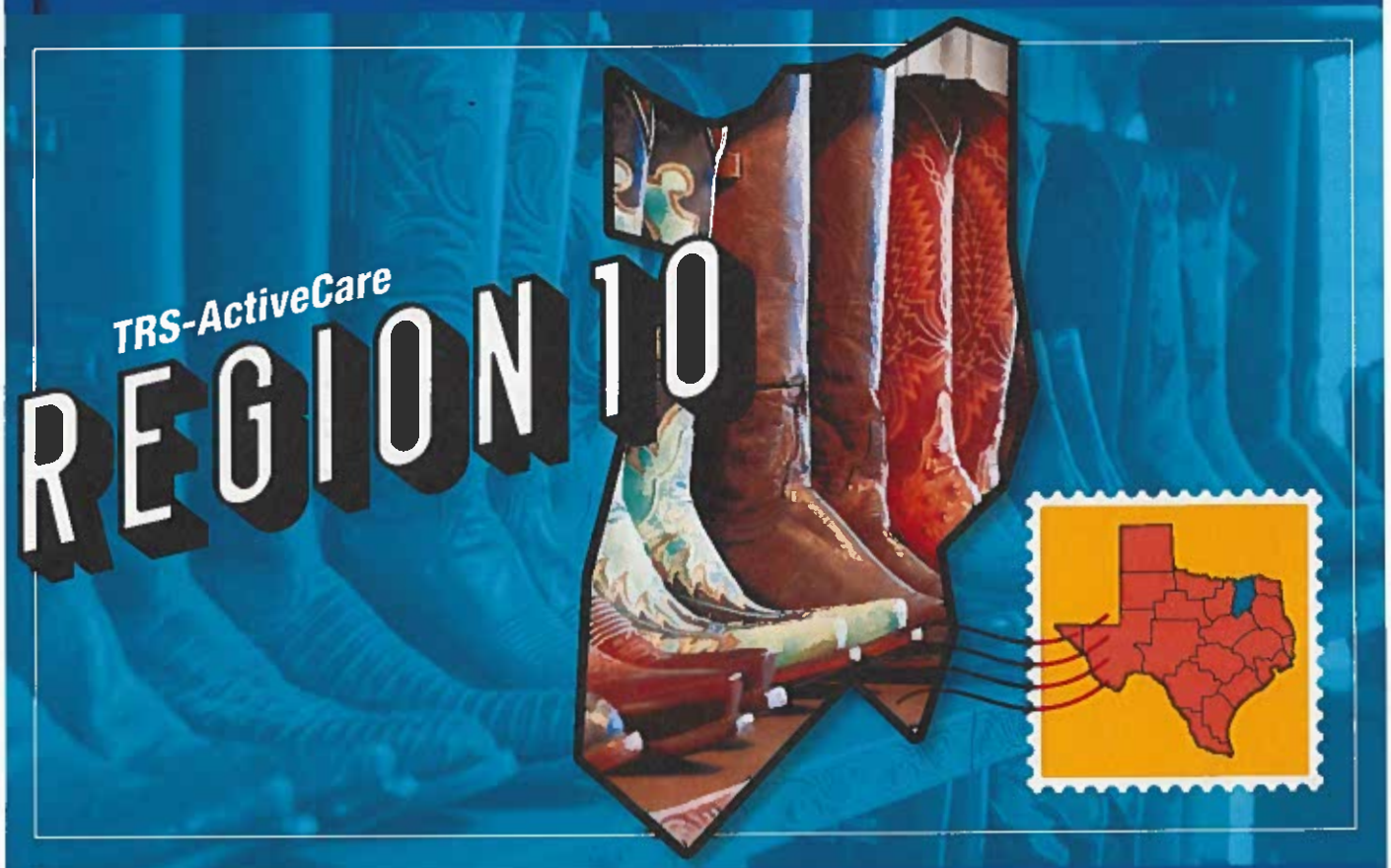
You bet your boots big things happen here, including TRS-ActiveCare's large network of doctors and hospitals.



TRS-ActiveCare **Plan Highlights** 2024-25

TRS ACTIVECARE

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.

