# EAGLE MOUNTAIN SAGINAW ISD

*Fostering a Culture of Excellence*

# 2019-2020 Benefits Guide

# Welcome

Eagle Mountain Saginaw ISD will be utilizing BCG's services for our benefit communication and enrollment this year. Benefit Counselors will provide you with a detailed explanation of your entire benefit program. They will review your benefits with you on an individual, confidential basis. They will also be able to discuss any personal situations you may have that could potentially impact your benefit decision.

Each year, we strive to offer comprehensive benefit plans to our employees. In the following pages, you will find a summary of our benefit plans for the 2019-2020 plan year (September 1 – August 31). Please read this Benefits Guidebook carefully as you prepare to make your elections for the upcoming plan year.

# About this Benefits Guidebook

This Benefits Guidebook describes the highlights of Eagle Mountain Saginaw ISD's benefits program in non-technical language. Included in this Benefits Guidebook is important information about each of the benefit plans offered to you and your family. It includes the benefits paid by Eagle Mountain Saginaw ISD as well as voluntary products which you can customize to meet your individual needs.

Please remember that these general descriptions are not intended to provide all the details of requirements of these benefits. The official Plan Documents will prevail if any inconsistencies are found between the Benefit Guidebook and the official Plan Documents. Any and all elements of Eagle Mountain Saginaw ISD's benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules or otherwise as decided by Eagle Mountain Saginaw ISD.

**Before you speak with a benefits counselor, please have the following dependent information ready:**

- Names
- Dates of birth
- Social Security Numbers
- Addresses
- Phone numbers

**Benefits Service Center**

**888-279-8716**

Monday –Friday: 8:00am – 5:00pm CST

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# ELIGIBILITY

## Employee Eligibility

EMS ISD Benefits Department
(817) 232-0880 x2978
jmcnutt-erwin@ems-isd.net

Group health insurance coverage is available to all full time and part-time (10 or more hours per week) employees. The insurance plan year is from September 1 through August 31 of each year. Payroll deductions will begin in September.

In order for an employee's coverage to take effect, the employee must call in to the Benefits Service Center for coverage for themselves and any eligible dependents. Your coverage will become effective on the actively at work date or the 1st day of the month following your date of hire.

If you apply for coverage, you may include your dependents. All employees must ensure that only family members who meet the following requirements are enrolled in the EMS ISD insurance and healthcare benefits programs.

Eligible dependents include one or more of the following:

- Your spouse / domestic partner;
- A child under the age of 26;
- A child of any age who is medically certified as disabled and dependent on the parent for support and maintenance.

## Qualifying Life Events

Please be aware that the only time, other than open enrollment, you are able to make changes to your benefits is if you experience a Qualifying Life Event (QLE). In the event of a QLE, please contact your Benefits department. Proof of the QLE must be submitted to the EMS ISD Benefits department within 30 days of the QLE in order to change current benefit elections. QLEs include:

- A change in the number of dependents (birth, adoption, death, legal guardianship);
- A change in marital status (marriage, divorce, death, legal separation);
- A dependent's loss of eligibility (attainment of limiting age or change in student status);
- A change in spouse's or eligible dependents' work hours;
- A termination or commencement of employment of employee's spouse or eligible dependents with coverage.
- Other events as the administrator determines to be permitted or any other applicable guidelines issued by the Internal Revenue Service.

# HEALTH AND WELL-BEING

## UNUM's Employee Assistance Program

### Help, when you need it most

With your Employee Assistance Program and Work/Life Balance services, confidential assistance is as close as your phone or computer.

### Always by your side

- Expert support 24/7
- Convenient website
- Short-term help
- Referrals for additional care
- Monthly webinars
- Medical Bill Saver™ — helps you save on medical bills

### Who is covered?

Unum's EAP services are available to all eligible employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

**Employee Assistance Program — Work/Life Balance**

Toll-free 24/7 access:

- 1-800-854-1446 (multi-lingual)
- www.unum.com/lifebalance

*Turn to us, when you don't know where to turn.*

### Unum Employee Assistance Program (EAP)

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor* who can help you.

**A Licensed Professional Counselor can help you with:**

- Stress, depression, anxiety
- Relationship issues, divorce
- Job stress, work conflicts
- Family and parenting problems
- Anger, grief and loss
- And more

### Work/Life Balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our Work/Life Specialists can answer your questions and help you find resources in your community.

**Ask our Work/Life Specialists about:**

- Child care
- Elder care
- Legal questions
- Identity theft
- Financial services, debt management, credit report issues
- Even reducing your medical/dental bills!
- And more

### Help is easy to access:

- **Online/phone support:** Unlimited, confidential, 24/7.
- **In-person:** You can get up to 3 visits available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

* The counselors must abide by federal regulations regarding duty to warn of harm to self or others. In these instances, the consultant may be mandated to report a situation to the appropriate authority.

Unum's Employee Assistance Program and Work/Life Balance services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Insurance products are underwritten by the subsidiaries of Unum Group.

unum.com

# Unum's Employee Assistance Program

## Medical Bill Saver™ makes Unum's EAP even more valuable

Better benefits at work.

**As health care costs continue to rise, many people have trouble paying medical expenses that insurance doesn't cover. Luckily, our EAP — with the Medical Bill Saver feature — can help.**

### How does it work?

When a covered employee has a medical or dental bill totaling over $400 in out-of-pocket costs, our skilled negotiating team works with the provider(s) to get a discount. Successful negotiations can save employees hundreds, and sometimes thousands, of dollars.

Our experts can also show employees how to keep bills lower in the future — for example, by using in-network providers.

By helping reduce employees' out-of-pocket-costs, Medical Bill Saver can make consumer-driven health plans (CDHPs) more attractive — and more effective.

Medical Bill Saver is one more way the Unum Employee Assistance Program helps employees manage the stresses of modern life.

### Real stories. Real people. Real results.

**MEDICAL BILL SAVER: CASE #1**

**Issue:** An employee had an outstanding bill for surgery performed at an out-of-network hospital.

**Resolution:** Unum's EAP service worked with the provider to reduce the bill.

**Billed Charges:** ..... $5,032
**Negotiated Discount:** .... 50%
**Savings:** ..... $2,516

**MEDICAL BILL SAVER: CASE #2**

**Issue:** An employee received a bill for a dental implant that was not covered by her dental plan.

**Resolution:** Unum's EAP service worked with the provider, who agreed to accept a lower fee.

**Billed Charges:** ..... $1,600
**Negotiated Discount:** .... 55%
**Savings:** ..... $880

**MEDICAL BILL SAVER: CASE #3**

**Issue:** Following a surgery, an employee received a large bill from a non-participating anesthesia group.

**Resolution:** Unum's EAP service negotiated an arrangement that reduced the employee's responsibility.

**Billed Charges:** ..... $3,275
**Negotiated Discount:** .... 38%
**Savings:** ..... $1,245

* The savings in these case studies cannot be guaranteed. Results may vary.

### The Medical Bill Saver advantage

- Negotiations for medical/dental bills with a non-covered balance of $400 or more
- Expert use of critical pricing-trend information to obtain discounts from providers
- Easy-to-read Savings Result Statement summarizing the outcome of the negotiation
- Provider sign-off on payment terms and conditions
- Speedy provider payments

### Employee Assistance Program services are available 24/7 at:

1-800-854-1446 (multi-lingual)
www.unum.com/lifebalance

# 2019–20 TRS-ActiveCare Plan Highlights

Effective Sept. 1, 2019 through Aug. 31, 2020 | In-Network Level of Benefits[1]

| Medical Coverage | TRS-ActiveCare 1-HD | TRS-ActiveCare Select or TRS-ActiveCare Select Whole Health (Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance) | TRS-ActiveCare 2 **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. |
|---|---|---|---|
| **Deductible** (per plan year) | | | |
| **In-Network** | $2,750 employee only/$5,500 family | $1,200 individual/$3,600 family | $1,000 individual/$3,000 family |
| **Out-of-Network** | $5,500 employee only/$11,000 family | Not applicable. This plan does not cover out-of-network services except for emergencies. | $2,000 individual/$6,000 family |
| **Out-of-Pocket Maximum** (per plan year; medical and prescription drug deductibles, copays, and coinsurance count toward the out-of-pocket maximum) | The individual out-of-pocket maximum only includes covered expenses incurred by that individual. | | |
| **In-Network** | $6,750 individual/$13,500 family | $7,900 individual/$15,800 family | $7,900 individual/$15,800 family |
| **Out-of-Network** | $20,250 individual/$40,500 family | Not applicable. This plan does not cover out-of-network services except for emergencies. | $23,700 individual/$47,400 family |
| **Coinsurance** | | | |
| **In-Network** Participant pays (after deductible) | 20% | 20% | 20% |
| **Out-of-Network** Participant pays (after deductible) | 40% of allowed amount unless otherwise noted | Not applicable. This plan does not cover out-of-network services except for emergencies. | 40% of allowed amount unless otherwise noted |
| **Office Visit Copay** Participant pays | 20% after deductible | $30 copay for primary<br>$70 copay for specialist | $30 copay for primary<br>$70 copay for specialist |
| **Diagnostic Lab** Participant pays | 20% after deductible | 20% after deductible | 20% after deductible |
| **Preventive Care** See below for examples | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Teladoc® Physician Services** | $40 consultation fee (counts toward deductible and out-of-pocket maximum) | Plan pays 100% | Plan pays 100% |
| **High-Tech Radiology** (CT scan, MRI, nuclear medicine) Participant pays | 20% after deductible | $100 copay plus 20% after deductible | $100 copay plus 20% after deductible |
| **Inpatient Hospital Facility Charges Only (preauthorization required)** | | | |
| **In-Network** | 20% after deductible | $150 copay per day plus 20% after deductible ($750 maximum copay per admission) | $150 copay per day plus 20% after deductible ($750 maximum copay per admission; $2,250 maximum copay per plan year) |
| **Out-of-Network** | Plan pays up to $500 per day cap of covered charges after deductible; you pay the excess over the $500 per day cap | 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 of over the $500 per day cap |
| **Urgent Care** | 20% after deductible | $50 copay per visit | $50 copay per visit |
| **Freestanding Emergency Room** Participant pays | $500 copay per visit plus 20% after deductible | $500 copay per visit plus 20% after deductible | $500 copay per visit plus 20% after deductible |
| **Emergency Room** (true emergency use) Participant pays | 20% after deductible | $250 copay plus 20% after deductible (copay waived if admitted) | $250 copay plus 20% after deductible (copay waived if admitted) |
| **Outpatient Surgery** Participant pays | 20% after deductible | $150 copay per visit plus 20% after deductible | $150 copay per visit plus 20% after deductible |
| **Bariatric Surgery (only covered if performed at an IOQ facility)** Physician charges; Participant pays | $5,000 copay (does apply to out-of-pocket maximum) plus 20% after deductible | Not covered | $5,000 copay (does not 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 | $70 copay for specialist | $70 copay for specialist |
| **Annual Hearing Examination** Participant pays | 20% after deductible | $30 copay for primary<br>$70 copay for specialist | $30 copay for primary<br>$70 copay for specialist |

## Preventive Care

Some examples of preventive care frequency and services:

