



*TRS-ActiveCare*  
**REGION 11**

**LEARN THE TERMS**

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- **PREMIUM:** The monthly amount you pay for health care coverage.
- **DEDUCTIBLE:** The annual amount for medical expenses you're responsible to pay before your plan begins to pay.
- **COPAY:** The set amount you pay for a covered service at the time you receive it. The amount can vary based on the service.
- **COINSURANCE:** The portion you're required to pay for services after you meet your deductible. It's often a specified percentage of the costs; e.g., you pay 20% while the health care plan pays 80%.
- **OUT-OF-POCKET MAXIMUM:** The maximum amount you pay each year for medical costs. After reaching the out-of-pocket maximum, the plan pays 100% of allowable charges for covered services.

# 2025-26 TRS-ActiveCare Plan Highlights Sept. 1, 2025 – Aug. 31, 2026



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

This plan is closed and not accepting new enrollees. If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan.

## How to Calculate Your Monthly Premium

- Total Monthly Premium
- − Your Employer Contribution

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- − 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.

	TRS-ActiveCare Primary	TRS-ActiveCare Primary+	TRS-ActiveCare HD
Plan Summary	<ul style="list-style-type: none"> <li>• Lowest premium of all three plans</li> <li>• Copays for doctor visits before you meet your deductible</li> <li>• Statewide network</li> <li>• Primary Care Provider referrals required to see specialists</li> <li>• Not compatible with a Health Savings Account</li> <li>• No out-of-network coverage</li> </ul>	<ul style="list-style-type: none"> <li>• Lower deductible than the HD and Primary plans</li> <li>• Copays for many services and drugs</li> <li>• Higher premium</li> <li>• Statewide network</li> <li>• Primary Care Provider referrals required to see specialists</li> <li>• Not compatible with a Health Savings Account</li> <li>• No out-of-network coverage</li> </ul>	<ul style="list-style-type: none"> <li>• Compatible with a Health Savings Account</li> <li>• Nationwide network with out-of-network coverage</li> <li>• No requirement for Primary Care Providers or referrals</li> <li>• Must meet your deductible before plan pays for non-preventive care</li> </ul>

Monthly Premiums	Total Premium	Employer Contribution	Your Premium	Total Premium	Employer Contribution	Your Premium	Total Premium	Employer Contribution	Your Premium
Employee Only	\$554	\$505	\$49.00	\$650	\$505	\$145.00	\$570	\$505	\$65.00
Employee and Spouse	\$1,496	\$505	\$991.00	\$1,690	\$505	\$1,185.00	\$1,539	\$505	\$1,034.00
Employee and Children	\$942	\$505	\$437.00	\$1,105	\$505	\$600.00	\$969	\$505	\$464.00
Employee and Family	\$1,884	\$505	\$1,379.00	\$2,145	\$505	\$1,640.00	\$1,938	\$505	\$1,433.00

TRS-ActiveCare 2
<ul style="list-style-type: none"> <li>• Closed to new enrollees</li> <li>• Current enrollees can choose to stay in plan</li> <li>• Lower deductible</li> <li>• Copays for many services and drugs</li> <li>• Nationwide network with out-of-network coverage</li> <li>• No requirement for Primary Care Providers or referrals</li> </ul>

Total Premium	Employer Contribution	Your Premium
\$1,013	\$505	\$508.00
\$2,402	\$505	\$1,897.00
\$1,507	\$505	\$1,002.00
\$2,841	\$505	\$2,336.00

Plan Features	In-Network Coverage Only	In-Network Coverage Only	In-Network	Out-of-Network
Type of Coverage	Individual/Family Deductible	\$2,500/\$5,000	\$1,200/\$2,400	\$3,300/\$6,600
Coinsurance	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible
Individual/Family Maximum Out of Pocket	\$8,050/\$16,100	\$6,900/\$13,800	\$8,300/\$16,600	\$20,500/\$41,000
Network	Statewide Network	Statewide Network	Nationwide Network	
PCP Required	Yes	Yes	No	

In-Network	Out-of-Network
\$1,000/\$3,000	\$2,000/\$6,000
You pay 20% after deductible	You pay 40% after deductible
\$7,900/\$15,800	\$23,700/\$47,400
Nationwide Network	
No	