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

TRS ActiveCare

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	• 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	$501	-	-	$588	-	-	$513	-	-
Employee and Spouse	$1,353	-	-	$1,529	-	-	$1,386	-	-
Employee and Children	$852	-	-	$1,000	-	-	$873	-	-
Employee and Family	$1,704	-	-	$1,941	-	-	$1,745	-	-

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 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 (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

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
• 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/Indpendent Lab: You pay $0	Office/Indpendent Lab: You pay $0	You pay 30% after deductible	You pay 50% after deductible	Office/Indpendent 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.*

TRS-ACTIVECARE PRIMARY

COVERAGE TYPE	TOTAL COST	DISTRICT CONTRIBUTION	EMPLOYEE COST PER PAY CHECK
Employee Only	$501.00	$334.00	$83.50
Employee & Spouse	$1,353.00	$334.00	$509.50
Employee & Child(ren)	$852.00	$334.00	$259.00
Employee & Family	$1,704.00	$334.00	$685.00

TRS-ACTIVECARE PRIMARY+

COVERAGE TYPE	TOTAL COST	DISTRICT CONTRIBUTION	EMPLOYEE COST PER PAY CHECK
Employee Only	$588.00	$334.00	$127.00
Employee & Spouse	$1,529.00	$334.00	$597.50
Employee & Child(ren)	$1,000.00	$334.00	$333.00
Employee & Family	$1,941.00	$334.00	$803.50

TRS-ACTIVECARE – H.D.

COVERAGE TYPE	TOTAL COST	DISTRICT CONTRIBUTION	EMPLOYEE COST PER PAY CHECK
Employee Only	$513.00	$334.00	$89.50
Employee & Spouse	$1,386.00	$334.00	$526.00
Employee & Child(ren)	$873.00	$334.00	$269.50
Employee & Family	$1,745.00	$334.00	$705.50

TRS-ACTIVECARE 2 (This plan is closed and not accepting new enrollees. If you are currently enrolled in TRS-ActiveCare 2, you can remain on this plan)

COVERAGE TYPE	TOTAL COST	DISTRICT CONTRIBUTION	EMPLOYEE COST PER PAY CHECK
Employee Only	$1,013.00	$334.00	$339.50
Employee & Spouse	$2,402.00	$334.00	$1,034.00
Employee & Child(ren)	$1,507.00	$334.00	$586.50
Employee & Family	$2,841.00	$334.00	$1253.50

Enrollment, Change and Declination Form

Eligibility:

Are you an active employee and making monthly contributions to TRS? ☐ Yes ☐ No

If no, are you regularly scheduled to work 10 or more hours per week? ☐ Yes ☐ No

*If no to both, you are not eligible for TRS ActiveCare coverage.

Section 1: Enrollment/Change Transaction Type

*Carefully review Options 1-3 before making any selections.

Option 1: Enrollments

☐ Annual Enrollment
☐ Add Dependent
☐ New Employee*
☐ Special Enrollment**

*Choose effective date if selecting **New Employee**:
☐ Effective on actively at work
☐ Effective 1st day of the following month

For District Use Only
TRS District #:
Actively at Work Date: / /
Effective/Change Date: / /
Employer Approval:

Choose a Life Event type if selecting **Special Enrollment:
☐ Marriage
☐ Birth/Adoption
☐ Loss of Coverage***
☐ Court Order
☐ Other:_____

***If you selected **Loss of Coverage** please specify:

Cancel Employee:
☐ Death
☐ Loss of Eligibility
☐ Retirement/Terminated
☐ Non-Payment
☐ Other:_____

Cancel Dependent:
☐ Divorce
☐ Death
☐ Loss of Eligibility
☐ Dropped Coverage
☐ Other:_____

Date of Life Event:___/___/_____

Were you previously covered by a different district? ☐ Yes ☐ No

If yes, District Name: _____

Option 2: Changes

☐ Name
☐ Address
☐ Plan/Coverage

Effective Date of Change:___/___/_____

Option 3: Decline Coverage

☐ Yes
☐ N/A

*If selecting yes, must complete Section 7

Section 2: Employee Information

Last Name:_____ First Name:_____ MI:_____ SSN:___-___-_____

Address:_____ City:_____ State:_____ Zip:_____

Alternate Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:___/___/_____ Work Phone:___-___-_____ Work Email:_____

Sex: ☐ M ☐ F Language: ☐ English ☐ Spanish Tobacco User: ☐ Yes ☐ No Race/Ethnicity: _____

Are you covered by other insurance? ☐ Yes ☐ No

Are you covered by Medicare? ☐ Yes ☐ No

Reason for Medicare Coverage:
☐ Entitlement Age
☐ Disability
☐ End State Renal Disease (ESRD)

Medicare Coverage Type:
☐ Medicare A and D Primary
☐ Medicare A, B and D Primary
☐ Medicare B and D Primary
☐ Medicare D Primary
☐ Medicare A Primary
☐ Medicare A and B Primary
☐ Medicare B Primary
☐ Medicare Unknown
☐ Other Coverage

Section 3: Coverage Selection

Plan Selection:
☐ TRS-ActiveCare Primary
☐ TRS-ActiveCare HD
☐ TRS-ActiveCare Primary+
☐ TRS-ActiveCare 2

OR

HMO Selection:
☐ South Texas Blue Essentials Plan*
☐ Central and North Texas Scott & White Health Plan*
☐ West Texas Blue Essentials Plan*

Coverage Tier:
☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

*plan eligibility is based on home or work location

Section 4: Primary Care Provider (PCP)

To elect coverage in the TRS-ActiveCare Primary, TRS-ActiveCare Primary+ or Blue Essentials HMO plans you must choose a Primary Care Provider (PCP) for yourself and your dependents. If you already have a PCP, you can enter the information in the box below.

