



TRS-ActiveCare

# REGION-10

*Except Arlington ISD*

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## LEARN THE TERMS

- **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%.
- **TIERING:** Grouping doctors and facilities into tiers based on quality, cost and best practice clinical guidelines. This helps you compare choices. Tier 1 providers and facilities offer top performance and best value. You pay less when you choose Tier 1 and may pay more when you choose Tier 2.
- **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.

# 2026-27 TRS-ActiveCare Plan Highlights

Sept. 1, 2026 – Aug. 31, 2027



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

## How to Calculate Your Monthly Premium

Total Monthly Premium  
➖ Your Employer Contribution

⌘ Your Premium

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

## Being Healthy is Easy

- \$0 preventive services
- One-on-one health coaches
- Weight loss programs and nutrition
- TRS Virtual Health
- Member Rewards is even better. Now you'll get a check when you use Member Rewards and choose low-cost, high-quality doctors and facilities – up to \$599\* per tax year.
- Airrosti Remote Recovery gives you in-home virtual physical therapy to relieve common aches and pains at no cost.\*

*\* Eligibility rules may apply.*

See the [Annual Enrollment Guide](#) for more details.

## Mental Health

You have in-office and virtual benefits:

- TRS-ActiveCare Primary Plan: \$30 copay for office visits or \$0 with Teladoc
- TRS-ActiveCare Primary+ Plan: \$15 copay for office visits or \$0 with Teladoc
- TRS-ActiveCare HD Plan: 30% coinsurance after deductible or \$42 with Teladoc
- TRS-ActiveCare 2 Plan: \$20 copay for office visits or \$12 with Teladoc

|              | TRS-ActiveCare Primary                                                                                                                                                                                                                                                                                                                                         | TRS-ActiveCare Primary+                                                                                                                                                                                                                                                                                                                                                                            | TRS-ActiveCare HD                                                                                                                                                                                                                                                                                                                                        |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Plan Summary | <ul style="list-style-type: none"><li>• Lowest premium of the three available 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>• Highest premium of the three available plans</li><li>• Copays for many services and drugs</li><li>• Lower deductible than the HD and Primary plans</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>• Higher premium of the three available plans</li><li>• Must meet your deductible before plan pays for non-preventive care</li><li>• Nationwide network with out-of-network coverage</li><li>• No requirement for Primary Care Providers or referrals</li><li>• Compatible with a Health Savings Account</li></ul> |

| Monthly Premiums      | Total Premium | Employer Contribution | Your Premium | Total Premium | Employer Contribution | Your Premium | Total Premium | Employer Contribution | Your Premium |
|-----------------------|---------------|-----------------------|--------------|---------------|-----------------------|--------------|---------------|-----------------------|--------------|
| Employee Only         | \$614         |                       |              | \$722         |                       |              | \$628         |                       |              |
| Employee and Spouse   | \$1,658       |                       |              | \$1,878       |                       |              | \$1,696       |                       |              |
| Employee and Children | \$1,044       |                       |              | \$1,228       |                       |              | \$1,068       |                       |              |
| Employee and Family   | \$2,088       |                       |              | \$2,383       |                       |              | \$2,136       |                       |              |

| 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              | \$3,400/\$6,800              | \$6,800/\$13,600             |
| 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            |
| 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)/<br>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)<br>Call <b>1-844-367-6108</b> to see if your specialty medication is covered by SaveOnSP. | You pay 30% after deductible;<br>\$0 if SaveOnSP eligible      | You pay 20% after deductible (\$500 max);<br>\$0 if SaveOnSP eligible                 | You pay 20% after deductible                                       |
| Insulin Out-of-Pocket Costs                                                                                      | \$25 copay for 31-day supply;<br>\$75 for 61- to 90-day supply | \$25 copay for 31-day supply;<br>\$75 for 61- to 90-day supply                        | You pay 25% after deductible                                       |

This plan is closed to new enrollees. Current TRS-ActiveCare 2 participants can stay enrolled.

| TRS-ActiveCare 2                                                                                                                                                                                                                                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Closed to new enrollees</li><li>• Current enrollees can choose to stay in the 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       |                       |              |
| \$2,402       |                       |              |
| \$1,507       |                       |              |
| \$2,841       |                       |              |

| 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            |
| No                           |                              |

|                                          |                              |
|------------------------------------------|------------------------------|
| Tier 1: \$20 copay<br>Tier 2: \$40 copay | You pay 40% after deductible |
| Tier 1: \$55 copay<br>Tier 2: \$85 copay | You pay 40% after deductible |

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

|                                                                                                           |
|-----------------------------------------------------------------------------------------------------------|
| \$200 brand deductible                                                                                    |
| \$20/\$45 copay                                                                                           |
| You pay 25% after deductible (\$40 min/\$80 max)/<br>You pay 25% after deductible (\$105 min/\$210 max)   |
| You pay 50% after deductible (\$100 min/\$200 max)/<br>You pay 50% after deductible (\$215 min/\$430 max) |
| You pay 30% after deductible (\$200 min/\$900 max);<br>\$0 if SaveOnSP eligible                           |
| \$25 copay for 31-day supply; \$75 for 61- to 90-day supply                                               |

## Questions?

Call a Personal Health Guide at **1-866-355-5999** for help with medical services.  
Call Express Scripts® by Evernorth Pharmacy Benefit Services at **1-844-367-6108**  
for help with your pharmacy benefits.

## Compare Prices for Common Medical Services

**Closed to new enrollees.**

| 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 Imaging<br>(like CT Scan, Mammogram and MRI)                        | 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<br>(like colonoscopy, cataract surgery and steroid injections)     | 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<br>(like childbirth, complex joint replacement and cardiac surgery) | 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<br>(one per plan year)                                     | Specialist: You pay \$70 copay                                      | Specialist: You pay \$70 copay                                      | You pay 30% after deductible               | You pay 50% after deductible                                  | Tier 1 Specialist: \$55 copay<br>Tier 2 Specialist: \$85 copay                                                     | You pay 40% after deductible                                     |
| Annual Hearing Exam<br>(one per plan year)                                    | PCP: \$30 copay<br>Specialist: \$70 copay                           | PCP: \$15 copay<br>Specialist: \$70 copay                           | You pay 30% after deductible               | You pay 50% after deductible                                  | Tier 1 PCP: \$20 copay<br>Tier 2 PCP: \$40 copay<br>Tier 1 Specialist: \$55 copay<br>Tier 2 Specialist: \$85 copay | You pay 40% after deductible                                     |