- **Routine physicals** – annually age 12 and over
- **Mammograms** – one every year age 35 and over
- **Smoking cessation counseling** – eight visits per 12 months
- **Well-child care** – unlimited up to age 12
- **Colonoscopy** – one every 10 years age 50 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 under the TRS-ActiveCare 1-HD and TRS-ActiveCare 2. There is no coverage for non-network services under the TRS-ActiveCare Select plan or TRS-ActiveCare Select Whole Health. For more information, please view the Benefits Booklet at **www.trsactivecareaetna.com**.

| Prescription Coverage | TRS-ActiveCare 1-HD | TRS-ActiveCare Select or ActiveCare Select Whole Health (Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance) | TRS-ActiveCare 2 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. |
|---|---|---|---|
| **Drug Deductible** (per person, per plan year) | Must meet plan-year deductible before plan pays.[2] | $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%.[2] | $15 copay | $20 copay |
| Tier 2 – Preferred Brand | 25% coinsurance after deductible[3] | 25% coinsurance (min. $40[4]; max. $80)[3] | 25% coinsurance (min. $40[4]; max. $80)[3] |
| Tier 3 – Non-Preferred Brand | 50% coinsurance after deductible[3] | 50% coinsurance[3] | 50% coinsurance (min. $100[4]; max. $200)[3] |
| **Extended-Day Supply at Mail Order or Retail-Plus Pharmacy Location** (60- to 90-day supply)[5] | | | |
| Tier 1 – Generic | 20% coinsurance after deductible | $45 copay | $45 copay |
| Tier 2 – Preferred Brand | 25% coinsurance after deductible[3] | 25% coinsurance (min. $105[4]; max. $210)[3] | 25% coinsurance (min. $105[4]; max. $210)[3] |
| Tier 3 – Non-Preferred Brand | 50% coinsurance after deductible[3] | 50% coinsurance[3] | 50% coinsurance (min. $215[4]; max. $430)[3] |
| **Specialty Medications** (up to a 31-day supply) | | | |
| Specialty Medications | 20% coinsurance after deductible | 20% coinsurance | 20% coinsurance (min. $200[4]; max. $900) |
| **Short-Term Supply of a Maintenance Medication at Retail Location** up to a 31-day supply<br>The second time a participant fills a short-term supply of a maintenance medication at a retail pharmacy, they will be charged the coinsurance and copays in the rows below. Participants can save more over the plan year by filling a larger day supply of a maintenance medication through mail order or at a Retail-Plus location. | | | |
| Tier 1 – Generic | 20% coinsurance after deductible | $30 copay | $35 copay |
| Tier 2 – Preferred Brand | 25% coinsurance after deductible[3] | 25% coinsurance (min. $60[4]; max. $120)[3] | 25% coinsurance (min. $60[4]; max. $120)[3] |
| Tier 3 – Non-Preferred Brand | 50% coinsurance after deductible[3] | 50% coinsurance[3] | 50% coinsurance (min. $105[4]; max. $210)[3] |

### 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.

[1] Illustrates benefits when in-network providers are used. For some plans non-network benefits are also available; there is no coverage for non-network benefits under the TRS-ActiveCare Select or TRS-ActiveCare Select Whole Health Plan; see Enrollment Guide for more information. Non-contracting providers may bill for amounts exceeding the allowable amount for covered services. Participants will be responsible for this balance bill amount, which maybe considerable.

[2] For TRS-ActiveCare 1-HD, certain generic preventive drugs are covered at 100%. Participants do not have to meet the deductible ($2,750 – individual, $5,500 – family) and they pay nothing out of pocket for these drugs. Find the list of drugs at **info.caremark.com/trsactivecare**.

[3] If a participant obtains a brand-name drug when a generic equivalent is available, they are responsible for the generic copay plus the cost difference between the brand-name drug and the generic drug.

[4] If the cost of the drug is less than the minimum, you will pay the cost of the drug.

[5] Participants can fill 32-day to 90-day supply through mail order.

* 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.

TRSAC-0097 (4/19)

# Puntos Importantes del Plan TRS-ActiveCare para el Año 2019-20

Vigente del 1ro de septiembre de 2019 al 31 de agosto de 2020 | Nivel de Beneficios Dentro de la Red[1]

| Cobertura Médica | TRS-ActiveCare 1-HD | TRS-ActiveCare Select/ TRS-ActiveCare Select Whole Health (Baptist Health System y HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance) | TRS-ActiveCare 2 **NOTA:** Si usted está actualmente inscrito en TRS-ActiveCare 2, puede permanecer en este plan. Sin embargo, a partir del 1ro de septiembre de 2018, TRS-ActiveCare 2 estará cerrado para todos los participantes que deseen inscribirse por vez primera. |
|---|---|---|---|
| **Deducible** (por año del plan) **Dentro de la Red** | $2,750 empleado solamente/ $5,500 familia | $1,200 por persona / $3,600 por familia | $1,000 por persona / $3,000 por familia |
| **Fuera de la Red** | $5,500 empleado solamente / $11,000 familia | No se aplica. Este plan no cubre los servicios prestados fuera de la red, a excepción de las emergencias. | $2,000 por persona / $6,000 por familia |
| **Desembolso Personal Máximo** (por año del plan, los deducibles médicos y para medicinas recetadas, copagos y coseguro cuentan contra el desembolso personal máximo) **Dentro de la Red** | El desembolso personal máximo solamente incluye los gastos cubiertos en que haya incurrido la persona individual. $6,750 por persona / $13,500 por familia | $7,900 por persona / $15,800 por familia | $7,900 por persona / $15,800 por familia |
| **Fuera de la Red** | $20,250 por persona / $40,500 por familia | No se aplica. Este plan no cubre los servicios prestados fuera de la red, a excepción de las emergencias. | $23,700 por persona / $47,400 por familia |
| **Coseguro** **Dentro de la Red:** El participante paga (después del deducible) | 20% | 20% | 20% |
| **Fuera de la Red:** El participante paga (después del deducible) | 40% de la cantidad permitida, a menos que se indique lo contrario | No se aplica. Este plano no cubre los servicios prestados fuera de la red, a excepción de las emergencias. | 40% de la cantidad permitida, a menos que se indique lo contrario |
| **Copago por Visita al Consultorio Médico** El participante paga | 20% después del deducible | $30 copago por médico primario<br>$70 copago por especialista | $30 copago por médico primario<br>$70 copago por especialista |
| **Laboratorio de Diagnóstico** El participante paga | 20% después del deducible | 20% después del deducible<br>(Kelsey Select - El plan paga un 100%) | 20% después del deducible |
| **Cuidado Preventivo** Vea los ejemplos que se muestran a continuación | El plan paga 100% | El plan paga 100% | El plan paga 100% |
| **Servicios Prestados por un Médico de Teladoc®** | $40 honorario por consulta (cuenta contra el deducible y desembolso personal máximo) | El plan paga 100% | El plan paga 100% |
| **Radiología de Alta Tecnología** (tomografía computarizada (CT scan), imágenes de resonancia magnética (MRI), medicina nuclear) El participante paga | 20% después del deducible | $100 copago más 20% después del deducible | $100 copago más 20% después del deducible |
| **Hospitalización – Gastos de Hospital Solamente (requiere autorización previa)** **Dentro de la Red** | 20% después del deducible | $150 copago por día más 20% después del deducible ($750 copago máximo por hospitalización) | $150 copago por día más 20% después del deducible ($750 copago máximo por hospitalización); $2,250 copago máximo por año del plan) |
| **Fuera de la Red** | El plan paga hasta $500 por máximo diario de los cargos cubiertos después del deducible. Usted paga la diferencia, es decir, la cantidad que sobrepase los $500 de copago máximo diario | No se aplica. Este plan no cubre servicios prestados fuera de la red a excepción de emergencias. | El plan paga hasta $500 por máximo diario de los cargos cubiertos después del deducible. Usted paga la diferencia, es decir, la cantidad que sobrepase los $500 de copago máximo diario |
| **Cuidado Urgente** | 20% después del deducible | $50 copago por visita | $50 copago por visita |
| **Sala de Emergencia Independiente** El participante paga | $500 copago por visita más 20% después del deducible | $500 copago por visita más 20% después del deducible | $500 copago por visita más 20% después del deducible |
| **Sala de Emergencia** (para uso en verdaderas emergencias) El participante paga | 20% después del deducible | $250 copago más 20% después del deducible (se omite el copago si lo hospitalizan) | $250 copago más 20% después del deducible (se omite el copago si lo hospitalizan) |
| **Cirugía Ambulatoria** El participante paga | 20% después del deducible | $150 copago por visita más 20% después del deducible | $150 copago por visita más 20% después del deducible |
| **Cirugía Bariátrica (se cubre solo si se efectúa en un Institute of Quality o IOQ, por sus siglas en inglés)** Cargos del médico; El participante paga | $5,000 copago (no se aplica contra el desembolso personal máximo) más 20% después del deducible | No se cubre | $5,000 copago (no se aplica contra el desembolso personal máximo) más 20% después del deducible |
| **Examen Anual de la Vista** (uno por año del plan, realizado por un oftalmólogo u optometrista). El participante paga | 20% después del deducible | $70 copago por especialista | $70 copago por especialista |
| **Examen Anual de la Capacidad Auditiva** El participante paga | 20% después del deducible | $30 copago por médico primario<br>$70 copago por especialista | $30 copago por médico primario<br>$70 copago por especialista |

## Cuidado Preventivo

A continuación, encontrará algunos ejemplos de la frecuencia y servicios relacionados con el cuidado preventivo:

- **Exámenes médicos de rutina:** anualmente después de cumplir 12 años
- **Mamografías:** anualmente después de cumplir 35 años
- **Consejería para dejar de fumar:** ocho visitas por período de 12 meses
- **Cuidado del niño sano:** sin límite hasta los 12 años de edad
- **Colonoscopia:** una cada 10 años después de cumplir 45 años
- **Consejería para una dieta sana y el control de la obesidad:** sin límite hasta los 22 años. Después de 26 visitas por 12 meses.
- **Examen para la mujer sana y Papa Nicolau:** anualmente después de cumplir 18 años
- **Examen para detectar el cáncer de próstata:** uno por año después de cumplir 50 años
- **Apoyo para mujeres que estén amamantando:** seis visitas de consejería de lactación por período de 12 meses

**Nota:** Los servicios cubiertos bajo este beneficio deberán facturarlos el proveedor como "cuidado preventivo". El cuidado médico preventivo que no sea de la red no se pagará en un 100%. Si recibe cuidado preventivo a través de un médico no perteneciente a la red, usted será responsable por cualquier deducible y coseguro aplicable bajo el plan. No hay cobertura para los servicios prestados fuera de la red bajo el plan TRS-ActiveCare Select ni TRS-ActiveCare Select Whole Health. Para más información, consulte el Folleto de Beneficios en el **www.trsactivecareaetna.com**.

