# 2019-2020 Benefits

## Open Enrollment Guidebook

Deadline
Friday, August 23

Plano ISD

**Benefits and Risk Management**
Email benefits@pisd.edu
Phone (469)752-8138
www.pisd.edu/benefits

## Get the Details

Visit **www.pisd.edu/benefits** for:

- Complete plan descriptions
- Network provider search
- Policy booklets
- TRS-ActiveCare presentation
- ALEX – an interactive tool to help you choose a medical plan

## When to Enroll

Anytime between

Thursday, July 25, 2019

and the **deadline**

**Friday, August 23, 2019**

**No exceptions - No extension**

## Oops…

If you have trouble with the online enrollment, **refer to Section 1** of this booklet for some tips.

Helpful **step-by-step videos** are available on our web site.

Contact the PISD benefits office for further assistance.

## Take Charge

We encourage you to complete your own enrollment and not rely on someone else to do it for you.

Each person's circumstances are different, and what works for one may not work for another.

Ask questions to understand a plan before enrolling in it.

## Email, Call, or Visit for Help:

Monday to Friday
8 AM to 5 PM

benefits@pisd.edu

(469)752-8138

Sockwell Center
6301 Chapel Hill Blvd

## Benefits Education Days

Learn more about your benefits and get your questions answered.

No appointment needed

**3:30 – 6:00 pm**

**August 2 @ Williams HS**

**August 7 @ Jasper HS**

**August 8 @ Admin Bldg**

The language of the official plan documents and policies will prevail over the language of any communications vehicle.

# Table of Contents

Section 1

# How to Enroll

## TEAMS Employee Service Center

***(For all plans except life insurance)***

**http://esc.pisd.edu**

**Login using your PISD network User ID and Password.**

Refer to pages 4-6 of this booklet for important details.

**Click "Submit" to save your enrollment!**

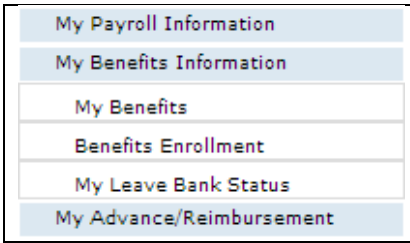
To make a change after you Submit,
contact the benefits office.

***DEADLINE – Friday, August 23, 2019***
***No exceptions - No extension***

- Use Google Chrome to access TEAMS to re-enroll, change, or waive coverage for the new plan year. All employees working 50% or more must take action. Coverage will not carry-forward.
- You must click the Submit button to save your benefit selections.
- To make a change after you've already submitted, contact the benefits office to reset your account. You must then re-do your enrollment by completing the full process and clicking the Submit button again.
- Dependent social security numbers are required by the Affordable Care Act.
- Life insurance will carry-forward, no action needed. To make changes to this coverage, go to www.pisd.edu/benefits, print and complete the appropriate forms, and return them to the PISD benefits office.

# Help with Online Enrollment

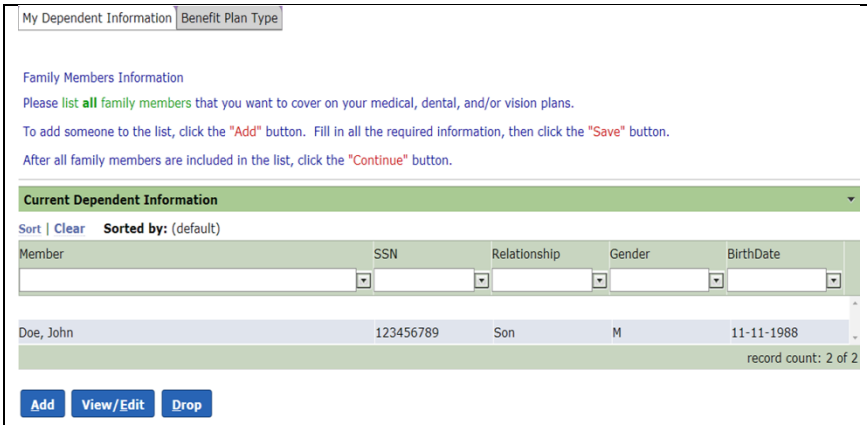
## Log in at http://esc.pisd.edu - *Use Google Chrome*




← Click My Benefits to review your selections for the current year

← **Click Benefits Enrollment to enroll for the new year**

## Dependent Information



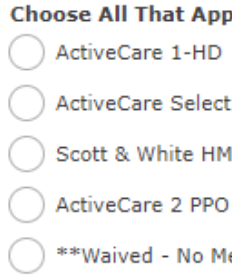

List all Family Members that will be covered on either medical, dental, or vision plans. Social Security Numbers are required.

Anyone who was covered last year will already be listed.

You cannot enroll a child who is over the maximum age for coverage.

## Medical Plan Selection

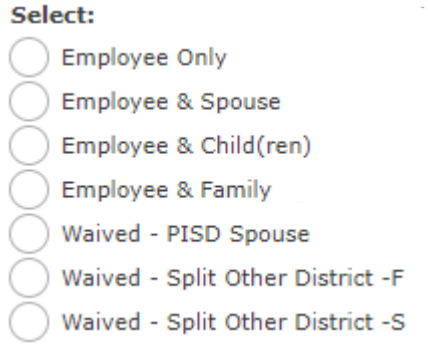
*Watch step-by-step videos on our web site!*




Choose the medical plan you want.

If you do not want any medical coverage, select the **Waived - No Medical** option.


Choose whether you want your premiums deducted pre-tax or not. "Yes" is the most common choice.




Choose the level of coverage you need.