If you are enrolling in TRS-ActiveCare Primary or TRS-ActiveCare Primary+, you can find your PCP ID number by going to www.bcbstx.com/trsactivecare/doctors-and-hospitals and clicking on the plan you're enrolling in. You will be taken to the Provider Finder search tool for that plan. Simply type in your desired PCP and input the PCP ID number found under Provider Highlights.

If you do not have a PCP, you can select one by following the link above to the Provider Finder search tool, clicking on the Browse by Category drop down, choose Medical Care and then Primary Care. You'll be able to select a PCP based off specialty and location.

If you are enrolling in Blue Essentials HMO, you can find a new PCP or your current PCP's ID number by going to www.bcbstx.com/trshmo/doctors-and-hospitals and following the instructions listed above.

If you enroll in these plans and do not choose a PCP one will be chosen for you and the provider number will be on your new ID cards for you and all dependents listed below. If you have questions about the TRS-ActiveCare Primary or TRS-ActiveCare Primary+ plans, please call your Personal Health Guide at (866) 355-5999.

Blue Essentials HMO participants can call Blue Essentials customer service line at (888)-378-1633.

Primary Care Provider name:
PCP ID #:

Section 5: Dependent Information (Use additional form for more dependents)

SPOUSE Last Name:_____ First Name:_____ MI:_____
Address:_____ ☐ Same as Employee
City:_____ State:_____ Zip:_____
Phone Number:___ - ___ - ____ Sex: ☐ M ☐ F Date of Birth:___/___/___ SSN:___ - ___ - ____
Primary Care Physician Name: _____
PCP ID #: _____
Are you covered by other insurance? ☐ Yes ☐ No If yes, Carrier/Plan:_____
Tobacco User: ☐ Yes ☐ No
If Medicare, select a coverage type:

☐ Medicare A and D Primary	☐ Medicare D Primary	☐ Medicare B Primary
☐ Medicare A, B and D Primary	☐ Medicare A Primary	☐ Medicare Unknown
☐ Medicare B and D Primary	☐ Medicare A and B Primary	☐ Other Coverage

CHILD Last Name:_____ First Name:_____ MI:
☐ Child ☐ Grandchild ☐ Disabled ☐ Other ☐ Tobacco user (*required for children 18 and older)
Address:_____ ☐ Same as Employee
City:_____ State:_____ Zip:_____
Phone Number:___ - ___ - ____ Sex: ☐ M ☐ F Date of Birth:___/___/___ SSN:___ - ___ - ____
Primary Care Physician Name: _____
PCP ID #: _____
Are you covered by other insurance? ☐ Yes ☐ No If yes, Carrier/Plan:_____
If Medicare, select a coverage type:

☐ Medicare A and D Primary	☐ Medicare D Primary	☐ Medicare B Primary
☐ Medicare A, B and D Primary	☐ Medicare A Primary	☐ Medicare Unknown
☐ Medicare B and D Primary	☐ Medicare A and B Primary	☐ Other Coverage

CHILD Last Name:_____ First Name:_____ MI:
☐ Child ☐ Grandchild ☐ Disabled ☐ Other ☐ Tobacco user (*required for children 18 and older)
Address:_____ ☐ Same as Employee
City:_____ State: Zip:_____
Phone Number:___ - ___ - ____ Sex: ☐ M ☐ F Date of Birth:___/___/___ SSN:___ - ___ - ____
Primary Care Physician Name: _____
PCP ID #: _____
Are you covered by other insurance? ☐ Yes ☐ No If yes, Carrier/Plan:_____
If Medicare, select a coverage type:

☐ Medicare A and D Primary	☐ Medicare D Primary	☐ Medicare B Primary
☐ Medicare A, B and D Primary	☐ Medicare A Primary	☐ Medicare Unknown
☐ Medicare B and D Primary	☐ Medicare A and B Primary	☐ Other Coverage