# Puntos Importantes del Plan TRS-ActiveCare para el Año 2019-20

| Cobertura Médica | TRS-ActiveCare 1-HD | TRS-ActiveCare Select/ ActiveCare Select Whole Health (Baptist Health System y HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance) | TRS-ActiveCare 2 **NOTA:** Si usted está actualmente inscrito en TRS-ActiveCare 2, puede permanecer en este plan. Sin embargo, a partir del 1ro de septiembre de 2018, TRS-ActiveCare 2 estará cerrado para todos los participantes que deseen inscribirse por vez primera. |
|---|---|---|---|
| **Deducible para Medicamentos** (por persona, por año del plan) | Deberá satisfacer el deducible del año del plan antes de que el plan pague.[2] | $0 genérico; $200 de marca | $0 genérico; $200 de marca |
| **Suministro a Corto Plazo Adquirido en una Farmacia Regular** (suministro de hasta 31 días) | | | |
| NIvel 1 – Genérico | 20% coseguro después del deducible, excepto para ciertos medicamentos genéricos preventivos, los cuales se cubren en un 100%.[2] | $15 copago | $20 copago |
| Nivel 2 – Marca Preferida | 25% coseguro después del deducible[3] | 25% coseguro (mínimo $40[4]; máximo $80)[3] | 25% coseguro (mínimo $40[4]; máximo $80)[3] |
| Nivel 3 – Marca No Preferida | 50% coseguro después del deducible[3] | 50% coseguro[3] | 50% coseguro (mínimo $100[4]; máximo $200)[3] |
| **Suministro para un Período Prolongado, Ordenado por Correo o Adquirido en una Farmacia *Retail-Plus*** (para un suministro de 60 a 90 días)[5] | | | |
| Nivel 1 – Genérico | 20% coseguro después del deducible | $45 copago | $45 copago |
| Nivel 2 – Marca Preferida | 25% coseguro después del deducible[3] | 25% coseguro (mínimo $105[4]; máximo $210)[3] | 25% coseguro (mínimo $105[4]; máximo $210)[3] |
| Nivel 3 – Marca No Preferida | 50% coseguro después del deducible[3] | 50% coseguro[3] | 50% coseguro (mínimo $215[4]; máximo $430)[3] |
| **Medicamentos de Especialidad** (un suministro de hasta 31 días) | | | |
| Medicamentos de Especialidad | 20% coseguro después del deducible | 20% coseguro | 20% coseguro (mínimo $200[4]; máximo $900) |
| **Suministro a Corto Plazo para Medicamentos de Mantenimiento Adquiridos en una Farmacia Regular** (suministro de hasta 31 días) La segunda vez que el participante adquiera, en una farmacia regular, un suministro a corto plazo para medicamentos de mantenimiento, tendrá que pagar el coseguro y copagos que aparecen a continuación. Los participantes pueden ahorrar más con el plan adquiriendo un suministro mayor para medicamentos de mantenimiento, ya sea por correo o en una farmacia *Retail-Plus*. | | | |
| Nivel 1 – Genérico | 20% coseguro después del deducible | $30 copago | $35 copago |
| Nivel 2 – Marca Preferida | 25% coseguro después del deducible[3] | 25% coseguro (mínimo $60[4]; máximo $120)[3] | 25% coseguro (mínimo $60[4]; máximo $120)[3] |
| Nivel 3 – Marca No Preferida | 50% coseguro después del deducible[3] | 50% coseguro[3] | 50% coseguro (mínimo $105[4]; máximo $210)[3] |

**¿Qué es un medicamento de mantenimiento?**
Los medicamentos de mantenimiento son medicinas recetadas comúnmente utilizadas para tratar enfermedades que se consideran crónicas o a largo plazo. Estas enfermedades requieren del uso diario y regular de medicamentos. Por ejemplo, los medicamentos de mantenimiento son los que se utilizan para tratar la hipertensión, la enfermedad cardiaca, el asma y la diabetes.

**¿Cuándo se aplica el honorario de conveniencia?**
Por ejemplo, usted pagará $15 de estar cubierto bajo TRS-ActiveCare Select, la primera vez que adquiera, en una farmacia regular, un suministro de 31 días para un medicamento genérico de mantenimiento. Después de eso, pagará $30 por cada mes en que adquiera, en una farmacia regular, un suministro de 31 días para un medicamento genérico de mantenimiento. Sin embargo, de adquirir un suministro de 90 días del mismo medicamento genérico de mantenimiento, le costaría $45 y usted se ahorraría $180 al año al adquirir un suministro de 90 días.

Un especialista es cualquier otro médico que no funja como médico de cabecera, internista, ginecólogo/obstetra o pediatra.

[1] Muestra los beneficios que se obtienen cuando se utilizan proveedores pertenecientes a la red. Para algunos planes, también hay disponibles beneficios fuera de la red. No hay cobertura para beneficios recibidos fuera de la red bajo los planes ActiveCare Select o ActiveCare Select Whole Health. Para más información, consulte la Guía de Inscripción. Los proveedores sin contrato podrían facturarle, a usted, la diferencia o cantidad que exceda la cantidad permitida para los servicios cubiertos. Los participantes serán responsables del pago de este saldo de la cantidad facturada, lo cual podría ser una suma considerable.

[2] Para ActiveCare 1-HD, ciertos medicamentos genéricos preventivos se cubren en un 100%. Los participantes no tienen que satisfacer el deducible ($2,750 por persona, $5,500 por familia) y no incurrirán en ningún gasto de desembolso personal por estos medicamentos. Usted encontrará la lista de medicamentos en **info.caremark.com/trsactivecare**.

[3] Si el participante obtiene un medicamento de marca habiendo un genérico equivalente, será entonces responsable por cubrir el copago del genérico más la diferencia en cuanto al costo que exista entre el medicamento de marca preferida y el medicamento genérico.

[4] Si el costo del medicamento es menos del mínimo, usted pagará entonces por el costo del medicamento.

[5] Los participantes pueden ordenar por correo suministros de 32 a 90 días.

*De no ser elegible para recibir subsidio del estado o distrito escolar, usted pagará la prima mensual completa. Comuníquese con su Administrador de Beneficios para conocer su prima mensual.

****La prima posterior a la contribución estatal de $75 y la del distrito escolar de $150 constituye la cantidad máxima que podría usted pagar cada mes. Consulte a su Administrador de Beneficios para conocer su costo mensual.** (Esta es la cantidad que tendrá que pagar usted cada mes después de haberse aplicado todos los subsidios disponibles para su prima)

***Esta porción la completará su administrador de beneficios. La contribución del estado o distrito escolar podría superar los $225.

CCG TRSAC-0097 (4/19)

# Scott and White Health Plan
# TRS-ActiveCare 2019-2020 Summary of Benefits

| Fully Covered Healthcare Services | |
|---|---|
| **Preventive Services** | **No Charge** |
| Standard Lab and X-Ray | No Charge |
| Disease Management and Complex Case Management | No Charge |
| **Well Child Care Annual Exams** | **No Charge** |
| Immunizations (age appropriate) | No Charge |
| **Plan Provisions** | |
| **Annual Deductible** | **$950 Individual/ $2,850 Family** |
| **Annual out-of-pocket maximum (including medical and prescription copays and coinsurance)** | **$7,450 Individual/ $14,900 Family** (includes combined Medical and Rx copays, deductibles and coinsurance) |
| Lifetime Paid Benefit Maximum | None |
| **Outpatient Services** | |
| **Primary Care[1]** | **$20 Copay** (First Primary Care Visit for Illness - $0 Copay[2] / $0 Copay for primary visit for dependents age 19 and under) |
| Specialty Care | $70 copay |
| Other Outpatient Services | 20% after deductible[3] |
| Diagnostic/Radiology Procedures | 20% after deductible |
| Eye Exam (one annually) | No Charge |
| Allergy Serum & Injections | 20% after deductible |
| Outpatient Surgery | $150 copay and 20% of charges after deductible |
| **Maternity Care** | |
| Prenatal Care | No Charge |
| Inpatient Delivery | $150 per day[4] and 20% of charges after deductible |
| **Inpatient Services** | |
| Overnight hospital stay: includes all medical services including semi-private room or intensive care | $150 per day[4] and 20% of charges after deductible |
| **Diagnostic & Therapeutic Services** | |
| Physical and Speech Therapy | $70 copay |
| **Manipulative Therapy[5]** | **20% without office visit $40 plus 20% with office visit** |
| **Equipment and Supplies** | |
| Preferred Diabetic Supplies and Equipment | $5/$12.50 copay; no deductible |
| Non-Preferred Diabetic Supplies and Equipment | 30% after Rx deductible |
| Durable Medical Equipment/ Prosthetics | 20% after deductible |

| Home Health Services | |
|---|---|
| Home Healthcare Visit | $70 copay |
| **Worldwide Emergency Care** | |
| Nurse Advice Line | 1-877-505-7947 |
| Online Services | No Charge — go to trs.swhp.org |
| After-Hours Primary Care Clinics | $20 copay |
| Ambulance and Helicopter | $40 copay and 20% of charges after deductible |
| Emergency Room[6] | $500 copay after deductible |
| Urgent Care Facility | $50 copay |
| **Prescription Drugs** | |
| Annual Benefit Maximum | Unlimited |
| Rx Deductible<br>Does not apply to preferred generic drugs | $150 |

| **Ask an SWHP Pharmacy representative how to save money on your prescriptions.** | **Retail Quantity** (Up to a 30-day supply) | **Maintenance Quantity** (Up to a 90-day supply) Available at BSW Pharmacies, in-network retail pharmacies and mail order |
|---|---|---|
| Preferred Generic | $5 copay | $12.50 copay |
| Preferred Brand | 30% after Rx deductible | 30% after Rx deductible |
| Non-Preferred | 50% after Rx deductible | 50% after Rx deductible |
| Online Refills | trs.swhp.org | |
| Mail Order | BSWH : 1-817-388-3090<br>OptumRx: 1-855-205-9182 | |

