2024-25 TRS-ActiveCare Plan Highlights Sept. 1, 2024 – Aug. 31, 2025

How to Calculate Your Monthly Premium

Total Monthly Premium
− Your Employer Contribution

= Your Premium

Ask your Benefits Administrator for your district's specific premiums.

Wellness Benefits at No Extra Cost*

Being healthy is easy with:

- $0 preventive care
- 24/7 customer service
- One-on-one health coaches
- Weight loss programs
- Nutrition programs
- Ovia™ pregnancy support
- TRS Virtual Health
- Mental health benefits
- And much more!

**Available for all plans. See the benefits guide for more details.*

Primary Plans & Mental Health

- Both Primary and Primary+ offer $0 virtual mental health visits with any in-network provider.

All TRS-ActiveCare participants have **three plan options**. Each includes a wide range of wellness benefits.

	TRS-ActiveCare Primary	TRS-ActiveCare Primary+	TRS-ActiveCare HD
Plan Summary	• Lowest premium of all three plans • Copays for doctor visits before you meet your deductible • Statewide network • Primary Care Provider referrals required to see specialists • Not compatible with a Health Savings Account • No out-of-network coverage	• Lower deductible than the HD and Primary plans • Copays for many services and drugs • Higher premium • Statewide network • Primary Care Provider referrals required to see specialists • Not compatible with a Health Savings Account • No out-of-network coverage	• Compatible with a Health Savings Account • Nationwide network with out-of-network coverage • No requirement for Primary Care Providers or referrals • Must meet your deductible before plan pays for non-preventive care

Monthly Premiums	Total Premium	Employer Contribution	Your Premium	Total Premium	Employer Contribution	Your Premium	Total Premium	Employer Contribution	Your Premium
Employee Only	$445	$445	$0	$522	$445	$77	$460	$445	$15
Employee and Spouse	$1,202	$445	$757	$1,358	$445	$913	$1242	$445	$797
Employee and Children	$757	$445	$312	$888	$445	$443	$780	$445	$337
Employee and Family	$1,513	$445	$1068	$1,723	$445	$1278	$1564	$445	$1119

Plan Features				
Type of Coverage	In-Network Coverage Only	In-Network Coverage Only	In-Network	Out-of-Network
Individual/Family Deductible	$2,500/$5,000	$1,200/$2,400	$3,200/$6,400	$6,400/$12,800
Coinsurance	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible
Individual/Family Max Out of Pocket	$8,050/$16,100	$6,900/$13,800	$8,050/$16,100	$20,250/$40,500
Network	Statewide Network	Statewide Network	Nationwide Network	
PCP Required	Yes	Yes	No	

Doctor Visits				
Primary Care	$30 copay	$15 copay	You pay 30% after deductible	You pay 50% after deductible
Specialist	$70 copay	$70 copay	You pay 30% after deductible	You pay 50% after deductible

Immediate Care				
Urgent Care	$50 copay	$50 copay	You pay 30% after deductible	You pay 50% after deductible
Emergency Care	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	
TRS Virtual Health-RediMD™	$0 per medical consultation	$0 per medical consultation	$30 per medical consultation	
TRS Virtual Health-Teladoc®	$12 per medical consultation	$12 per medical consultation	$42 per medical consultation	

Prescription Drugs			
Drug Deductible	Integrated with medical	$200 deductible per participant (brand drugs only)	Integrated with medical
Generics (31-Day Supply/90-Day Supply)	$15/$45 copay; $0 copay for certain generics	$15/$45 copay	You pay 20% after deductible; $0 coinsurance for certain generics
Preferred (Max does not apply if brand is selected and generic is available)	You pay 30% after deductible	You pay 25% after deductible ($100 max)/ You pay 25% after deductible ($265 max)	You pay 25% after deductible
Non-preferred	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Specialty (31-Day Max)	$0 if SaveOnSP eligible; You pay 30% after deductible	$0 if SaveOnSP eligible; You pay 30% after deductible	You pay 20% after deductible
Insulin Out-of-Pocket Costs	$25 copay for 31-day supply; $75 for 61-90 day supply	$25 copay for 31-day supply; $75 for 61-90 day supply	You pay 25% after deductible

Compare Prices for Common Medical Services

REMEMBER: Call a Personal Health Guide 24/7 to help you find the best price for a medical service. Reach them at **1-866-355-5999**.

Benefit	TRS-ActiveCare Primary	TRS-ActiveCare Primary+	TRS-ActiveCare HD		TRS-ActiveCare 2	
	In-Network Only	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Labs**	Office/Indpendent Lab: You pay $0 Outpatient: You pay 30% after deductible	Office/Indpendent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	Office/Indpendent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 40% after deductible
High-Tech Radiology	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible + $100 copay per procedure	You pay 40% after deductible + $100 copay per procedure
Outpatient Costs	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible ($150 facility copay per incident)	You pay 40% after deductible ($150 facility copay per incident)
Inpatient Hospital Costs	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible ($500 facility per day maximum)	You pay 20% after deductible ($150 facility copay per day)	You pay 40% after deductible ($500 facility copay per incident)
Freestanding Emergency Room	You pay $500 copay + 30% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 30% after deductible	You pay $500 copay + 50% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 40% after deductible
Bariatric Surgery	Facility: You pay 30% after deductible Professional Services: You pay $5,000 copay + 30% after deductible Only covered if rendered at a BDC+ facility	Facility: You pay 20% after deductible Professional Services: You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility	Not Covered	Not Covered	Facility: You pay 20% after deductible ($150 facility copay per day) Professional Services: You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility	Not Covered
Annual Vision Exam (one per plan year; performed by an ophthalmologist or optometrist)	You pay $70 copay	You pay $70 copay	You pay 30% after deductible	You pay 50% after deductible	You pay $70 copay	You pay 40% after deductible
Annual Hearing Exam (one per plan year)	$30 PCP copay $70 specialist copay	$15 PCP copay $70 specialist copay	You pay 30% after deductible	You pay 50% after deductible	$30 PCP copay $70 specialist copay	You pay 40% after deductible

***Pre-certification for genetic and specialty testing may apply. Contact a PHG at **1-866-355-5999** with questions.*

www.trs.texas.gov

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