Do not select any of the "waived" coverage levels unless you have spoken with the benefits office about a split premium.

| | |
|---|---|
| Does Your Spouse Work for the District? ★ ○ Yes ◉ No<br>Does your Spouse work for another Employer who participates in TRS ActiveCare? ★ ○ Yes ◉ No | If you select Family coverage, these options will appear. These are to setup a split premium.<br>Most employees should select No for both options.<br>To select Yes, please contact the benefits office first. |

## Flex Accounts

| | |
|---|---|
| General Health FSA ◉ Yes ○ No<br>Employee Monthly Amount: [ ] Monthly contributions limits:<br>Limited Purpose FSA ○ Yes ○ No<br>Dependent Care FSA ○ Yes ○ No | If you want a flex account, *select the appropriate account carefully*.<br>Enter a monthly amount within the minimum and maximum.<br>Don't use $ sign. Enter numbers only. |

## Final Screen

| | |
|---|---|
| **Summary of Benefit Selections**<br>Submit | Check your selections carefully!<br>← **You must click the SUBMIT button, or NOTHING will be saved.** |

## After your submit your enrollment, you can Double-Check.

| | |
|---|---|
| My Payroll Information<br>My Benefits Information<br>My Benefits<br>Benefits Enrollment<br>My Leave Bank Status<br>My Advance/Reimbursement | ← Go to My Benefits to double-check your choices for the new year<br>The Benefits Enrollment link will disappear after you click Submit. Contact the benefits office if you need to make a change. |

**If you get stuck or aren't sure what to do,**
**please contact the benefits office *before continuing*.**

**Email benefits@pisd.edu  Phone (469)752-8138**

*Enrollment Deadline*

*August 23*



# What is Changing?

Section 2

## TRS-ActiveCare Medical Plans

- Premium changes (see page 10)
- Deductibles (the amount you pay first before the plan begins to pay) will not increase.
- ActiveCare 1-HD participants will continue to get certain generic preventive drugs at no cost.
- ActiveCare Select Baylor participants will see decreases up to 25% for the cost of generic prescription drugs.
- In-network maximum out-of-pocket (MOOP) for all plans will go up by no more than 7.5%.
- TRS curates a high-quality network of providers who deliver the best health outcomes while helping to manage costs. It's in your interest and the TRS-ActiveCare fund's interest to stay in network, and most participants do. Last year, 97% of health care services were in-network; however, the small portion of out-of-network care is a significant cost to you and the plan.
  - To continue to encourage participants to stay in the network, out-of-network MOOPs will increase for ActiveCare 1-HD and ActiveCare 2, with a cap on covered charges of $500 per day for out-of-network facilities. ActiveCare Select Baylor and Scott & White HMO will continue only covering care in network.
- The price of brand name and specialty medications has skyrocketed in recent years. While fewer than two percent of participants take these medications, the costs of these drugs make up more than 45% of all prescription drug costs for TRS-ActiveCare.
  - To encourage participants to use generic and effective lower-cost medications, the cost of brand name medications will increase for ActiveCare 1-HD from 20% to 25% after the deductible.
  - ActiveCare Select Baylor and ActiveCare 2 participants will now pay 25% for brand name medications, but the cost will be capped at twice the current copay.
- TRS now requires you to indicate tobacco user status when you complete your online enrollment. Aetna has resources to help you quit. Contact a Health Concierge at 1-800-222-9205 or through the TRS Health app. Tobacco cessation counseling and medications are covered 100%.

## Remember:

- Both ActiveCare Select Baylor and Scott & White HMO use the Baylor Scott & White network. These plans may not be right for you if you cover dependents out of the area. There is no coverage out-of-network.
- You have only 31 days to add a newborn to your medical plan. Contact the PISD benefits office as soon as possible to complete paperwork. If you miss this deadline, your baby will not be covered.

## ID Cards

- You will only receive a new ID card if you change medical plans. Otherwise, continue to use your current ID card.
- **Enroll by August 7 to receive the new ID card by September 1.**
- If you submit a change after August 7, you'll be able to view your ID card online or through the mobile app on September 1, but the paper ID card will not arrive until mid-September.

*Is your address up-to-date with the PISD HR Department?*

## Dental Plans

The dental insurance will switch to Delta Dental. No changes to coverage or premiums.

If you have any dental work already in progress, you can contact Delta Dental at 1-800-521-2651 to confirm whether claims will be paid under the previous Cigna plan or the new Delta plan.

## Life Insurance

The life insurance carrier will switch to Dearborn Life. No changes to coverage. Slight decrease in premiums.

## Disability Insurance

Premiums will increase 5%.

## Flexible Spending Accounts (FSA)

Increased maximum contributions:
Health Care $222/month Dependent Day Care $413/month

## NEW – Health Savings Account (HSA)

This is a savings tool that allows you to set aside money to pay for out-of-pocket expenses related to a High Deductible Health Plan, such as ActiveCare 1-HD.

You cannot enroll in both an HSA and the General Health FSA. However, you can enroll in an HSA and the Limited Purpose FSA which reimburses only dental and vision expenses.

FSA and HSA both help with pre-tax health care expenses, but with significant differences. Be sure to choose the one that's right for you.

Learn more at a Benefits Education Day or online at www.pisd.edu/benefits.

*Enrollment Deadline*

*August 23*



# How are Premiums Paid?

Section 3

## For Bus Drivers, Bus Assistants, Bus Driver Mentors, Food Service Workers, Child Caregiver Aides, PASAR, and Substitutes

Premiums are deducted from almost every paycheck from September 20, 2019, through June 11, 2020. Your deduction amount is calculated by estimating the total premium cost for the entire year (September 2019 through August 2020), and then dividing by the number of paychecks during that time. On this schedule, your premiums for the summer months can be paid in full by the time you receive your last paycheck for the school year.

For example: If you select TRS-ActiveCare 1-HD coverage for yourself only, the monthly cost may be $78. The estimated cost for the entire plan year is $936 ($78 x 12 months). The estimated number of paychecks with benefit deductions during that time is 17. So, the amount to be deducted from each paycheck would be ($936 ÷ 17) = $55.06.

Fill in your personal selections:
Monthly premium $ _____ x 12 = $ _____ ÷ 17 = $ _____ per check

Please contact the benefits office for help calculating your deduction amount.