Doctor Visits	Primary Care	Specialist	In-Network	Out-of-Network
Primary Care	\$30 copay	\$70 copay	\$15 copay	You pay 30% after deductible
Specialist	\$70 copay	\$12 per medical consultation	\$70 copay	You pay 50% after deductible

In-Network	Out-of-Network
\$30 copay	You pay 40% after deductible
\$70 copay	You pay 40% after deductible

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

In-Network	Out-of-Network
\$50 copay	You pay 40% after deductible
You pay a \$250 copay plus 20% after deductible	\$0 per medical consultation
\$0 per medical consultation	\$12 per medical consultation

Prescription Drugs	Drug Deductible	Generic (31-Day Supply/90-Day Supply)	Preferred (Max does not apply if brand is selected and generic is available)	Non-preferred	Specialty (31-Day Max)	Insulin Out-of-Pocket Costs
Integrated with medical	\$200 deductible per participant (brand drugs only)	\$15/\$45 copay; \$0 copay for certain generics	You pay 30% after deductible	You pay 50% after deductible	\$0 if SaveOnSP eligible; you pay 30% after deductible	\$25 copay for 31-day supply; \$75 for 61-90 day supply
Integrated with medical	\$200 deductible per participant (brand drugs only)	\$15/\$45 copay	You pay 25% after deductible (\$100 max/ You pay 25% after deductible (\$265 max)	You pay 50% after deductible	\$0 if SaveOnSP eligible, You pay 30% after deductible	\$25 copay for 31-day supply; \$75 for 61-90 day supply
Integrated with medical	\$200 deductible per participant (brand drugs only)	\$15/\$45 copay	You pay 25% after deductible (\$100 min/\$80 max/ You pay 25% after deductible (\$105 min/\$210 max)	You pay 50% after deductible (\$100 min/\$200 max/ You pay 50% after deductible (\$215 min/\$430 max)	\$0 if SaveOnSP eligible; You pay 30% after deductible (\$200 min/\$900 max/ No 90-day supply of specialty medications	\$25 copay for 31-day supply; \$75 for 61-90 day supply
Integrated with medical	\$200 deductible per participant (brand drugs only)	\$15/\$45 copay	You pay 25% after deductible (\$100 min/\$80 max/ You pay 25% after deductible (\$105 min/\$210 max)	You pay 50% after deductible (\$100 min/\$200 max/ You pay 50% after deductible (\$215 min/\$430 max)	\$0 if SaveOnSP eligible; You pay 30% after deductible (\$200 min/\$900 max/ No 90-day supply of specialty medications	\$25 copay for 31-day supply; \$75 for 61-90 day supply

In-Network	Out-of-Network
\$200 brand deductible	\$200 brand deductible
\$20/\$45 copay	\$20/\$45 copay
You pay 25% after deductible (\$40 min/\$80 max/ You pay 25% after deductible (\$105 min/\$210 max)	You pay 25% after deductible (\$40 min/\$80 max/ You pay 25% after deductible (\$105 min/\$210 max)
You pay 50% after deductible (\$100 min/\$200 max/ You pay 50% after deductible (\$215 min/\$430 max)	You pay 50% after deductible (\$100 min/\$200 max/ You pay 50% after deductible (\$215 min/\$430 max)
\$0 if SaveOnSP eligible; You pay 30% after deductible (\$200 min/\$900 max/ No 90-day supply of specialty medications	\$0 if SaveOnSP eligible; You pay 30% after deductible (\$200 min/\$900 max/ No 90-day supply of specialty medications
\$25 copay for 31-day supply; \$75 for 61-90 day supply	\$25 copay for 31-day supply; \$75 for 61-90 day supply

# 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/Independent Lab: You pay \$0	Office/Independent Lab: You pay \$0	You pay 30% after deductible	You pay 50% after deductible	Office/Independent Lab: You pay \$0	You pay 40% after deductible
	Outpatient: You pay 30% after deductible	Outpatient: You pay 20% after deductible			Outpatient: You pay 20% 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	Facility: You pay 20% after deductible	Not Covered	Not Covered	Facility: You pay 20% after deductible (\$150 facility copay per day)	Not Covered
	Professional Services: You pay \$5,000 copay + 30% after deductible	Professional Services: You pay \$5,000 copay + 20% after deductible			Professional Services: You pay \$5,000 copay + 20% after deductible	
	Only covered if rendered at a BDC+ facility	Only covered if rendered at a BDC+ facility			Only covered if rendered at a BDC+ facility	
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.