

Denton Independent School District Medical Plans 2026-2027			
	Blue Choice High Deductible PPO Plan	Blue Essential HMO Plans	
Carrier	BCBS	BCBS	BCBS
Plan Name	Denton HD PPO	Denton 1250 HMO	Denton 3500 HMO
In Network	BCBS High Deductible PPO	BCBS Platinum	BCBS Gold
Deductible (Ind/Family)	\$5,000 / \$11,000	\$3,750 / \$7,400	\$5,200/ \$12,000
Max Out of Pocket (Ind/Family)	\$8,000 / \$16,000	\$7,500 / \$17,000	\$9,000 / \$20,000
Coinsurance Deductible	30%	20%	30%
Physician Services			
DISD Employee Health & Wellness Center	\$10	\$0	\$0
Primary Care	Deductible + 30%	\$45	\$50
Specialist	Deductible + 30%	\$75	\$85
Virtual Visits - MD Live	\$0	\$0	\$0
Other Services			
Inpatient Hospitalization	Deductible + 30%	20% Coinsurance after \$1,000 Deductible	30% Coinsurance after Deductible
Outpatient Surgery	Deductible + 30%	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Emergency Room	Deductible + 30%	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	Deductible + 30%	\$75 Copay	\$100 Copay
Complex Imaging	Deductible + 30%	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Prescription Drugs			
Rx Deductible	Integrated with Medical	\$250	Integrated with Medical
Generic Rx	20% After Deductible	\$15	\$30
Preferred Brand Name	30% After Deductible	30% after Pharmacy Deductible	30% after deductible
Non-Preferred Brand Name	50% After Deductible	50% after Pharmacy Deductible	50% after deductible
Specialty	20% after Deductible	20% Coinsurance after Pharmacy Deductible	30% after deductible
Mail Order - 90 day Supply	2.5 X Retail	2.5 X Retail	2.5 X Retail
Out of Network			
Deductible - Ind / Family	\$7,000 / \$18,000	Not Covered	Not Covered
Maximum Out of Pocket - Ind / Family	\$18,000 / \$54,000	Not Covered	Not Covered
Coinsurance	50%	Not Covered	Not Covered
Monthly Premiums (District contribution of \$260 has already been applied to the amounts below)			
Employee Only Premium	\$370.00	\$615.00	\$415.00
Employee +Spouse	\$1,370.00	\$1,815.00	\$1,485.00
Employee +Children	\$820.00	\$1,265.00	\$965.00
Employee+Family	\$1,820.00	\$2,465.00	\$2,035.00
Variance to Plan 25-26			
Employee Only Premium	\$16.04	\$181.64	\$104.35
Employee +Spouse	\$22.39	\$259.50	\$250.75
Employee +Children	\$36.15	\$346.17	\$254.75
Employee +Family	\$108.15	\$498.15	\$462.19

TRS Active Care Plan Highlights 2026-2027			
	Blue Choice High Deductible PPO Plan	Blue Essential HMO Plans	
Carrier	BCBS	BCBS	BCBS
Plan Name	TRS Active Care HD	TRS Active Care Primary +	TRS Active Care Primary
In Network	BCBS High Deductible PPO	BCBS Platinum	BCBS Gold
Deductible (Ind/Family)	\$3,300 / \$6,600	\$1,200 / \$2,400	\$2,500 / \$5,000
Max Out of Pocket (Ind/Family)	\$8,300 / \$16,600	\$6,900 / \$13,800	\$8,050 / \$16,100
Coinsurance Deductible	30% After Deductible	20% After Deductible	30% after Deductible
Physician Services			
Primary Care	Ded +30%	\$15	\$30
Specialist	Ded +30%	\$70	\$70
Urgent Care	30% After Deductible	\$50	\$50
Virtual Visits - Redi MD	\$30	\$0	\$0
Virtual Visiits Teledoc	\$42	\$12	\$12
Other Services			
Inpatient Hospitalization	Deductible + 30%	20% Coinsurance after \$1,000 Deductible	30% Coinsurance after Deductible
Outpatient Surgery	Deductible + 30%	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Emergency Room	Deductible + 30%	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	Deductible + 30%	\$50 Copay	\$50 Copay
Complex Imaging	Deductible + 30%	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Prescription Drugs			
Rx Deductible	Integrated with Medical	\$200.00	Integrated with Medical
Generic Rx	20% After Deductible	\$15.00	\$15.00
Preferred Brand Name	25% After Deductible	25% after deductible (\$100 max)	30% After Deductible
Non-Preferred Brand Name	50% After Deductible	50%after deductible	50% After deductible
Specialty	20% After Deductible	20% after deductible w/\$500 Cap per month	30% After deductible
Out of Network			
Deductible - Ind / Family	\$6,600 / \$13,200	Not Covered	Not Covered
Maximum Out of Pocket - Ind / Family	\$18,000 / \$54,000	Not Covered	Not Covered
Coinsurance	50%	Not Covered	Not Covered
Monthly Premiums (District contribution of \$260 has already been applied to the amounts below)			
Employee Only Premium	\$370	\$460	\$352
Employee+Spouse	\$1,441	\$1,612	\$1,393
Employee+Children	\$811	\$964	\$781
Employee+Family	\$1,882	\$2,116	\$1,821
Variance to Plan 26-27 Denton ISD			
Employee Only Premium	\$0.00	\$155.00	\$63.00
Employee+Spouse	(\$71.00)	\$203.00	\$92.00
Employee+Children	\$9.00	\$301.00	\$184.00
Employee+Family	(\$62.00)	\$349.00	\$214.00