## For All Other Employees

Premiums are deducted once a month. If you receive one check per month, the full monthly premium is deducted from that check. If you receive biweekly paychecks, the full monthly premium is deducted from your second check of the month. Premiums are paid in arrears (premiums deducted from the September 25th paycheck will pay for the month of September). The majority of employees, including campus employees, receive paychecks through the summer, and the regular monthly premiums will be deducted from those summer checks.

## If premiums cannot be deducted from your paycheck

If you do not receive a check or your check amount is too low to make all deductions, the missing premium may be deducted from your next paycheck as a double-deduction. If that is not possible, you will receive an invoice from the benefits office, which must be paid within 30 days. If the invoice is not paid and the premium cannot be deducted from a future paycheck, your coverage will be cancelled retroactively.

## If your employment ends or you stop being eligible for coverage

You will receive an invoice for any premium balance due. In the event that you have already paid more than is necessary, a refund would be issued to you.

If you stop working for PISD at the end of the school year and do not return for the 2020-2021 school year, you have the option of keeping certain coverage through August 31, 2020. You may receive an invoice for any premium balance that is still due.

Section 4

# Plan Summaries & Costs

These are only summaries of the plans. Please review the full plan documents, plan descriptions, eligibility requirements, and network physician search at www.pisd.edu/benefits – click on 2019-20 Open Enrollment.

| Who Can Enroll: | Eligible For: |
|---|---|
| ❶ Employees/TRS Members working 25 or more hours per week (63%) | All types of plans, and the District Contribution to the medical premium |
| ❷ Employees/TRS Members working between 20-24 hours per week (50-62%) | Medical plan only, with the District Contribution to the premium |
| ❸ Employees working between 10-19 hours per week (25-49%) | Medical plan only, no District Contribution |
| ❹ Substitutes regularly working 10 or more hours per week | Medical plan only, no District Contribution |

## Medical Plans: TRS-ActiveCare

*Check out the online TRS-ActiveCare Enrollment Guide for details.*

| | Total Monthly Cost (for groups ❸ & ❹) | PISD Contribution | Reduced Monthly Cost (for groups ❶ & ❷) |
|---|---|---|---|
| **ActiveCare 1-HD** | | | |
| Employee Only | $378 | $300 | $78 |
| Employee & Spouse | $1,066 | $300 | $766 |
| Employee & Child(ren) | $722 | $300 | $422 |
| Employee & Family | $1,415 | $300 | $1,115 |
| **ActiveCare Select Baylor** *Caution: Limited Provider Network* | *If you live in Collin, Dallas, Denton, Ellis, McLennan, Parker, Rockwall, or Tarrant county, the network is Baylor Scott & White Quality Alliance. There is no coverage out-of-network. This plan may not be right for you if you cover dependents out of area.* | | |
| Employee Only | $556 | $300 | $256 |
| Employee & Spouse | $1,367 | $300 | $1,067 |
| Employee & Child(ren) | $902 | $300 | $602 |
| Employee & Family | $1,718 | $300 | $1,418 |
| **Scott & White HMO** *Must work or live in service area* | *The HMO service area includes Collin, Dallas, Denton, Ellis, Rockwall, and Tarrant counties. No PCP is required, but you must use providers in the HMO network. This plan may not be right for you if you cover dependents out of area.* | | |
| Employee Only | $558.54 | $300 | $258.54 |
| Employee & Spouse | $1,306.58 | $300 | $1,006.58 |
| Employee & Child(ren) | $876.76 | $300 | $576.76 |
| Employee & Family | $1,457.28 | $300 | $1,157.28 |
| **ActiveCare 2** | *Closed to new participants* | | |
| Employee Only | $852 | $300 | $552 |
| Employee & Spouse | $2,020 | $300 | $1,720 |
| Employee & Child(ren) | $1,267 | $300 | $967 |
| Employee & Family | $2,389 | $300 | $2,089 |

## Search the list of in-network providers before enrolling

| | |
|---|---|
| ActiveCare 1-HD<br>and<br>ActiveCare 2 | www.aetna.com/docfind/custom/TRS_ActiveCare |
| ActiveCare Select Baylor | www.aetna.com/docfind/custom/TRS_ActiveCare<br><br>Be sure to select the correct network for your county.<br>For DFW Region, **choose Baylor Scott & White Quality Alliance**.<br>Do not choose ActiveCare Select. |
| Scott & White HMO | http://trs.swhp.org<br><br>Scroll down and click on the blue "Find a Provider" button. |

## New TRS Health mobile app

Everything you need in one place.
Download your TRS Health app today.

TRS HEALTH
powered by aetna

- Provider search
- ID cards
- Coverage details
- Rx costs

And much more

## Additional services available

| | |
|---|---|
| ActiveCare 1-HD<br>and<br>ActiveCare Select Baylor<br>and<br>ActiveCare 2 | 24/7 Nurse Advice Line 1-800-556-1555<br>Talk to a registered nurse anytime. No limit on number of calls.<br>No extra cost. Available to all covered family members.<br><br>Teladoc 1-855-835-2362<br>Register in advance so your account is ready to go.<br>Phone consultation with a doctor, once per day.<br>Rx can be sent to local pharmacy. See plan summaries for costs.<br>Adult must request consult for minor child.<br>Members age 18+ must request their own consult. |
| Scott & White HMO | 24/7 Nurse Advice Line 1-877-505-7947<br>Talk to a registered nurse anytime. No limit on number of calls.<br>No extra cost. Available to all covered family members. |

## Combined Premiums for Families

If both you and your spouse work for a school district in TRS-ActiveCare, you may choose to combine your family coverage, but you are not required to do so.

***CAUTION:*** Combining coverage may not save money in premiums. Review your coverage options carefully to determine if this arrangement would be beneficial for your situation.

Please contact the benefits office for assistance in reviewing this option.