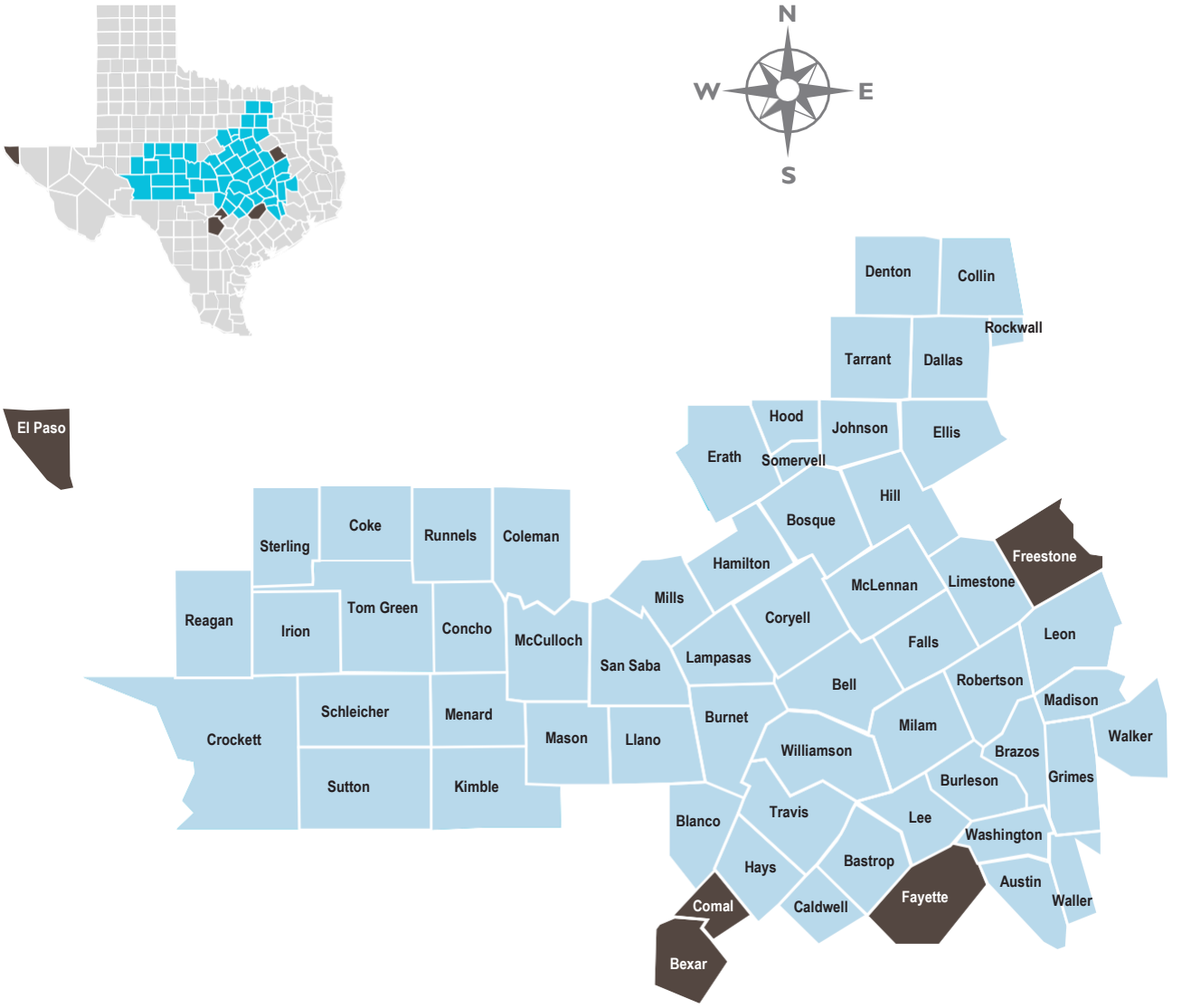
| **Specialty Medications** (up to a 30-day supply) | |
|---|---|
| Tier 1 | 15% after Rx deductible |
| Tier 2 | 15% after Rx deductible |
| Tier 3 | 25% after Rx deductible |

**The SWHP MOMS Program provides you with** specialized nurses who are notified of the delivery of your baby. These licensed professionals will contact you after you return home and help you with everything from the general well-being of both you and your baby, to breast/bottle feeding, to information on how to add your baby to your health plan.

[1]Including all services billed with office visit
[2] Does not apply to wellness or preventive visits
[3]Includes other services, treatments, or procedures received at time of office visit
[4]$750 maximum copay per admission and 20% after deductible
[5]35 maximum visits per year
[6]Copay waived if admitted within 24 hours

# Join the 22,000+ TRS employees already covered by Scott and White Health Plan

**Teacher Retirement System • Scott and White Health Plan Service Area • 2019-20**




## Who can select/access Scott and White Health Plan?

If you live OR work in any county shown in blue, you can choose coverage with SWHP and see in-network providers in all counties shown.

## Open Access

Our Open Access HMO means members can see any network provider (PCP or specialist) without a referral and still receive in-network benefits.

# MEDICAL SERVICES

## TRS Medical Rates

*2019-2020 Plan Year*

*(Effective 09/01/2019 - 08/31/2020)*

| ACTIVECARE 1-HD | Total Cost | Employer Contribution | Your Monthly Cost |
|---|---|---|---|
| Employee Only | $378 | $250 | $128 |
| Employee & Child(ren) | $722 | $250 | $472 |
| Employee & Spouse | $1,066 | $250 | $816 |
| Employee & Family | $1,415 | $250 | $1,165 |

| ACTIVECARE SELECT | Total Cost | Employer Contribution | Your Monthly Cost |
|---|---|---|---|
| Employee Only | $556 | $250 | $306 |
| Employee & Child(ren) | $902 | $250 | $652 |
| Employee & Spouse | $1,367 | $250 | $1,117 |
| Employee & Family | $1,718 | $250 | $1,468 |

| ACTIVECARE 2 | Total Cost | Employer Contribution | Your Monthly Cost |
|---|---|---|---|
| Employee Only | $852 | $250 | $602 |
| Employee & Child(ren) | $1,267 | $250 | $1,017 |
| Employee & Spouse | $2,020 | $250 | $1,770 |
| Employee & Family | $2,389 | $250 | $2,139 |

| Scott & White | Total Cost | Employer Contribution | Your Monthly Cost |
|---|---|---|---|
| Employee Only | 558.54 | $250 | $308.54 |
| Employee & Child(ren) | 876.76 | $250 | $626.76 |
| Employee & Spouse | 1,306.58 | $250 | $1,056.58 |
| Employee & Family | 1,457.28 | $250 | $1,207.28 |

Aetna-TRS Activecare
(800) 222-9205
www.trsactivecareaetna.com

TRS-Caremark Prescriptions
(800) 552-8159
www2.caremark.com/trsactivecare/
customerservice@caremark.com

# 10 WAYS TO GET THE MOST FROM YOUR TRS-ACTIVECARE PLAN

**Put your TRS-ActiveCare plan to work for a better you. Here are 10 ways to make the most of your plan's features and resources:**

## 1. CHOOSE THE PLAN THAT'S RIGHT FOR YOU

How do you and your family use health care services? When you compare premium costs, keep in mind that a lower premium cost means higher out-of-pocket costs for care — and vice versa. What's most important to you in a health plan? The enrollment resources can help you learn about your options and match a plan to your unique needs.

## 2. KNOW YOUR BENEFITS

After you choose, you may not remember what your deductible is or what the plan pays. To see what you'll pay out of your own pocket for care, look at your deductibles, coinsurance and copays. Download the TRS Health mobile app to view your plan, call a nurse or connect directly to a doctor right from your phone!

## 3. FIND A DOCTOR

Use the provider search tool on your Aetna member website to find high-quality, in-network doctors near you. Find a primary care physician (PCP) that will coordinate your care and help you with your health care needs and health goals. Register and log in at **aetna.com**.

## 4. KNOW WHERE TO GO

The ER is always the place to go when a life is in danger. When it's not life-threatening, you've got options: You can visit your PCP, an urgent care center, a walk-in clinic, and call or video chat with a doctor. The provider search tool can help you find the right provider in Aetna's network.

## 5. PLAN FOR EMERGENCIES

It's good to know ahead of time where your closest urgent care and ER are located and how to get there. **Tip:** Post the facility name, address and phone number where you can access it quickly.

## 6. SCHEDULE YOUR ROUTINE EXAM

An annual physical exam tells you and your doctor a great deal about your current state of health as well as your risk for potential problems.

## 7. SAVE ON YOUR RX

Ask your doctor to prescribe generic drugs when possible. If generics are not available for the medications you use, he or she may be able to recommend lower-cost alternatives. You can also check the drug cost estimator at **caremark.com/trsactivecare** for lower costs.

## 8. RESEARCH COSTS

The place where you get your surgery, labwork and imaging done affects your out-of-pocket costs, even within the network. **Try this:** Use the cost estimator tool at your Aetna member website to find and compare prices for treatments, procedures and tests.

## 9. SET A HEALTH GOAL

You may want to lose a few pounds, run a race or simply keep up with the kids. Get help to reach your goal from the wellness tools and resources at your Aetna member website.

## 10. STAY INFORMED

Online resources at **trsactivecareaetna.com** and **aetna.com** offer a wealth of health, wellness and benefits information. Need a quick answer or solution? Call TRS-ActiveCare Customer Service at **1-800-222-9205** to talk with an Aetna Health Concierge.

Download the new TRS Health app today!



TRS ACTIVECARE
TEACHER RETIREMENT SYSTEM OF TEXAS

# Health Savings Account (HSA)

## Proficient Benefit Solutions (PBS)

Now, more than ever, healthcare dollars need to go further. With a Health Savings Account (HSA), you'll pay less in taxes and increase your take-home pay. So enroll in an HSA and keep more of the money you've earned. *That's real savings, real simple.*

### What is a Health Savings Account (HSA)?

An HSA works with a high deductible heath plan (HDHP), and allows you to use before-tax dollars to reimburse yourself for eligible out- of-pocket health expenses for you, your spouse and your dependents, which in turn saves you on taxes and increases your spendable income.

### How it works

Anyone can deposit money into your HSA account, up to an annual individual or family limit* set by the IRS. When you enroll, an account will be created for you at a sponsor bank. You'll be given access to a secure, easy-to-use web portal where you can track your account balance, view your investment accounts and submit requests for reimbursements.

In addition, you'll receive a convenient benefit card to make it easy to access the money in your HSA. The card contains the value of your HSA account and you can use it to pay for eligible services and products. When you use the card, payments are automatically withdrawn from your account, so there are no out- of-pocket costs and you won't have to submit receipts to verify the purchase. Just swipe the card and go. It's that easy! Please note: the IRS requires that you retain documentation for your eligible expenses.

**IRS limits for 2019 and 2020*

| Type | 2019 | 2020 |
|---|---|---|
| **Individual** | **$3,500** | **$3,550** |
| **Family** | **$7,000** | **$7,100** |

### Benefits to You:

- An HSA is yours. Funds in your HSA account stay with you, even if you change jobs.
- Contribute tax free. An HAS reduces your taxable income. The money is tax free both when you put it in and when you take it out to cover qualified health expenses.
- Grow funds tax free. An HAS grows with you. If you maintain a minimum balance of $2,000 your additional funds may be invested in mutual funds yielding tax-free earnings.
- Spend tax free. Withdrawals used for eligible expenses are tax free.
- Funds can be withdrawn anytime for health expenses.
- After age 65, the funds can be used for any purpose, without penalty

### You can use your HSA dollars and card to pay for:

- ✓ Routine Healthcare: office visits, X-rays, lab work
- ✓ Hospital Expenses: room and board, surgery
- ✓ Medications: prescription and over-the-counter (OTC) drugs when prescribed by a physician
- ✓ Dental Care: cleanings, fillings, crowns
- ✓ Vision Care: eye exams, glasses, contacts
- ✓ Copays and Coinsurance (the portions of healthcare bills paid by you)
- ✓ Eligible OTC Items* such as: first aid dressings and supplies – bandages, rubbing alcohol
- ✓ Contact Lens Solution/Supplies
- ✓ Diagnostic Products such as: thermometers, blood pressure monitors, cholesterol testing
- ✓ Insulin and Diabetic Testing Supplies

**The list of eligible OTC items changed per the Patient Protection and Affordable Care Act of 2010. Contact your plan administrator for more information or visit www.irs.gov for details.*


**The amount you save in taxes with a Health Savings Account will vary depending on the amount you set aside in the account, your annual earnings, whether or not you pay Social Security taxes, the number of exemptions and deductions you claim on your tax return, your tax bracket and your state and local tax regulations. Check with your tax advisor for information.**

**This brochure highlights some of the benefits of a Card. If there is a discrepancy between this material and your official plan document, the plan document will govern. WEX Health reserves the right to amend or modify the services at any time.**

# What if you could save 30% on your healthcare expenses?

You are not eligible to contribute to a FSA if you are enrolled in a Medical HSA Account

## Health FSA

No matter what health plan option you choose, chances are you and your family will incur out-of-pocket costs this plan year – in the form of deductibles, copays, coinsurance, etc. Health FSA dollars can be used to pay for these expenses for you, your spouse and children (up to the age of 27). You can choose to contribute up to the maximum of $2,700 per plan year and it is all tax-sheltered dollars. The best part is – there is a 2 ½ month grace period extension to this plan. And because the Health FSA is pre-funded, your entire annual election is available for use at the beginning of your plan year.

