAN

TRS ACTIVECARE TEACHER RETIREMENT SYSTEM OF TEXAS

trs.swhp.org

2017-2018 HMO Rates and Benefit Changes

Changes effective September 1, 2017

Coverage Tier/Benefit	2016-2017	2017-2018
Employee Only	$530.16	$561.04
Employee & Spouse	$1,192.82	$1,263.08
Employee & Child(ren)	$839.16	$888.42
Employee & Family	$1,322.98	$1,400.98
Out-of-Pocket Maximum	Individual - $5,000 Family - $10,000	Individual - $6,550 Family - $13,100
Primary Care Office Visit Copay	$20; copay for first visit for illness waived, does not apply to wellness or preventive visits	No Change
Manipulative Therapy	New benefit; 20% without office visit, $40 plus 20% with office visit (5 visits max per month, 35 max visits per year)	No Change
Prescription Drugs – Deductible	$100 Rx deductible Preferred Generic $3 Copay	$150 Rx deductible Preferred Generic $5 Copay/ Mail order $10
Preferred Diabetic Supplies and Equipment	$3 copay; no deductible	$5 copay; no deductible