*Aetna*
*1-800-222-9205*

*Scott & White*
*1-800-321-7947*

| | ActiveCare 1-HD | ActiveCare Select Baylor |
|---|---|---|
| **Provider Network** | Aetna Open Access Choice POS II | Caution: Limited Network<br>Baylor Scott & White Quality Alliance<br>No coverage out-of-network |
| **Deductible** (per plan year)<br>In-Network<br>Out-of-Network | <br>$2,750 employee only / $5,500 family<br>$5,500 employee only / $11,000 family | <br>$1,200 individual / $3,600 family<br>n/a – no coverage out-of-network |
| **Out-of-Pocket Maximum**<br>(per plan year; includes deductibles, copays, and coinsurance)<br>In-Network<br>Out-of-Network | The individual out-of-pocket maximum only includes covered expenses incurred by that individual.<br>$6,750 individual / $13,500 family<br>$20,250 individual / $40,500 family | <br>$7,900 individual / $15,800 family<br>n/a – no coverage out-of-network |
| **Co-insurance** (you pay after deductible)<br>In-Network<br>Out-of-Network | <br>20%<br>40% of allowed amount | <br>20%<br>n/a – no coverage out-of-network |
| **Office Visit Copay** | 20% after deductible | $30 copay for primary<br>$70 copay for specialist |
| **Preventive Care** | Plan pays 100% | Plan pays 100% |
| **Teladoc Physician Services** | $40 consultation fee<br>(applies to deductible and out-of-pocket max) | Plan pays 100% |
| **Diagnostic Lab** | 20% after deductible | 20% after deductible |
| **High-Tech Radiology**<br>(CT scan, MRI, nuclear medicine) | 20% after deductible | $100 copay plus 20% after deductible |
| **Urgent Care** | 20% after deductible | $50 copay |
| **Emergency Room** (true emergency use) | 20% after deductible | $250 copay plus 20% after deductible |
| **Freestanding ER** | $500 copay plus 20% after deductible | $500 copay plus 20% after deductible |
| **Outpatient Surgery** | 20% after deductible | $150 copay plus 20% after deductible |
| **Inpatient Hospital Facility Charges**<br>(preauthorization required)<br>In-Network<br><br>Out-of-Network | <br>20% after deductible<br><br>Plan pays up to $500 per day after deductible<br>You pay the excess over the $500 per day cap | <br>$150 copay per day plus 20% after deductible<br>$750 maximum copay per admission<br>n/a – no coverage out-of-network |
| **Bariatric Surgery**<br>Physician charges | $5,000 copay plus 20% after deductible | Not covered |
| **Prescription Drugs***<br>Drug deductible (per plan year) | Must meet plan year deductible first | $0 for generic drugs<br>$200 per person for brand-name drugs |
| **Retail Short-Term Supply**<br>(up to a 31-day supply; first fill only)<br>• Generic copay<br>• Preferred Brand copay<br>• Non-Preferred Brand copay | <br><br>20% after deductible<br>25% after deductible<br>50% after deductible | <br><br>$15 copay<br>25% after deductible (min $40, max $80)<br>50% after deductible |
| **Retail Short-Term Supply - Ongoing**<br>(after first fill; up to a 31-day supply)<br>• Generic copay<br>• Preferred Brand copay<br>• Non-Preferred Brand copay | <br><br>20% after deductible<br>25% after deductible<br>50% after deductible | <br><br>$30 copay<br>25% after deductible (min $60, max $120)<br>50% after deductible |
| **Mail Order and Retail-*Plus***<br>(up to a 90-day supply)<br>• Generic copay<br>• Preferred Brand copay<br>• Non-Preferred Brand copay | <br><br>20% after deductible<br>25% after deductible<br>50% after deductible | <br><br>$45 copay<br>25% after deductible (min $105, max $210)<br>50% after deductible |
| **Specialty Drugs**<br>(limited to a 31-day supply per fill) | <br>20% after deductible | <br>20% after deductible |

* If the patient obtains a brand-name drug when a generic equivalent is available, the patient will be responsible for the generic copayment plus the cost difference between the brand-name and the generic.

**Note:** Items covered at 100% or with 20% coinsurance are for in-network providers only. For out-of-network providers, the coinsurance is 40%.

