



## 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.

# 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.

## 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"><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         | \$520         |                       |              | \$610         |                       |              | \$539         |                       |              |
| Employee and Spouse   | \$1,404       |                       |              | \$1,586       |                       |              | \$1,456       |                       |              |
| Employee and Children | \$884         |                       |              | \$1,037       |                       |              | \$917         |                       |              |
| Employee and Family   | \$1,768       |                       |              | \$2,013       |                       |              | \$1,833       |                       |              |

| 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              | \$3,300/\$6,600              | \$6,600/\$13,200             |
| 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                           |                              |

| 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)                                                       | \$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"><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       |                       |              |
| \$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)/<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)                     |
| \$0 if SaveOnSP eligible;<br>You pay 30% after deductible (\$200 min/\$900 max)/<br>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<br>\$70 specialist copay                             | \$15 PCP copay<br>\$70 specialist copay                             | You pay 30% after deductible               | You pay 50% after deductible                                  | \$30 PCP copay<br>\$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](http://www.trs.texas.gov)

## 2025-26 Health Maintenance Organization Plans and Premiums for Select Regions of the State

**REMEMBER:** When you choose an HMO, you're choosing a regional network.

TRS contracts with HMOs in certain regions to bring participants in those areas additional options. HMOs set their own rates and premiums. They're fully insured products who pay their own claims.

|                                                                                   | Blue Essentials - South Texas HMO <sup>SM</sup><br><i>Brought to you by TRS-ActiveCare</i>                | Blue Essentials - West Texas HMO <sup>SM</sup><br><i>Brought to you by TRS-ActiveCare</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <b>You can choose this plan if you live in one of these counties:</b><br>Cameron, Hidalgo, Starr, Willacy | <b>You can choose this plan if you live in one of these counties:</b><br>Andrews, Armstrong, Bailey, Borden, Brewster, Briscoe, Callahan, Carson, Castro, Childress, Cochran, Coke, Coleman, Collingsworth, Comanche, Concho, Cottle, Crane, Crockett, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Eastland, Ector, Fisher, Floyd, Gaines, Garza, Glasscock, Gray, Hale, Hall, Hansford, Hartley, Haskell, Hemphill, Hockley, Howard, Hutchinson, Irion, Jones, Kent, Kimble, King, Knox, Lamb, Lipscomb, Llano, Loving, Lubbock, Lynn, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Parmer, Pecos, Potter, Randall, Reagan, Reeves, Roberts, Runnels, San Saba, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Taylor, Terry, Throckmorton, Tom Green, Upton, Ward, Wheeler, Winkler, Yoakum |

| Total Monthly Premiums | Total Premium | Employer Contribution | Your Premium | Total Premium | Employer Contribution | Your Premium |
|------------------------|---------------|-----------------------|--------------|---------------|-----------------------|--------------|
| Employee Only          | -             | -                     | -            | \$1,214.50    |                       |              |
| Employee and Spouse    | -             | -                     | -            | \$2,961.60    |                       |              |
| Employee and Children  | -             | -                     | -            | \$1,915.00    |                       |              |
| Employee and Family    | -             | -                     | -            | \$3,145.30    |                       |              |

| Plan Features                           |     |                              |
|-----------------------------------------|-----|------------------------------|
| Type of Coverage                        | N/A | In-Network Coverage Only     |
| Individual/Family Deductible            | N/A | \$950/\$2,850                |
| Coinsurance                             | N/A | You pay 25% after deductible |
| Individual/Family Maximum Out of Pocket | N/A | \$7,450/\$14,900             |

| Doctor Visits |     |            |
|---------------|-----|------------|
| Primary Care  | N/A | \$20 copay |
| Specialist    | N/A | \$70 copay |

| Immediate Care |     |                                                      |
|----------------|-----|------------------------------------------------------|
| Urgent Care    | N/A | \$50 copay                                           |
| Emergency Care | N/A | \$500 copay before deductible + 25% after deductible |

| Prescription Drugs  |     |                                                            |
|---------------------|-----|------------------------------------------------------------|
| Drug Deductible     | N/A | \$150                                                      |
| Days Supply         | N/A | 30-Day Supply/90-Day Supply                                |
| Generics            | N/A | \$5/\$12.50 copay; \$0 for certain generics                |
| Preferred Brand     | N/A | You pay 30% after deductible                               |
| Non-preferred Brand | N/A | You pay 50% after deductible                               |
| Specialty           | N/A | You pay 15%/25% after deductible (preferred/non-preferred) |

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