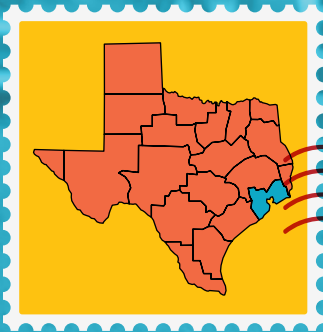


Go ahead and sign up for the Houston rodeo – 90% of Texas emergency rooms are covered with TRS-ActiveCare.

TRS-ActiveCare REGION 4



TRS-ActiveCare Plan Highlights 2024-25



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%.
- **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.

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



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.

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"> • 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 | \$471 | - | - | \$553 | - | - | \$484 | - | - |
| Employee and Spouse | \$1,272 | - | - | \$1,438 | - | - | \$1,307 | - | - |
| Employee and Children | \$801 | - | - | \$941 | - | - | \$823 | - | - |
| Employee and Family | \$1,602 | - | - | \$1,825 | - | - | \$1,646 | - | - |

| Plan Features | In-Network Coverage Only | In-Network Coverage Only | In-Network | Out-of-Network |
|---|------------------------------|------------------------------|------------------------------|------------------------------|
| 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 Maximum 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 | You pay 30% after deductible | You pay 25% after deductible | 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 | |

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

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

| 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 |
| Nationwide Network | |
| No | |

| | |
|------------|------------------------------|
| \$30 copay | You pay 40% after deductible |
| \$70 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)/ 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 |

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.