| | Scott & White HMO | ActiveCare 2 |
|---|---|---|
| **Provider Network** | Must live or work in HMO service area<br>No Primary Care Physician required to make referrals.<br>No coverage out-of-network | Aetna Open Access Choice POS II<br>**(Closed plan – no new enrollments)** |
| **Deductible** (per plan year)<br>In-Network<br>Out-of-Network | <br>$950 individual / $2,850 family<br>n/a – no coverage out-of-network | <br>$1,000 individual / $3,000 family<br>$2,000 individual / $6,000 family |
| **Out-of-Pocket Maximum**<br>(per plan year; includes deductibles, copays, and coinsurance)<br>In-Network<br>Out-of-Network | <br><br>$7,450 individual / $14,900 family<br>n/a – no coverage out-of-network | <br><br>$7,900 individual / $15,800 family<br>$23,700 individual / $47,400 family |
| **Co-insurance** (you pay after deductible)<br>In-Network<br>Out-of-Network | <br>20%<br>n/a – no coverage out-of-network | <br>20%<br>40% of allowed amount |
| **Office Visit Copay** | $20 copay for primary<br>(copay waived for first visit for illness and for wellness/preventive visits)<br>$70 copay for specialist | $30 copay for primary<br>$70 copay for specialist |
| **Preventive Care** | Plan pays 100% | Plan pays 100% |
| **Teladoc Physician Services** | Not available | Plan pays 100% |
| **Diagnostic Lab** | 20% after deductible | 20% after deductible |
| **High-Tech Radiology**<br>(CT scan, MRI, nuclear medicine) | 20% after deductible | $100 copay plus 20% after deductible |
| **Urgent Care** | $50 copay | $50 copay |
| **Emergency Room** (true emergency use) | $500 copay after deductible | $250 copay plus 20% after deductible |
| **Freestanding ER** | n/a – no coverage out-of-network | $500 copay plus 20% after deductible |
| **Outpatient Surgery** | $150 copay per visit plus 20% after deductible | $150 copay plus 20% after deductible |
| **Inpatient Hospital Facility Charges**<br>(preauthorization required)<br>In-Network<br><br>Out-of-Network | <br>$150 copay per day plus 20% after deductible<br>$750 maximum copay per admission<br>n/a – no coverage out-of-network | <br>$150 copay per day plus 20% after deductible<br>$750 maximum copay per admission<br>Plan pays up to $500 per day after deductible<br>You pay the excess over the $500 per day cap |
| **Bariatric Surgery**<br>Physician charges | Not covered | $5,000 copay (does not apply to out-of-pocket maximum) plus 20% after deductible |
| **Prescription Drugs***<br>Drug deductible (per plan year) | $0 for generic drugs<br>$150 per person for brand-name drugs | $0 for generic drugs<br>$200 per person for brand-name drugs |
| **Retail Short-Term Supply**<br>(up to a 31-day supply; first fill only)<br>• Generic copay<br>• Preferred Brand copay<br>• Non-Preferred Brand copay | <br>$5 copay<br>30% after deductible<br>50% after deductible | <br>$20 copay<br>25% after deductible (min $40, max $80)<br>50% after deductible (min $100, max $200) |
| **Retail Short-Term Supply - Ongoing**<br>(after first fill; up to a 31-day supply)<br>• Generic copay<br>• Preferred Brand copay<br>• Non-Preferred Brand copay | <br>$12.50 copay<br>30% after deductible<br>50% after deductible | <br>$35 copay<br>25% after deductible (min $60, max $120)<br>50% after deductible (min $105, max $210) |
| **Mail Order and Retail-*Plus***<br>(up to a 90-day supply)<br>• Generic copay<br>• Preferred Brand copay<br>• Non-Preferred Brand copay | <br>$12.50 copay<br>30% after deductible<br>50% after deductible | <br>$45 copay<br>25% after deductible (min $105, max $210)<br>50% after deductible (min $215, max $430) |
| **Specialty Drugs**<br>(limited to a 31-day supply per fill) | Tier 1 and 2 – 15% after deductible<br>Tier 3 – 25% after deductible | 20% after deductible (min $200, max $900) |

## ALEX – online tool to help choose a medical plan

When using ALEX, you will need to enter the total annual premium amounts:

| | ActiveCare 1-HD | ActiveCare Select Baylor | ActiveCare 2 |
|---|---|---|---|
| Employee Only | $4,536 | $6,672 | $10,224 |
| Employee & Spouse | $12,792 | $16,404 | $24,240 |
| Employee & Child(ren) | $8,664 | $10,824 | $15,204 |
| Employee & Family | $16,980 | $20,616 | $28,668 |

*These are total costs without the district contribution.*
*Scott & White HMO is not part of the ALEX program, as it is not administered by Aetna.*


## Employee Assistance Program (EAP)

The EAP is automatically available to all full-time employees. The EAP offers solutions and resources for living well at home and at work. It provides **confidential** support for a variety of concerns. Up to **6 free counseling visits** are available every plan year to each member. Services are available 24 hours a day, 7 days a week.

**Emotions**
- Stress management
- Anxiety and depression
- Grief and loss
- Mood swings

**Relationships**
- Healthy marriages
- Social development
- Conflict resolution

**Day-to-Day**
- Money management
- Legal/financial guidance
- Education planning
- Pet care

**Work**
- Worklife balance
- Personal growth
- Workplace relationships

**Family Care**
- Child/Elder care
- Adoption
- Healthy pregnancy
- Parenting skills

**Healthy Living**
- Fitness
- Weight management
- Chronic illness
- Addiction assistance

**Visit the web site for:**

- Thousands of informative articles and videos
- Interactive tools and assessments
- Self-searches for providers and services

***Guidance Resources***

**1-800-272-7255**

**www.GuidanceResources.com**

**Web ID: PLANOISD**

**Create your own username & password**

## Dental Plans

*Offered to Employees/TRS Members working 25 or more hours per week (63%)*

Dental insurance is available through **Delta Dental**. Using an in-network dentist will provide the greatest savings. To search the network, visit deltadentalins.com.

If you have any dental work already in progress, you can contact Delta Dental at 1-800-521-2651 to confirm whether claims will be paid under the previous Cigna plan or the new Delta plan.

Delta will mail ID cards to your home address, but you can access an electronic ID card through Delta's mobile app. After your coverage begins, create an online account at deltadentalins.com to view your benefits, claims, and more.

### Monthly Premiums

| Premium Dental | Monthly Cost |
|---|---|
| Employee Only | $33.51 |
| Employee & Spouse | $76.98 |
| Employee & Child(ren) | $70.81 |
| Employee & Family | $105.08 |

| Basic Dental | Monthly Cost |
|---|---|
| Employee Only | $18.93 |
| Employee & Spouse | $37.97 |
| Employee & Child(ren) | $30.45 |
| Employee & Family | $56.24 |

### Coverage Comparisons

For details regarding covered, excluded, and limited services, please refer to www.pisd.edu/benefits.

| | Premium Dental | Basic Dental |
|---|---|---|
| **Annual Maximum Benefit** | $1,250 per person | $1,000 per person |
| **Annual Deductible** | $50 indiv. / $150 family | $50 indiv. / $150 family |
| **Class 1 Services – Diagnostic & Preventive** | Plan pays 80%<br>(no deductible) | Plan pays 50%<br>(no deductible) |
| **Class 2 Services - Basic** | Plan pays 80% | Plan pays 50% |
| **Class 3 Services - Major** | Plan pays 50% | Plan pays 50% |
| **Class 4 Services - Orthodontics**<br>Only for children under age 26 | Plan pays 50%<br>Lifetime maximum $1,250 | Not Covered |
| **Network of Dentists** | **Delta Dental DPO**<br>If you use a non-network dentist, the plan's payments will be based on the maximum reimbursable charge, and your dentist may bill you for the difference. | |



## Vision Plans

*Offered to Employees/TRS Members working 25 or more hours per week (63%)*

Both **Vision Service Plan, Inc (VSP)** and **Davis Vision** offer low & high plan options, with different coverage levels. Each company has different strengths, so you have the flexibility to choose the best fit for you.