## Helpful Tips:

- **Know your coverage.** Every health plan will have out-of-pocket costs in the form of deductibles, copays, and coinsurance.
- **Consider your budget and financial goals.** Ensure your contributions fit into your overall personal finances. Ask yourself how many office visits, prescriptions, specialists, labs, and other procedures you or your family is likely to need.
- **Factor in major purchases.** Look up average costs for any major planned treatments or procedures.
- **Look back at prior years.** Your prior year spending may give you a hint as to how much you are likely to spend this year.

## It's time to make those decisions again:

- Regardless of which health insurance plan you choose, you are likely to incur out-of-pocket costs. An FSA allows you to stretch your healthcare dollars an average of 30% by using pre-tax funds.
- Put the 'right' amount of money into your account. Consider your financial goals, your likely spending needs, and your budget constraints.

## Dependent Care FSA

The most you can set aside is $5,000 if single or married and filing jointly or $2,500 if married and filing separately. The person whose expenses you are claiming must be

- your qualifying child under the age of 13, who shares the same residence with you; or
- your spouse or qualifying child or qualifying relative who is physically or mentally unable to care for him/herself who shares the same residence with you and has income less than the Federal exemption amount.

## You must make a new election each year!

# Dental

*MetLife*

**MetLife**
(800) 942-0854
https://www.askmetlife.com

MetLife gives you the freedom to choose whether you would like to visit a participating dentist or an out-of-network dentist. There are considerable cost savings when using a dentist who is in the network. The following is a brief summary of the major plan provisions.

*Please note: An Insurance ID card will not be issued. Please have your provider call MetLife to verify your benefits using your SSN.*

| Benefit | High Plan PPO | Low Plan PPO |
|---|---|---|
| **Deductible (annual; maximum 3 per family. Applies to Class B and C services)** | $50 | $50 |
| **Benefit Year Maximum (per calendar year. Includes Class A, B, and C services)** | $2,000 | $1,000 |
| **Class A: Preventive Services**<br>Routine exams: 2 per 12 months<br>Prophylaxis: 2 per 12 months<br>Bitewing X-rays: 2 per 12 months<br>Full-mouth X-ray: 1 per 36 months<br>Fluoride: 1 per 12 months<br>Sealants: 1 per molar in 60 months | 100% | 100% |
| **Class B: Basic Services**<br>Space maintainers to age 14: 1 per lifetime<br>Repairs<br>General Anesthesia<br>Oral Surgery<br>Amalgam and Composite Fillings<br>Emergency Palliative Treatment | 80% | 80% |
| **Class C: Major Services**<br>Endodontics (root canals), Inlays, and Onlays<br>Surgical periodontics (gum treatments)<br>Crowns, bridges, dentures, and implants<br>Repairs: crown, denture, and bridge | 50% | 50% |
| **Class D: Orthodontics (dependent child to age 19 only)** | 50% with Lifetime Orthodontics Maximum of $1,000 | 50% with Lifetime Orthodontics Maximum of $750 |

| Coverage Category | High Plan PPO | Low Plan PPO |
|---|---|---|
| Employee Only | $42.72 | $22.14 |
| Employee + 1 Dependent | $76.33 | $40.82 |
| Family | $120.23 | $63.01 |

# HEALTH AND WELL-BEING

## Vision

*MetLife*

**MetLife**
(855) 638-3931
https://www.askmetlife.com

MetLife provides you and your family with quality vision benefits at an affordable cost. This program includes access to both independent practitioners and large retail chains, providing cost-savings for the solution that best fits your vision needs.

*Please note: An Insurance ID card will not be issued. Please have your provider call MetLife to verify your benefits using your SSN.*

| Benefit | Vision Plan | |
|---|---|---|
| | VSP Network | Out-of-Network Allowance |
| **Exam** | $10 copay | Up to $45 |
| **Materials** | $25 copay | N/A |
| **Standard Plastic Lenses** | | |
| Single Vision | Covered by copay | Up to $30 |
| Bifocal | Covered by copay | Up to $50 |
| Trifocal | Covered by copay | Up to $65 |
| Lenticular | Covered by copay | Up to $100 |
| Progressive | Up to $175 copay | Up to $50 |
| **Lens Options** | | |
| Standard scratch resistant coating | $17 – $33 copay | Up to $45 |
| Polycarbonate lenses for children | 100% | Up to $45 |
| **Frames** | Up to $150 | Up to $70 |
| **Contact Lenses*** | | |
| Elective | Up to $150 allowance | Up to $105 |
| Medically Necessary | 100% | Up to $210 |

** Contact lenses are in lieu of eyeglasses and frames*

| Coverage Category | Vision |
|---|---|
| Employee Only | $9.41 |
| Employee + 1 Dependent | $16.02 |
| Family | $23.53 |

# Basic Life and AD&D

*Unum*

**Unum**
(866) 679-3054
https://www.unum.com

Eagle Mountain Saginaw ISD provides Basic Life insurance and Accidental Death and Dismemberment (AD&D) insurance. Eagle Mountain Saginaw ISD provides Basic Life insurance in the amount of $10,000. The AD&D insurance provides a monetary benefit to an employee or beneficiary when the employee experiences certain bodily injuries or death resulting from a covered accident while insured in the amount equal to the Basic Life insurance amount.

*Please note: The Benefit reduces to 65% at age 65 and to 50% at age 70.*

# Lifetime Benefit Term Insurance

*CHUBB*

**CHUBB**
(866) 324-8222
https://www.chubb.com

CHUBB's Lifetime Benefit Term Life Insurance provides money to your family at death, and while you are living too, if you need home health care, assisted living, or nursing care. For about the same premium, Lifetime Benefit Term Life Insurance provides higher benefits than permanent life insurance and lasts to age 121.

- Fully Portable- Your policy cannot be canceled as long as premiums are paid as due*
- Guaranteed Premiums- Life insurance premiums will never increase and are guaranteed to age 100.
- Long Term Care (LTC)- If you need long term care, you can access your death benefit while you are living for home health care, assisted living, adult day care, and nursing home care. You get 4% of your death benefit per month while you are living for up to 25 months to help pay for LTC. Insurance premiums are waived while this benefit is being paid*.

# CHUBB® Lifetime Benefit Term

Chubb's LifeTime Benefit Term (LBT) innovative design provides lifetime guarantees at a fraction of the cost of whole life insurance. It's term insurance that lasts a lifetime. And with LBT's flexibility, death benefits can be taken early and doubled or even tripled to supplement the cost of Long Term Care. solutions address differing employee needs for permanent life insurance and peace of mind for a lifetime, and are available for employees, their spouse, and children. The options include the industry's most comprehensive Living Benefits package.

## Product Features:

- Valuable life insurance protection through age 120!
- LifeTime Benefit Term life insurance up to $225,000 for eligible actively at work employees.
- Life base insurance premiums are guaranteed never to increase through age 100.
- No medical exams required. Issuance of coverage depends upon answers to a few health questions.
- Provides paid-up death benefit values after only ten years, so if you decide to stop paying premiums at some time in the future, you are guaranteed paid-up coverage of a reduced amount.
- Flexible! You have the option to: Continue your coverage at the same premium; or Elect paid-up insurance coverage of a reduced amount after 10 years with no further premium payments—Guaranteed!
- Fully portable – you own it and take it with you when you leave your employment.
- Spouse and child coverages are available.

Please speak with a benefits counselor for personalized rates.

# FINANCIAL FUTURE

## Supplemental Life Insurance

*Unum*

Supplemental Life and AD&D insurance provides you financial security at an affordable cost. Employees can elect up to five times their annual salary (up to $500,000) of coverage. If you elect employee coverage, you will have the option to enroll your spouse for up to 100% of the elected employee amount (up to $100,000) and your children for $10,000 worth of coverage.

These coverage maximums are guaranteed issue amounts, meaning that you will not have to provide an Evidence of Insurability (EOI) form or go through the medical underwriting process.

*Please note: The Benefit reduces to 65% at age 65 and to 50% at age 70.*

**Unum**
(866) 679-3054
https://www.unum.com

| Guaranteed Issue* | |
|---|---|
| **Employee** | $200,000 |
| **Spouse** | $50,000 |
| **All Children** | $10,000 |

| Supplemental Life Insurance Monthly Premium Rates per $1,000 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Age** | **0–29** | **30–34** | **35–39** | **40–44** | **45–49** | **50–54** | **55–59** | **60–64** | **65–69** | **70+** |
| Employee | $0.060 | $0.080 | $0.110 | $0.160 | $0.270 | $0.460 | $0.775 | $1.125 | $1.870 | $3.680 |
| Spouse | $0.060 | $0.080 | $0.110 | $0.160 | $0.270 | $0.460 | $0.775 | $1.125 | $1.870 | $3.680 |
| Child(ren) | $2.00 per family unit at a flat $10,000 | | | | | | | | | |

*Guaranteed Issue applicable for new hires ONLY

# Educator Select Income Select Protection

**Unum's Educator Select Protection Plan is designed to pay you a percentage of your gross monthly salary if you cannot work due to a covered injury or illness. Your rate for this benefit is dependent upon the elimination period and the requested benefit amount.**

We understand the unique needs of those who work in education, and we have created Educator Select disability insurance to meet those requirements. Unum's Educator Select disability insurance can replace a portion of your salary if you become ill or injured and can't work. It can help you cover your expenses and protect your finances at a time when you're not getting a paycheck and have extra medical bills.

- **Employee Benefit**: You may purchase a monthly benefit in $100 units, starting at a minimum of $200, up to 66 2/3% of your monthly earnings rounded to the nearest $100, but not to exceed a monthly maximum benefit of $8,000. Please see your Plan Administrator for the definition of monthly earnings.
- **Definition of Disability**: During the first 24 months, Unum will define disability as follows:

  You are unable to perform the material and substantial duties of your regular occupation due to sickness or injury; you have a 20% or more loss of indexed monthly earnings due to the same sickness or injury; and during the elimination period you are unable to perform any of the material and substantial duties of your regular occupation..

  After benefits have been paid for 24 months, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

  You must be under the regular care of a physician in order to be considered disabled.

- **Elimination Period:** The Elimination Period is the length of time of continuous disability, due to sickness or injury, which must be satisfied before you are eligible to receive benefits.