CHILD Last Name:_____ First Name:_____ MI:
☐ Child ☐ Grandchild ☐ Disabled ☐ Other ☐ Tobacco user (*required for children 18 and older)
Address:_____ ☐ Same as Employee
City:_____ State:_____ Zip:_____
Phone Number:___ - ___ - ____ Sex: ☐ M ☐ F Date of Birth:___/___/___ SSN:___ - ___ - ____
Primary Care Physician Name: _____
PCP ID #: _____
Are you covered by other insurance? ☐ Yes ☐ No If yes, Carrier/Plan:_____
If Medicare, select a coverage type:

☐ Medicare A and D Primary	☐ Medicare D Primary	☐ Medicare B Primary
☐ Medicare A, B and D Primary	☐ Medicare A Primary	☐ Medicare Unknown
☐ Medicare B and D Primary	☐ Medicare A and B Primary	☐ Other Coverage

CHILD Last Name:______________________ First Name:______________ MI:

☐ Child ☐ Grandchild ☐ Disabled ☐ Other ☐ Tobacco user (*required for children 18 and older)

Address:______________________________________ ☐ Same as Employee

City:______________________________ State: Zip:______

Phone Number:____-____-____ Sex: ☐ M ☐ F Date of Birth:____/____/____ SSN:____-____-____

Primary Care Physician Name: ______________________________

PCP ID #: ______________________________

Are you covered by other insurance? ☐ Yes ☐ No If yes, Carrier/Plan: ______________

If Medicare, select a coverage type:

☐ Medicare A and D Primary ☐ Medicare D Primary ☐ Medicare B Primary

☐ Medicare A, B and D Primary ☐ Medicare A Primary ☐ Medicare Unknown

☐ Medicare B and D Primary ☐ Medicare A and B Primary ☐ Other Coverage

Section 6: Disabled Dependents Over Age 26

☐ Request for Dependent Child Statement of Disability

* Please note that a Dependent Child Statement of Disability is required for coverage of a disabled child over age 26 and must be **submitted within 31 days** of the child's 26th birthday. See your Benefits Administrator for the form, which must be completed in full and submitted to your Benefits Administrator.

Section 7: Declination of Coverage

* This is to certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage available to me and my dependents and have voluntarily elected to decline the coverage as elected below.

Name:______________________ SSN:____-____-____ ☐ Employee

Gender: ☐ M ☐ F Date of Birth:____/____/____ ☐ Other Coverage: ______________

Address: ______________________________

Name:______________________ SSN:____-____-____ ☐ Spouse

Gender: ☐ M ☐ F Date of Birth:____/____/____ ☐ Other Coverage: ______________

Address:______________________________ ☐ Same as Employee

Name:______________________ SSN:____-____-____ ☐ Child

Gender: ☐ M ☐ F Date of Birth:____/____/____ ☐ Other Coverage: ______________

Address:______________________________ ☐ Same as Employee

Name:______________________ SSN:____-____-____ ☐ Child

Gender: ☐ M ☐ F Date of Birth:____/____/____ ☐ Other Coverage: ______________

Address:______________________________ ☐ Same as Employee

Name:______________________ SSN:____-____-____ ☐ Child

Gender: ☐ M ☐ F Date of Birth:____/____/____ ☐ Other Coverage: ______________

Address:______________________________ ☐ Same as Employee

Name:______________________ SSN:____-____-____ ☐ Child

Gender: ☐ M ☐ F Date of Birth:____/____/____ ☐ Other Coverage: ______________

Address:______________________________ ☐ Same as Employee

Section 8: Coverage Conditions

I am eligible to participate in the coverage(s) offered by the TRS-ActiveCare program which is administered by Blue Cross and Blue Shield of Texas (BCBSTX), a Division of Health Care Service Corporation Health, with HMO benefits provided by Baylor, Scott and White Health Plan and Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation Health Plans. On behalf of myself and any dependents listed, I apply for those coverage(s) for which I am eligible.

- If I am enrolling a grandchild, I certify that my household is the grandchild's primary residence and the grandchild is my dependent for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.
- If I am enrolling a child as an "other child" in Section 5, I certify that my household is the child's primary residence, that I provide at least 50% of the child support, that neither of the children's natural parents resides in my household, and that I have the legal right to make decisions regarding the child's medical care.

Only those coverage(s) and amount for which I am eligible will be available to me. I understand that if my coverage requests are accepted, the coverage(s) will become effective in accordance with the provisions or the TRS-ActiveCare program.

I understand that by enrolling for coverage that any TRS-ActiveCare coverage I previously elected under another TRS-ActiveCare participating district/entity will be terminated under TRS Rules.

I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.

I understand that by declining TRS-ActiveCare coverage now or by terminating TRS-ActiveCare coverage during the plan year, I am not eligible to re-enroll in TRS-ActiveCare until the next plan year unless I experience a special enrollment event.

I state that the information provided in this enrollment is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).

Applicant Signature:_____ Date:____/____/____