**Monthly Premiums**

| **VSP Standard** | Monthly Cost |
|---|---|
| Employee Only | $9.10 |
| Employee & Spouse | $19.51 |
| Employee & Child(ren) | $19.51 |
| Employee & Family | $19.51 |
| | |
| **VSP Buy Up** | Monthly Cost |
| Employee Only | $17.11 |
| Employee & Spouse | $36.69 |
| Employee & Child(ren) | $36.69 |
| Employee & Family | $36.69 |

| **Davis Designer** | Monthly Cost |
|---|---|
| Employee Only | $6.36 |
| Employee & Spouse | $13.64 |
| Employee & Child(ren) | $13.64 |
| Employee & Family | $13.64 |
| | |
| **Davis Premier** | Monthly Cost |
| Employee Only | $12.89 |
| Employee & Spouse | $27.63 |
| Employee & Child(ren) | $27.63 |
| Employee & Family | $27.63 |

**ID cards:**

- VSP does not issue ID cards, although you can print a membership card from their web site if needed. You'll tell your optometrist that your coverage is through VSP, and they will submit your claims.
- Davis Vision will mail you an ID card, which you can present to your optometrist.

**Main considerations in choosing a plan:**

- Compare the premium charts above
- Compare the coverage charts on the next page
- PPO networks – VSP has a unique network of independent optometrists that may not be in-network with Davis. The Davis network is a combination of both independent optometrists and retail options like Walmart, Costco, and Visionworks, etc. Check the network lists at www.vsp.com and www.davisvision.com.

**Bottom line:**

- VSP may be a good choice for you if your optometrist is only in the VSP network and you don't want to change. You would pay a higher premium, but you would be able to keep your optometrist in-network.
- Davis may be a good choice for you if you want lower premiums, are willing to change optometrists, or have access to retail service providers in-network.



## Vision Plans (continued)

### Coverage at In-Network Providers:

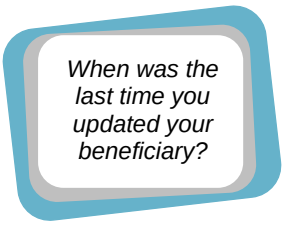
| | VSP Standard | Davis Designer |
|---|---|---|
| Exam copay | $25 total copay | $10 |
| Materials Copay | | $15 |
| **Frequency** | | |
| Exam | 12 months | 12 months |
| Lenses / Frames | 12 months / 24 months | 12 months / 24 months |
| Frame Allowance | $120 | 100% covered – Davis Designer Collection<br>$170 – Visionworks stores<br>$120 – Other providers/frames |
| Covered Lens Options | Polycarbonate for children | Polycarbonate for children; Scratch Resistant |
| **Contact Lenses** | Every 12 months, in lieu of glasses | Every 12 months, in lieu of glasses |
| Fitting & Evaluation | $60 allowance | $15 copay or<br>$60 allowance for specialty contacts |
| Materials & Exam | $150 allowance | 100% covered – Davis Collection, max 4 boxes<br>$120 allowance – Other contacts |
| Additional Benefits & Discounts | 20% off additional pairs of glasses<br>Laser Vision Correction discount<br>Diabetic EyeCare Plus Program | 50% off 2nd pair of glasses at Visionworks<br>20-30% off 2nd pair of glasses at other in-network<br>Laser Vision Correction discount<br>1 year breakage warranty on Davis Collection frames<br>Hearing Aid discounts through Epic Hearing |

| | VSP Buy Up | Davis Premier |
|---|---|---|
| Exam copay | $5 | $5 |
| Materials Copay | $10 | $10 |
| **Frequency** | | |
| Exam | 12 months | 12 months |
| Lenses / Frames | 12 months / 12 months | 12 months / 12 months |
| Frame Allowance | $150 | 100% covered – Davis Designer & Premier Collection<br>$200 – Visionworks stores<br>$150 – Other providers/frames |
| Covered Lens Options | Polycarbonate for children & adults; Anti Reflective; Progressives | Polycarbonate for children & adults; Scratch Resistant; UV Coating; Anti Reflective; Progressives |
| **Contact Lenses** | Every 12 months, in lieu of glasses | Every 12 months, in lieu of glasses |
| Fitting & Evaluation | Up to $60 | $10 copay or<br>$60 allowance for specialty contacts |
| Materials & Exam | $150 | 100% covered – Davis Collection, max 8 boxes<br>$150 allowance – Other contacts |
| Additional Benefits & Discounts | 20% off additional pairs of glasses<br>15% off Laser Vision Correction<br>Diabetic EyeCare Plus Program<br>Hearing Aid discounts through TruHearing | 50% off 2nd pair of glasses at Visionworks<br>20-30% off 2nd pair of glasses at other in-network<br>Laser Vision Correction discount<br>1 year breakage warranty on Davis Collection frames<br>Hearing Aid discounts through Epic Hearing |

## Life Insurance

*Offered to Employees/TRS Members working 25 or more hours per week (63%)*

Group term life insurance is available through **Dearborn National**. The policy certificate is available on our web site, or you may also request a printed copy from the benefits office. Life insurance currently in effect will continue with no action required.




### For Employees

*- Application form is online -*

New applications, as well as applications to increase coverage above $250,000, will require a health questionnaire. However, if you are currently enrolled in life insurance and are only requesting an increase of $20,000 (for example, from $60,000 to $80,000), a health questionnaire is not required, as long as your coverage level would still be $250,000 or less.