  **You may choose an Elimination Period (injury days/sickness days) of 7/7, 14/14, 30/30, 60/60, 90/90 or 180/180 days.**

| | **Elimination Period (Days)** | | | | | |
|---|---|---|---|---|---|---|
| **Injury (Days)** | 7* | 14* | 30* | 60 | 90 | 180 |
| **Sickness (Days)** | 7* | 14* | 30* | 60 | 90 | 180 |
| | **Rate Per Increment of $100** | | | | | |
| | 3.42 | 3.09 | 2.47 | 2.09 | 1.77 | 1.33 |

**If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.*

- **Pre-existing Condition Exclusion:** Benefits will not be paid for disabilities caused by, contributed to by, or resulting from a pre-existing condition. You have a pre-existing condition if:

  - you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage.

- **Benefit Integration:** Your disability benefit will be reduced by deductible sources of income and any earnings you have while disabled.

# INCOME PROTECTION CONT.

Unum
(866) 679-3054
https://www.unum.com

- **Duration of Benefits:** The duration of your benefit payments is based on your age when your disability occurs. Your LTD benefits are payable for the period during which you continue to meet the definition of disability. If your disability occurs before age 62, benefits could be payable up to the Social Security Normal Retirement Age. If your disability occurs at or after age 62, your benefits would be paid according to the benefit duration schedule.

| Age at Disability | Maximum Duration of Benefits |
|---|---|
| Less than Age 62 | To Social Security Normal Retirement Age |
| Age 62 | 60 months |
| Age 63 | 48 months |
| Age 64 | 42 months |
| Age 65 | 36 months |
| Age 66 | 30 months |
| Age 67 | 24 months |
| Age 68 | 18 months |
| Age 69 or older | 12 months |

| Year of Birth | Social Security Normal Retirement Age |
|---|---|
| 1937 or before | 65 years |
| 1938 | 65 years 2 months |
| 1939 | 65 years 4 months |
| 1940 | 65 years 6 months |
| 1941 | 65 years 8 months |
| 1942 | 65 years 10 months |
| 1943-1954 | 66 years |
| 1955 | 66 years 2 months |
| 1956 | 66 years 4 months |
| 1957 | 66 years 6 months |
| 1958 | 66 years 8 months |
| 1959 | 66 years 10 months |
| 1960 and after | 67 years |

- **Survivor Benefit:** Your eligible survivor will receive a lump sum benefit equal to 3 months of your gross disability payment. This benefit will be paid if, on the date of your death, your disability had continued for 180 or more consecutive days, and you were receiving or were entitled to receive payments under the plan. You may receive your survivor benefit prior to your death if you are receiving monthly payments and your physician certifies in writing that you have been diagnosed as terminally ill and your life expectancy has been reduced to less than 12 months.

**Group LTD Standard Plan Features Include:**

- **Rehabilitation and Return to Work Assistance Program** - Provides a rehabilitation and return to work assistance benefit for disabled employees who are receiving LTD payments, and who are medically able to participate. Unum will determine eligibility for this program.
- **Work-life balance employee assistance program** - provides a 24-hour phone line and web resources to help employees and their family members address both everyday issues, such as budgeting or selecting child care, as well as more serious ones, like substance abuse or divorce. This plan includes up to three face-to-face sessions for each separate problem an employee faces, to provide advice and identify resources.
- **Worldwide emergency travel assistance** - Emergency medical assistance for employees and their families when traveling 100 miles or more from home, anywhere in the world. Round-the-clock phone service provides access to Western-style medical resources, prescription refills and emergency medical transportation.

# FINANCIAL FUTURE

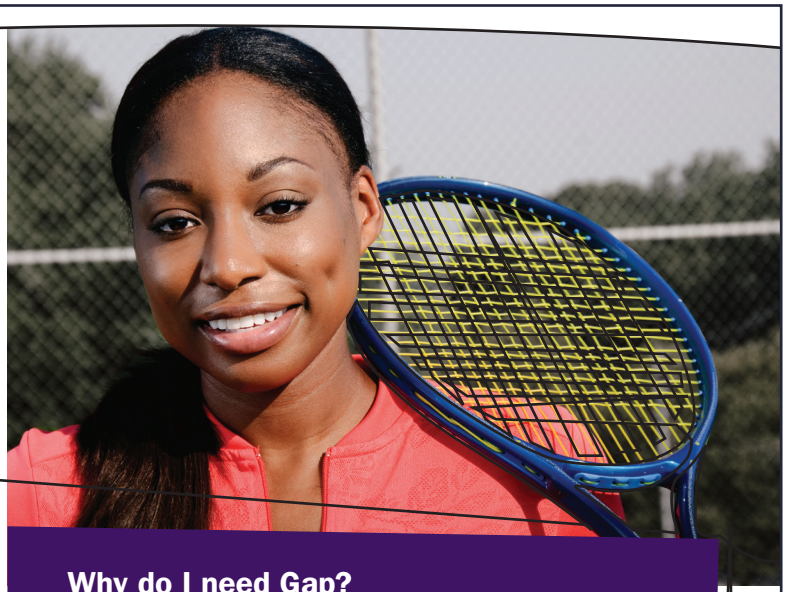
# Supplemental Medical

*Beazley*

Beazley
(855) 805-9176
https://www.beazley.com

Life is full of ups and downs. Some twists and turns are inevitable. But what would happen if out-of-pocket health expenses landed in your court? Wouldn't you love to have a safety net?

Thanks to your employer, you have access to insurance that could help fill gaps — just when you need it most.



## What is Supplemental Medical (Gap) insurance?

Like many workers today, you may now be responsible for paying some of your healthcare costs. Even with your major medical insurance, you may have certain expenses that are not covered.

For example, you may need to meet a deductible before your health insurance kicks in. Or you may need to cover co-pays and co-insurance out of your own pocket. As such, you may be concerned about those expenses taking a bite out of your budget.

Supplemental Medical (Gap) insurance covers certain out-of-pocket medical expenses you incur in inpatient and outpatient settings (as defined by the policy).

*Note: Supplemental Medical (Gap) does NOT replace your health insurance. But it can help fill gaps and offset medical expenses that you may have.*

### Why do I need Gap?

- Over 2 million people have declared bankruptcy due to unpaid medical bills.[1]
- More than three in five Americans don't have enough money saved to pay for an unexpected medical emergency, averaging $1,000.[2]
- Employees' average annual out-of-pocket expenses have grown from $1,500 in 2012 to nearly $2,500 in 2016.[3]

[1] NerdWallet Health, 2013
[2] Wall Street Journal, 2015
[3] Aon Health Care Cost Analysis, 2016

## How does Supplemental Medical (Gap) help me?

Under your major medical plan, you are responsible for paying deductibles, co-pays and co-insurance out of your own pocket. When you enroll in the Supplemental Medical (Gap) plan, offered by your employer, you get coverage to help with some of these out-of-pocket expenses.

For example, if you have a minor knee surgery at an outpatient surgery center, the plan will cover eligible out-of-pocket expenses, up to the outpatient benefit amount.

Or, if you (or your spouse) are hospitalized for the birth of your child, the plan will cover eligible out-of-pocket expenses for you AND nursery charges for your baby, up to the inpatient benefit amount.

## Who is Beazley?

Beazley provides a suite of gap protection products that helps protect employees against life's uncertainties. Beazley Insurance Company, Inc. is rated A by A.M. Best. It is a subsidiary of Beazley Group, which was founded in 1986.

## What are the specific plan benefits?

**Supplemental Medical (Gap) Plan for EAGLE MOUNTAIN SAGINAW ISD**

| Plan Features | Description |
|---|---|
| **Inpatient Benefit** | **$2,000 benefit amount:** Reimburses eligible out-of-pocket expenses incurred during inpatient hospitalization, up to an annual benefit max (see sidebar for definitions). |
| **Outpatient Benefit** | **$1,000 benefit amount:** Reimburses eligible out-of-pocket expenses performed in these settings, up to an annual benefit max (see sidebar for definitions). |
| **Guarantee Issue** | You are eligible for this coverage (regardless of your health status), and you do not have to answer any medical questions to qualify for coverage. |
| **Dependent Coverage** | You may also opt for coverage for your spouse or child(ren), as long as they participate in your employer's underlying major medical plan.<br>Your family maximum will be **two** times the individual benefit amounts above. |

## How much does the plan cost?

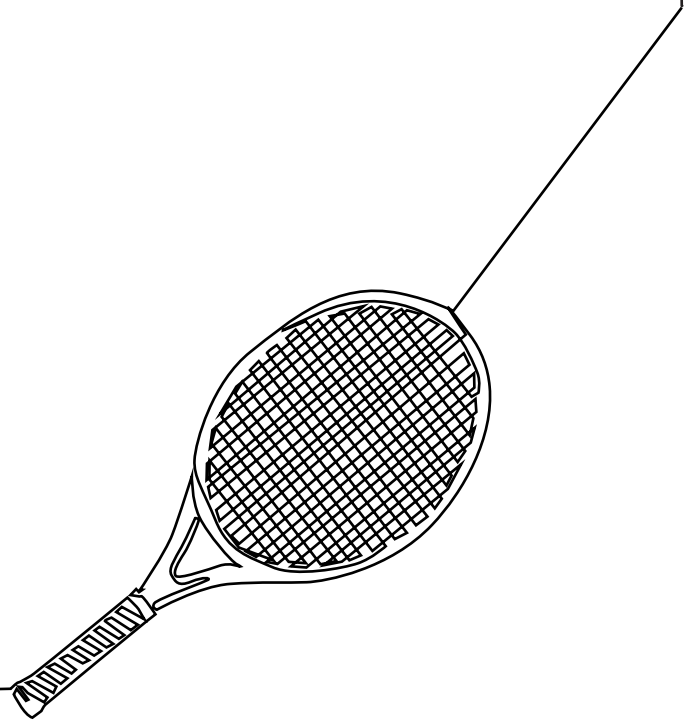
The grid below identifies the Premium Amount, based on your age and whether you want to cover family members.

| GAP COVERAGE | | |
|---|---|---|
| **Coverage Type** | **Monthly Premium Amount** | |
| **Age Bands** | **18-49** | **50-99** |
| **EE only** | $33.25 | $60.02 |
| **EE + Spouse** | $71.49 | $129.04 |
| **EE + Child(ren)** | $58.19 | $90.03 |
| **Family** | $104.74 | $165.06 |

### Coverage Definitions

Your plan may cover these out-of-pocket medical expenses, summarized below:

- **Inpatient Hospital Benefit:** Reimburses deductibles, co-pays and co-insurance incurred during inpatient hospitalization, such as hospital room and board and other inpatient hospital expenses.
- **Outpatient Benefit:** Reimburses eligible out-of-pocket expenses performed in these settings only:
  - Treatment in a hospital ER (but not admitted to inpatient)
  - Surgery in an Outpatient Hospital facility or freestanding surgery center
  - Radiological diagnostic testing in an Outpatient Hospital facility or MRI facility
  - Chemotherapy or radiation therapy in a licensed facility



# Accident Insurance

*MetLife*

MetLife
(800) 638-5433
https://www.askmetlife.com

You do everything you can to keep your family safe, but accidents do happen. Take comfort knowing you have help to manage the medical costs associated with accidental injuries, both on and off the job. Accident Insurance provides you with additional coverage for medical expenses and living costs when you get hurt.

