### 2019–20 TRS-ActiveCare Plan Highlights
**Effective Sept. 1, 2019 through Aug. 31, 2020 | In-Network Level of Benefits**

#### Medical Coverage

<table>
<thead>
<tr>
<th></th>
<th>TRS-ActiveCare 1–HD</th>
<th>TRS-ActiveCare Select/TRS-ActiveCare Select Whole Health</th>
<th>TRS-ActiveCare 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$2,750 employee only/$5,500 family</td>
<td>$1,200 individual/$3,600 family</td>
<td>$1,000 individual/$3,000 family</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$5,500 employee only/$11,000 family</td>
<td>Not applicable. This plan does not cover out-of-network services except for emergencies.</td>
<td>$2,000 individual/$6,000 family</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>The individual out-of-pocket maximum only includes covered expenses incurred by that individual.</td>
<td>Not applicable. This plan does not cover out-of-network services except for emergencies.</td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$6,750 individual/$13,500 family</td>
<td>$7,900 individual/$15,800 family</td>
<td>$7,900 individual/$15,800 family</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$20,250 individual/$40,500 family</td>
<td>Not applicable. This plan does not cover out-of-network services except for emergencies.</td>
<td>$23,700 individual/$47,400 family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network Participant pays (after deductible)</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Out-of-Network Participant pays (after deductible)</td>
<td>40% of allowed amount unless otherwise noted</td>
<td>Not applicable. This plan does not cover out-of-network services except for emergencies.</td>
<td>40% of allowed amount unless otherwise noted</td>
</tr>
</tbody>
</table>

#### Preventive Care

- Well-child care – unlimited up to age 12
- Colonoscopy – every 10 years age 45 and over
- Healthy diet/obesity counseling – unlimited to age 22; age 22 and over – 26 visits per 12 months
- Well woman exam & pap smear – annually age 18 and over
- Prostate cancer screening – one per year age 50 and over
- Breastfeeding support – six lactation counseling visits per 12 months

**Note:** Covered services under this benefit must be billed by the provider as “preventive care.” Non-network preventive care is not paid at 100%. If you receive preventive services from a non-network provider, you will be responsible for any applicable deductible and coinsurance.

#### Outpatient Surgery

- Bariatric Surgery (only covered if performed at an IOQ facility) Participant pays: $5,000 copay (does apply to out-of-pocket maximum) plus 20% after deductible
- Annual Vision Examination (one per plan year; performed by an ophthalmologist or optometrist) Participant pays: 20% after deductible
- Annual Hearing Examination Participant pays: 20% after deductible

#### Urgent Care

- $50 copay per visit
- $150 copay per visit

#### Freestanding Emergency Room

- $500 copay per visit plus 20% after deductible
- $1,000 copay per visit plus 20% after deductible

#### Emergency Room (true emergency use)

- $250 copay plus 20% after deductible (waived if admitted)
- $500 copay plus 20% after deductible (waived if admitted)

#### Out-of-Network

- Plan pays up to $500 per day cap of covered charges after deductible; you pay the excess over $500 per day
- Not applicable. This plan does not cover out-of-network services except for emergencies.
- Plan pays up to $500 per day cap of covered charges after deductible; you pay the excess over $500 per day

#### Teladoc® Physician Services

- $40 consultation fee (counts toward deductible and out-of-pocket maximum)
- Plan pays 100%
- Plan pays 100%

#### Inpatient Hospital Facility Charges Only (preauthorization required)

- 20% after deductible

#### Deductible (per plan year)

- $2,250 employee only/$4,500 family
- $5,500 employee only/$11,000 family
- $7,250 employee only/$14,500 family
- $2,000 individual/$6,000 family
- $4,000 individual/$8,000 family
### Prescription Coverage

**Drug Deductible**
- (per person, per plan year)
  - Must meet plan-year deductible before plan pays.**
- $0 generic; $200 brand
- $0 generic; $200 brand

**Short-Term Supply at a Retail Location**
- (up to a 31-day supply)
  - Tier 1 – Generic
    - 20% coinsurance after deductible, except for certain generic preventive drugs that are covered at 100%.**
    - $15 copay
    - $20 copay
  - Tier 2 – Preferred Brand
    - 25% coinsurance after deductible**
    - 25% coinsurance (min. $404; max. $80)**
    - 25% coinsurance (min. $404; max. $80)**
  - Tier 3 – Non-Preferred Brand
    - 50% coinsurance after deductible**
    - 50% coinsurance**
    - 50% coinsurance (min. $100; max. $200)**

**Extended-Day Supply at Mail Order or Retail-Plus Pharmacy Location**
- (60- to 90-day supply)**
  - Tier 1 – Generic
    - 20% coinsurance after deductible
    - $45 copay
    - $45 copay
  - Tier 2 – Preferred Brand
    - 25% coinsurance after deductible**
    - 25% coinsurance (min. $1054; max. $210)**
    - 25% coinsurance (min. $1054; max. $210)**
  - Tier 3 – Non-Preferred Brand
    - 50% coinsurance after deductible**
    - 50% coinsurance**
    - 50% coinsurance (min. $215; max. $430)**

**Specialty Medications**
- (up to a 31-day supply)
  - Specialty Medications
    - 20% coinsurance after deductible
    - 20% coinsurance
    - 20% coinsurance (min. $200; max. $900)

**What is a maintenance medication?**
Maintenance medications are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

**When does the convenience fee apply?**
For example, if you are covered under TRS-ActiveCare Select, the first time you fill a 31-day supply of a generic maintenance drug at a retail pharmacy you will pay $15, then you will pay $30 each month that you fill a 31-day supply of that generic maintenance drug at a retail pharmacy. A 90-day supply of that same generic maintenance medication would cost $45, and you would save $180 over the year by filling a 90-day supply.

A specialist is any physician other than family practitioner, internist, OB/GYN or pediatrician.

**NOTE:** If you’re currently enrolled in TRS-ActiveCare 2, you can remain in this plan. However, as of Sept. 1, 2018, TRS-ActiveCare 2 is closed to new enrollees.

### Monthly Premiums

<table>
<thead>
<tr>
<th>TRS-ActiveCare Monthly Premium</th>
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</thead>
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<tr>
<td></td>
<td>Full monthly premium*</td>
<td>Premium with min. state/district contribution**</td>
<td>Your monthly premium***</td>
</tr>
<tr>
<td>Individual</td>
<td>$378</td>
<td>$153</td>
<td>$556</td>
</tr>
<tr>
<td>+Spouse</td>
<td>$1,066</td>
<td>$841</td>
<td>$1,367</td>
</tr>
<tr>
<td>+Children</td>
<td>$722</td>
<td>$497</td>
<td>$902</td>
</tr>
<tr>
<td>+Family</td>
<td>$1,415</td>
<td>$1,190</td>
<td>$1,718</td>
</tr>
</tbody>
</table>

*If you are not eligible for the state/district subsidy, you will pay the full monthly premium. Please contact your Benefits Administrator for your monthly premium.

**The premium after state, $75 and district, $150 contribution is the maximum you may pay per month. Ask your Benefits Administrator for your monthly cost. (This is the amount you will owe each month after all available subsidies are applied to your premium.)

***Completed by your benefits administrator. The state/district contribution may be greater than $225.