**Monthly Premiums:** (cannot be deducted pre-tax)

| Amount | Age 39 & Under | Age 40 & Over |
|---|---|---|
| $ 20,000 | $1.00 | $2.56 |
| $ 30,000 | $1.50 | $3.84 |
| $ 40,000 | $2.00 | $5.12 |
| $ 50,000 | $2.50 | $6.40 |
| $ 60,000 | $3.00 | $7.68 |
| $ 70,000 | $3.50 | $8.96 |
| $ 80,000 | $4.00 | $10.24 |
| $ 90,000 | $4.50 | $11.52 |
| $100,000 | $5.00 | $12.80 |
| $110,000 | $5.50 | $14.08 |
| $120,000 | $6.00 | $15.36 |
| $130,000 | $6.50 | $16.64 |
| $140,000 | $7.00 | $17.92 |
| $150,000 | $7.50 | $19.20 |
| $160,000 | $8.00 | $20.48 |
| $170,000 | $8.50 | $21.76 |
| $180,000 | $9.00 | $23.04 |
| $190,000 | $9.50 | $24.32 |
| $200,000 | $10.00 | $25.60 |

| Amount | Age 39 & Under | Age 40 & Over |
|---|---|---|
| $210,000 | $10.50 | $26.88 |
| $220,000 | $11.00 | $28.16 |
| $230,000 | $11.50 | $29.44 |
| $240,000 | $12.00 | $30.72 |
| $250,000 | $12.50 | $32.00 |
| $260,000 | $13.00 | $33.28 |
| $270,000 | $13.50 | $34.56 |
| $280,000 | $14.00 | $35.84 |
| $290,000 | $14.50 | $37.12 |
| $300,000 | $15.00 | $38.40 |
| $310,000 | $15.50 | $39.68 |
| $320,000 | $16.00 | $40.96 |
| $330,000 | $16.50 | $42.24 |
| $340,000 | $17.00 | $43.52 |
| $350,000 | $17.50 | $44.80 |
| $360,000 | $18.00 | $46.08 |
| $370,000 | $18.50 | $47.36 |
| $380,000 | $19.00 | $48.64 |
| $390,000 | $19.50 | $49.92 |
| $400,000 | $20.00 | $51.20 |

Automatic reduction of value: When you reach age 70, the value of the life insurance becomes half the original value. For example, if you are enrolled in $150,000, the coverage will reduce to $75,000 on the September 1 after you turn 70.

Although you may purchase high life insurance amounts through the district, we encourage you to have other life insurance that is not tied to your employment. If you resign, you can convert this group insurance to a personal policy, but the cost usually increases significantly.



## Life Insurance (continued)

## For Dependents

You may purchase life insurance on your spouse and/or children; however, you must be enrolled in employee life insurance in order to request dependent life insurance. Spouses are eligible until age 70, and children are eligible until age 26.

**Monthly Premiums:** (cannot be deducted pre-tax)
**Plan A**: $5,000 spouse, $2,000 each child = total monthly premium **$2.12**
**Plan B**: $10,000 spouse, $4,000 each child = total monthly premium **$5.10**

## Disability Insurance

*Offered to Employees/TRS Members working 25 or more hours per week (63%)*

Disability insurance is available through **Cigna**. The policy certificate and premium charts are available online at www.pisd.edu/benefits, or you may request a printed copy from the benefits office. Premiums are based on your elimination period, benefit level, and your age as of September 1, 2019. Premiums cannot be deducted pre-tax.

Disability insurance can replace a portion of your income if you are unable to work due to illness or injury. When accidents or long-term illness arise, most people see their expenses go up, and their income go down. Disability income protection can be very beneficial, and is most appreciated when the unexpected happens.

You may choose from 4 elimination periods (7 days, 14 days, 30 days, or 90 days), which is the length of time you must be off work before benefit payments can begin. The 7, 14, and 30 day plans also include a first-day hospital benefit, which begins benefit payments immediately following a 24-hour inpatient hospital admission with room & board charges. Benefits are paid directly to you, and are not subject to taxes.

### Reminders

*Watch the step-by-step video online to help you enroll in this plan.*

- Coverage you select now will take effect on September 1, 2019.
- You may add or change the disability plan during the annual open enrollment period only. Proof of good health is not required, but pre-existing condition limitations will apply.
- **Pregnancy:** The disability plan will cover pregnancy claims if the coverage took effect prior to conception. Benefits will be based on the lower of the coverage you had at the time you became pregnant or the time your claim begins.
- **Other income offsets:** If you also receive certain types of other income (such as social security, retirement, or workers compensation), any benefit payments from the disability plan will be offset by the amount of other income.
- You may select any benefit level up to two-thirds of your gross monthly salary. If your benefit amount is not at the maximum allowed, any increase you make in future years will be subject to pre-existing limitations. The TEAMS enrollment system will show you what your maximum is, so you can see if you need to increase or decrease your benefit amount due to any salary changes.

## Flexible Spending Accounts & Health Savings Account

*Offered to Employees/TRS Members working 25 or more hours per week (63%)*

The District offers Flexible Spending Accounts (FSA) and a Health Savings Account (HSA) for you to set aside part of your pay on a pre-tax basis to pay for eligible expenses. While all of these accounts help with pre-tax expenses, there are significant differences. If you choose to enroll, be sure to choose the account that is right for your circumstances.

Information is available on our web site about what expenses are eligible under the different accounts.