| Benefit | Low Plan | High Plan |
|---|---|---|
| **Accidental Death Benefit Rider**<br>Employee<br>Spouse<br>Children | <br>$50,000<br>$25,000<br>$10,000 | <br>$50,000<br>$25,000<br>$10,000 |
| **Accidental Death Benefit Rider Common Carrier**<br>Employee<br>Spouse<br>Children | <br>$150,000<br>$75,000<br>$30,000 | <br>$150,000<br>$75,000<br>$30,000 |
| **Initial Accident Doctor's Office Visit** | $50 | $100 |
| **Accident Follow-Up Treatment** | $75 | $100 |
| **Ambulance**<br>**Air** | $300<br>$1,000 | $400<br>$1,500 |
| **Appliance** | Up to $1,000 | Up to $1,500 |
| **Blood, Plasma, and Platelets** | $400 | $500 |
| **Burns** | Up to $10,000 | Up to $15,000 |
| **Dislocation** | Up to $6,000 | Up to $9,000 |
| **Initial Accident Doctor's Office Visit** | $50 | $100 |
| **Emergency Dental Benefit** | Up to $200 | Up to $400 |
| **Emergency Room Treatment** | $100 | $150 |
| **Eye Injury** | $300 | $400 |
| **Fractures** | Up to $6,000 | Up to $9,000 |
| **Herniated Disc** | $1,000 | $1,500 |
| **Hospital Admission** | $1,000 | $2,000 |
| **Hospital Confinement (per day up to 365 days)** | $200 | $400 |
| **Hospital ICU (per day up to 15 days)** | $2,000 | $4,000 |
| **Loss of finger, toe, hand, foot, or sight of an eye** | Up to $50,000 | Up to $50,000 |
| **Prosthetic Device or Artificial Limb** | Up to $1,500 | Up to $2,000 |
| **Skin Grafts** | 50% of burn benefit | 50% of burn benefit |
| **Concussion** | $400 | $600 |
| **Annual Wellness Exam / Screening** | $100 | $100 |

| Coverage Category | Low Plan | High Plan |
|---|---|---|
| Employee Only | $13.07 | $17.23 |
| Employee + Spouse | $26.24 | $35.53 |
| Employee + Child(ren) | $26.67 | $36.27 |
| Family | $33.46 | $45.40 |

# Critical Illness with Cancer Insurance

MetLife
(800) 638-5433
https://www.askmetlife.com

## *MetLife*

Critical Illness Insurance protects you and your family in the event of a serious illness or other medical condition with coverage that is portable (meaning you can take it with you, if you leave).

Depending on the diagnosis you receive, your benefit payment may be 100% or 25% of your selected benefit amount. Payments are made directly to the employee and can be applied to claims, household bills, or other expenses as needed.

Rates will be based on the amount you have selected, your age upon issuance, and whether you use tobacco.

*Please speak with a Benefits Counselor for personalized rates.*

| Benefit | Critical Life Events<br>Benefit Amount |
|---|---|
| **Coverage Amounts** | |
| Employee<br>Spouse<br>Child | $10,000 to $50,000<br>50% of employee amount<br>50% of employee amount |
| | |
| Heart Attack<br>Stroke<br>Major Organ Transplant<br>Coronary Artery Bypass Graft<br>End Stage Renal Failure<br>Alzheimer's Disease<br>Full Cancer Benefit | 100% |
| | |
| ALS<br>Cerebral Palsy<br>Cystic Fibrosis<br>Partial Cancer Benefit | 25% |
| **Pre-Existing Conditions** | |
| | 3-month look back / 6-month waiting |
| **Health Screening Benefit** | |
| Annual Wellness Exam | $75 |

| Critical Illness Monthly Deductions per $1,000 (Non-Tobacco) | | | | | | |
|---|---|---|---|---|---|---|
| **Age** | **18 – 29** | **30 – 39** | **40 – 49** | **50 – 59** | **60 –69** | **70+** |
| **Employee** | $0.47 | $0.74 | $1.48 | $2.56 | $3.74 | $4.89 |
| **Employee + Spouse** | $0.80 | $1.27 | $2.51 | $4.30 | $6.16 | $8.01 |
| **Employee + Child(ren)** | $0.70 | $0.97 | $1.71 | $2.79 | $3.97 | $5.12 |
| **Family** | $1.03 | $1.50 | $2.74 | $4.53 | $6.39 | $8.24 |

| Critical Illness Monthly Deductions per $1,000 (Tobacco) | | | | | | |
|---|---|---|---|---|---|---|
| **Age** | **18 – 29** | **30 – 39** | **40 – 49** | **50 – 59** | **60 –69** | **70+** |
| **Employee** | $0.68 | $1.15 | $2.40 | $4.22 | $6.27 | $8.35 |
| **Employee + Spouse** | $1.13 | $1.93 | $4.03 | $7.07 | $10.33 | $13.71 |
| **Employee + Child(ren)** | $0.91 | $1.38 | $2.63 | $4.45 | $6.50 | $8.58 |
| **Family** | $1.36 | $2.16 | $4.26 | $7.30 | $10.56 | $13.94 |

# Hospital Indemnity

*Beazley*

Beazley
(855) 805-9176
https://www.beazley.com

Your employer is providing you access to a Hospital Indemnity policy that will help protect you and your family if you incur certain medical expenses. Read on to learn more about what is covered.

## What is Hospital Indemnity Insurance?

Hospital Indemnity insurance provides coverage, based on a set schedule of benefits for basic medical services.

**Note:** *Group Limited Indemnity is NOT major medical insurance.*

## What does the plan cover

The plan provides a benefit amount for select benefits, such as inpatient hospitalization.

You may opt for coverage for your spouse or child(ren). You are eligible for this coverage (regardless of your health status), and you do not have to answer any medical questions to qualify for coverage.

(For plan specifics and coverage definitions, see next page.)

## Who is Beazley?

Beazley provides a suite of gap protection products that helps protect employees against life's uncertainties. Beazley Insurance Company, Inc. is rated A by A.M. Best. It is a subsidiary of Beazley Group, which was founded in 1986.

## How does it work?

Once you are enrolled, the premium amount will be deducted from each paycheck. You will receive an ID card to present to your medical provider, indicating you have coverage.

To submit a claim, you will submit a copy of the itemized bill from the medical provider.

## Hospital Indemnity at a Glance

**What is it?**

- Covers basic medical services at a specific benefit amount for a specified number of days

**Why should I have it?**

- To fill gaps and protect your income and assets.
- To take advantage of the opportunity to select benefit options offered at work.

**How does it help me?**

Here's a sample scenario to demonstrate how the product can help fill gaps:

*Jerry enrolled in the Hospital Indemnity plan, offered by his employer. When Jerry became ill with pneumonia, he was admitted to the hospital for a few days to allow for medication and recovery. His plan paid out a lump-sum benefit for the hospital admission, as well as a daily amount for the short period of confinement.*

*Later that year, Jerry and his wife welcomed a new baby to the family. Because the baby was delivered C-section, Jerry's wife had to remain in the hospital for 2 days. Again the plan paid a lump-sum amount for the admission, and a daily amount for her short hospital stay.*

## How much does it cost?

| Coverage Type | Monthly Premium Amount |
|---|---|
| **Employee** | $11.53 |
| **Employee + Spouse** | $23.64 |
| **Employee + Child(ren)** | $20.50 |
| **Family** | $34.07 |

| HOSPITAL INDEMNITY PLAN FOR EAGLE MOUNTAIN SAGINAW ISD | | |
|---|---|---|
| **BENEFITS** | **BENEFIT DEFINITIONS** | **BENEFIT AMOUNTS AND MAXIMUMS** |
| **HOSPITAL INDEMNITY BENEFITS** | | |
| **Hospital Confinement** | For treatment in a hospital due to sickness or injury for 23 or more continuous hours (i.e., not less than a day) | $200 per insured, per day<br>15 days per insured, per year |
| **Hospital Admission** | Lump sum benefit for a hospital admission, due to sickness or injury | $1,000 per insured, per admission<br>1 admission per insured, per year |

US OMNI

EAGLE MOUNTAIN SAGINAW ISD

We are excited to announce **U.S. OMNI** as our **403(b) & 457(b) Third Party Plan Administrator!**

In partnership with **Eagle Mountain Saginaw Independent School District** OMNI will ensure that the plan sponsor, the participants, each of our investment providers and their agents adhere to the many compliance regulations mandated by the Internal Revenue Service.

## Starting or changing your contributions

If you wish to start contributing or make a change to your current contributions you will need to submit a **Salary Reduction Agreement (SRA)** form. Changes include: starting a new deduction, stopping an existing deduction, changing the amount of an existing deduction, or changing your investment service provider.

The SRA form can be found in the "Forms" section of OMNI's website at www.omni403b.com. You have the option of printing out a form and faxing it to OMNI or completing the form electronically on their secure website. It is suggested that you complete the electronic SRA form to expedite your request.


**OMNI's** services include the review and approval of all 403(b) & 457(b) transactions, and implementation of Salary Reduction Agreement (SRA) forms.

**OMNI** is available from 7:30am to 8:00pm Monday - Friday EST to assist with any questions you may have.

**OMNI's** call center representatives can be reached at:

1-877-544-OMNI (6664)

www.omni403b.com

## TRANSACTIONS

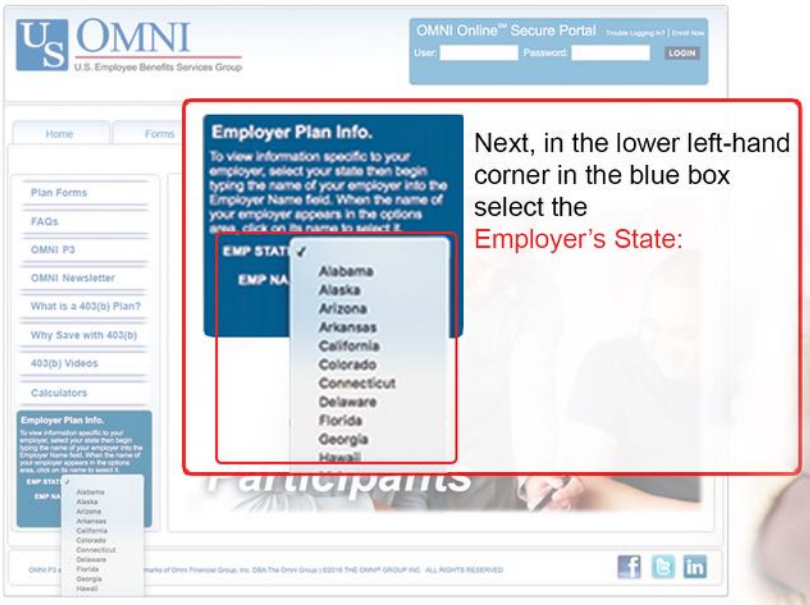
Refer to the instructions on the following pages to submit an SRA or any of the transactions below.

- Distributions (including distributions due to age, death, disability, separation from service, and domestic relations orders).
- Exchanges/Transfers/Rollovers of 403(b) funds between vendors or 403(b) plans
- Hardship distributions
- Loans
- Purchase of Service Credits
- QDRO's

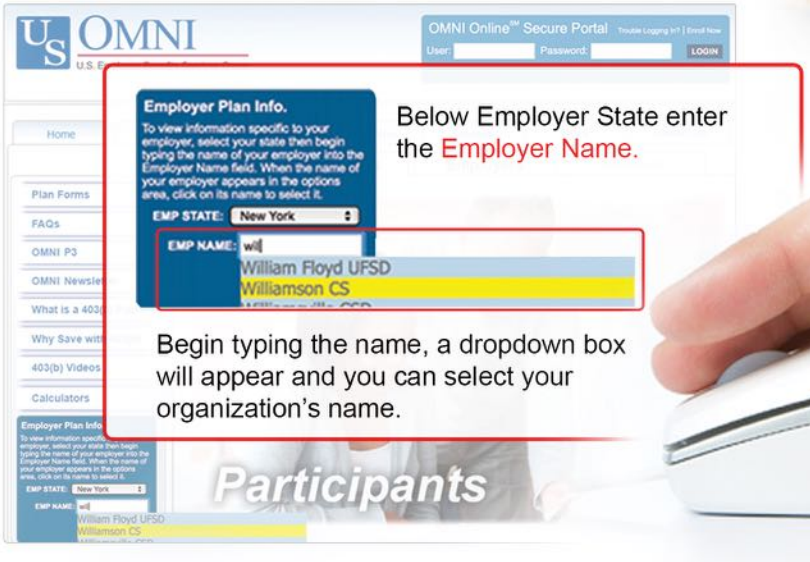
US OMNI

Specific plan information is available on OMNI's website at www.omni403b.com.
This information can be viewed by following the steps below:


Go to OMNI's website at **www.omni403b.com** and select the purple button labeled "Participants":




Next, in the lower left-hand corner in the blue box select the Employer's State:



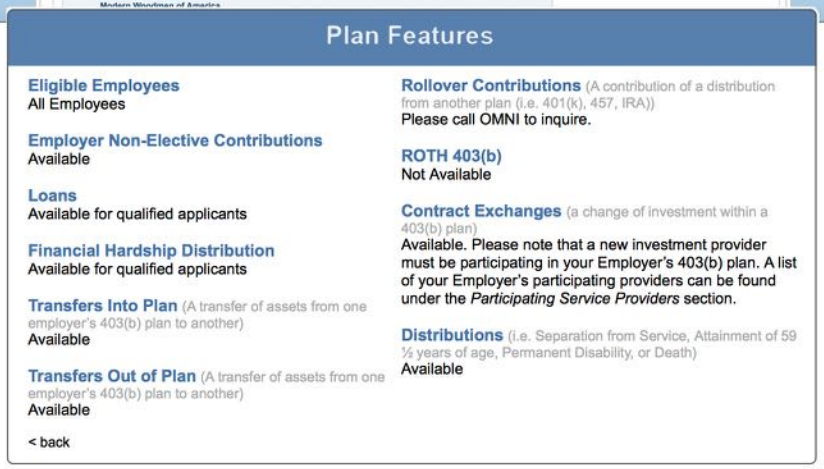

Below Employer State enter the Employer Name.

Begin typing the name, a dropdown box will appear and you can select your organization's name.

# EAGLE MOUNTAIN SAGINAW ISD

US OMNI

You have now reached the **Eagle Mountain Saginaw Independent School District** webpage where you will find the following information:


## PLAN DETAILS

### 403(b)

1. Salary Reduction Agreement (SRA) – You can submit an on-line SRA form to start, stop or make a change to your contribution. You must already have an account established with your selected service provider before submitting an SRA.
2. Participating Service Providers – Add or open an account choosing from the investment service providers that have been approved in your plan.
3. Plan Transactions – You'll find the forms needed to initiate transactions such as a distribution, hardship or loan.
4. Plan Features – Click on Plan Features in the lower right hand corner. This will bring up another window that displays what is or is not permitted within the plan based on your current plan document.

To access **457(b) Plan Details** click on 457(b) Plan tab.

**Please note:** If you are currently contributing to multiple investment providers, please be sure to list all contributions you wish to continue on the new SRA. Any current 403(b) or ROTH 403(b) contributions not listed on the new SRA will be discontinued.

**Please note:** any TRS approved 403(b) Service Provider which has entered into an Information Sharing Agreement (ISA) with The OMNI Group may be added to the following list at any time.

Please contact The OMNI Group at 877-544-6664 if you have questions concerning this process.

**Listed below are the Service Providers which currently participate in your organization's plan.** Service Providers with a double asterisk notation (**) are not authorized to accept new accounts under your employer's plan. Please contact OMNI® with any questions.

## 403(B)

**AMERICAN CENTURY SERVICES LLC**
AMERICAN FUND/CAPITAL GUARDIAN**
**AMERIPRISE FINANCIAL SERVICES, INC.**
ANNUITY INVESTORS LIFE INS. CO.**
ASPIRE FINANCIAL SERVICES
ATHENE ANNUITY AND LIFE (AVIVA)**
**AXA EQUITABLE LIFE INSURANCE COMPANY**
FIDELITY SECURITY LIFE INS. CO.**
FIDUCIARY TRUST INTL-FRANKLIN TEMPLETON**
**FORESTERS FINANCIAL (FIRST INVESTORS)**
**GREAT AMERICAN INSURANCE GROUP**
**GWN/EMPLOYEE DEPOSIT ACCT**
**HORACE MANN LIFE INS. CO.**
INDUSTRIAL ALLIANCE - (SEC.BEN.)**
**LINCOLN FINANCIAL GROUP**
**MASS MUTUAL VA**
**MET LIFE INVESTORS**
**METLIFE**
MIDLAND NATIONAL LIFE INSURANCE**
MODERN WOODMEN OF AMERICA**
**NATIONAL LIFE GROUP (LSW)**
NY LIFE INS. & ANNUITY CORP.**
**OPPENHEIMER SHAREHOLDER SVCS.**
**PLANMEMBER SERVICES CORP.**
PUTNAM INVESTMENTS**
**RIVERSOURCE LIFE INSURANCE CO OF NY**
**ROTH - AXA EQUITABLE**
**ROTH - FORESTERS FINANCIAL (FIRST INV.)**
**ROTH - LINCOLN FINANCIAL GROUP**
**ROTH - NATIONAL LIFE GROUP (LSW)**
**ROTH - PLANMEMBER SERVICES CORP.**
TRANSAMERICA**
UNITED TEACHER ASSOC. INS. CO**
USAA LIFE INSURANCE CO.**
**VALIC**
VANGUARD FIDUCIARY TRUST CO.**
**VOYA FINANCIAL (RELIASTAR)**

## 457(B)

AMERICAN UNITED LIFE INS. CO.**
**FORESTERS FINANCIAL(FIRST INV.)**
LINCOLN LIFE**

# Important Notices

### Health Insurance Portability and Accountability Act (HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. A copy of the Privacy Practices is available for from the Benefits Department.

### Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother of her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

### Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

### Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Act of 2008 general requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/ surgical benefits.

### Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan.

### Patient Protection Rights under Health Care Reform

HMO health plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, your HMO health plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your HMO health plan using the contact information provided in the Benefit Guide.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your HMO health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your HMO health plan using the contact information provided in the Benefit Guide.

If you would like more information about these notices, contact:

EMSISD Benefits Department

817.232.0880 ext. 2978

# HIPAA Special Enrollment Rights

## HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents

(including your spouse) because of other health insurance or group health

plan coverage, you may be able to enroll yourself and your dependents in

this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Benefits Department at 817.232.0880 ext. 2978

# Medicare Part D Creditable Coverage Notice

**An Important Notice from Eagle Mountain Saginaw ISD About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Eagle Mountain Saginaw ISD** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- **Eagle Mountain Saginaw ISD** has determined that the prescription drug coverage offered by the **TRS-ActiveCare 1-HD Plan is not, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore not considered Creditable Coverage**. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

**When Can You Join a Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your current **Eagle Mountain Saginaw ISD** coverage will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current **Eagle Mountain Saginaw ISD** coverage, be aware that you and your dependents will be able to get this coverage back.

**When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with **Eagle Mountain Saginaw ISD** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Name of Entity/Sender: Eagle Mountain Saginaw ISD
Contact--Position/Office: Jamie McNutt-Erwin—Benefits Specialist
Address: 1200 Old Decatur Road Ft. Worth, TX
Phone Number: 76179 817.232.0880 ext. 2978

**For More Information About Your Options Under Medicare Prescription Drug Coverage…**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

## Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

**If you live in Texas, you may be eligible for assistance paying your employer health plan premiums. If you do not reside in Texas, you should contact your State for more information on eligibility .**

| TEXAS – Medicaid |
| --- |
| Website: http://gethipptexas.com/<br><br>Phone: 1-800-440-0493 |

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

| | |
| --- | --- |
| U.S. Department of Labor | U.S. Department of Health and Human Services |
| Employee Benefits Security Administration | Centers for Medicare & Medicaid Services |
| **www.dol.gov/agencies/ebsa** | **www.cms.hhs.gov** |
| 1-866-444-EBSA (3272) | 1-877-267-2323, Menu Option 4, Ext. 61565 |

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

# Contacts

| Plan | Group Number | Carrier | Website | Contact |
|---|---|---|---|---|
| Medical | | Aetna – TRS<br>TRS Caremark<br>Scott and White | www.trsactivecareaetna.com<br>www2.caremark.com/trsactivecare<br>https://www.swhp.org | (800)222-9205<br>(800)552-8159<br>(800) 321-7947 |
| Dental<br>Vision<br>Accident<br>Critical Illness | 200702 | MetLife | www.askmetlife.com | (800)942-0854<br>(855)638-3931<br>(800)638-5433<br>(800)638-5433 |
| Disability<br>Basic Life and<br>AD&D<br>Supplemental Life | 657260<br>657258<br>657259 | Unum | www.unum.com | (866) 679-3054 |
| GAP<br>Hospital Indemnity | Y4E746 | Beazley | www.beazley.com | (855) 805-9176 |
| Lifetime Benefit Term | | CHUBB | www.chubb.com | (866) 324-8222 |
| HSA<br>FSA | Eagle Mountain Saginaw ISD | Proficient Benefits | https://proficientbenefits.com | (888) 659-8151 |
| 403(b) & 457(b) | | Omni | www.omni403b.com | (877) 544-6664 |
| Benefits Call Center | | BCG | www.bcgenrolls.com | (888) 279-8716 |

| | | |
|---|---|---|
| Eagle Mountain Saginaw ISD Benefits Department<br>Jamie Erwin | jmcnutt-erwin@ems-isd.net | (817) 232-0880 x2978 |

| Brown & Brown Insurance | E-mail | Phone |
|---|---|---|
| Paula Colón<br>Benefits Account Manager | pcolon@alamoinsgrp.com | (210) 524-7112 |
| Travis Tucker<br>Account Executive | ttucker@alamoinsgrp.com | (210) 524-7110 |

EAGLE MOUNTAIN SAGINAW ISD
*Fostering a Culture of Excellence*

Brown & Brown INSURANCE

**Benefits Service Center**

(888) 279-8716

Monday – Friday: 8:00am – 5:00pm CST