*Questions? Call Flexible Benefit Admin 1-800-437-3539*

### *Health Savings Account (HSA)*

- Can only be chosen if you are enrolled in a High Deductible Health Plan (HDHP), such as TRS-ActiveCare 1-HD
- Cannot be chosen if you are enrolled in Medicare or Tricare, or if anyone else can claim you as a dependent for tax purposes
- Cannot be chosen if either you or your spouse is enrolled in a traditional/general FSA
- For medical, dental, and vision expenses
- For you, your spouse, and dependent children, even if not covered on insurance
- No minimum contribution
- Maximum $3,500 annually if HDHP medical plan enrollment is for employee only, or $7,000 annually if HDHP medical plan enrollment includes any family members
- Maximum contributions are combined if both you and your spouse each have an HSA
- Money is not available up front
- Account balance rolls over from year to year, earns interest along the way, and stays with you even if you leave PISD
- Contribution amount can be changed during the year
- Monthly administration fee $2.00

### *Health Care FSA*

#### General Health FSA

- Cannot be chosen if you enroll in a Health Savings Account
- For medical, dental, and vision expenses
- For you, your spouse, and dependent children, even if not covered on insurance
- Minimum $25 per month
- Maximum $222 per month
- Full annual amount is available up front
- Use it or lose it – only contribute what you know you will spend within the plan year
- Enrollment is irrevocable for the rest of the plan year, except in limited circumstances
- Monthly administration fee $3.00

#### Limited Purpose FSA

- Can be chosen if you enroll in a Health Savings Account, but is not required
- For dental and vision expenses only
- For you, your spouse, and dependent children, even if not covered on insurance
- Minimum $25 per month
- Maximum $222 per month
- Full annual amount is available up front
- Use it or lose it – only contribute what you know you will spend within the plan year
- Enrollment is irrevocable for the rest of the plan year, except in limited circumstances
- Monthly administration fee $3.00



You cannot enroll in both an HSA and the General Health FSA – see comparison chart below.

However, you can enroll in an HSA and the Limited Purpose FSA.

Enrollment in an HSA or FSA is optional.

| | Health Savings Account HSA | General Health FSA |
|---|---|---|
| Can only be paired with a High Deductible Health Plan | Yes – cannot be covered by any other type of plan | No – medical plan choice is irrelevant |
| Employees on Medicare or Tricare can participate | No | Yes |
| Money can only be used for medical, dental, and vision expenses | Yes[1] | Yes |
| Full election amount available right away | No | Yes |
| Money rolls over from year to year | Yes | No – unused funds are forfeited at end of plan year |
| You keep the money in your account if you resign | Yes | No |
| Debit card can be used to pay eligible expenses | Yes – up to amount currently in the account | Yes – full annual election available up front |
| Employer is responsible for verifying expenses are eligible | No – you are responsible for keeping receipts in case of audit | Yes – you must provide receipts to FSA administrator |
| Account fee | $2.00 per month | $3.00 per month |
| Annual Maximum Contribution | $3,500 - employee HDHP coverage<br>$7,000 - family HDHP coverage | $2,664 annually |
| Additional catch-up contributions if age 55+ | $1,000 annually | None |
| You can change your election during the year | Yes | No – only limited circumstances may allow a change |
| Contributions are pre-tax | Yes | Yes |
| Money in the account earns interest | Yes | No |
| Money in the account can be invested in mutual funds | Yes – if account balance is greater than $1,000, additional fee applies | No |
| Employee must file form 8889 with Federal Income Tax Return | Yes | No |

[1] Money withdrawn before age 65 for non-medical expenses is subject to additional 20% tax penalty.

## *Dependent Care FSA*

- For dependent care expenses such as day care for children or a disabled spouse
- Minimum $25 per month
- Maximum $413 per month (or $205 if married filing separate tax returns)
- Take summer months into consideration when calculating contributions – payroll deductions continue in the summer
- Electing this account may affect your eligibility for the Federal Income Tax Credit
- Use it or lose it – only contribute what you know you will spend within the plan year
- Enrollment is irrevocable for the rest of the plan year, except in limited circumstances
- Monthly administration fee $3.00

IRS regulations state that dependent care services must already have been performed in order to be eligible for reimbursement. For example, it is common to pay for childcare at the first of the month for the entire month. This is not permitted for flex accounts under IRS guidance. The childcare must already have been performed in order to claim reimbursement.

Therefore, if you select this flex account, it is extremely important that you carefully consider the amount you set aside. For example, you may choose to reduce the amount of your flex account to allow for days that your child is sick and does not attend childcare as planned. While you may still be required to pay your childcare provider for those days, those charges are not eligible for reimbursement according to IRS rules.

## *Flex Card*

The flex card can provide added convenience for paying eligible expenses on your FSA or HSA, although you still have the option to submit paper claims. The card allows immediate access to the funds in your account at the time you need them. The card will work only at specific merchants based on the type of account you are enrolled in.

**Use of the Flex Card does not remove your responsibility to keep all receipts and documentation to prove the eligibility of an expense**. For FSA, the IRS requires the administrator to audit every transaction so they may request copies of your documentation to validate a transaction. For HSA, you are responsible for using the account appropriately within IRS regulations.

The Flexible Benefit Plan document contains complete details regarding use of the Flex Card, including:

- how the card works
- how to use it properly
- your obligations when using the card
- the Plan's rights to deny access to your card
- the Plan's rights to recover ineligible expenses

## TRS – Long Term Care Insurance

*This plan is not sponsored by Plano ISD, but is listed here for your convenience.*
*More information is available by calling 1-866-659-1970.*

TRS sponsors a group long term care insurance program, administered by Genworth Life Insurance Company. With the right long term care insurance in place, you can help protect your family's financial security, have more control over decisions about your custodial care, and take comfort knowing that you're confidently moving toward a more secure and independent future.

Did you know that 42% of people receiving long term care services are under age 65? Many people think a long term health event would be covered by their health or disability insurance. However, plans like TRS-ActiveCare are not designed to cover long term custodial care costs. Only long term care insurance is designed to help pay for many of the care services you may need in your own home or in an assisted living or nursing facility.

To learn more about eligibility, costs, benefits and restrictions, call 1-866-659-1970 or go to www.genworth.com/trsactivemember, Group ID: TRS, Access Code: groupltc

Section 5

# Leave Bank

## General Information

Eligible full-time employees may join the Leave Bank by donating one local sick day for each year they are Leave Bank members. The days donated to the Leave Bank are not refundable.

When you complete your online enrollment, you will be asked to answer Yes or No regarding Leave Bank membership for the coming year.

## What type of absences qualify for Leave Bank?

Absences of **5 or more** full consecutive work days for the following reasons:

- Employee's illness (including up to 6-week period after delivery of baby)
- Family member's illness (family member is defined in policy DEC(Local))
- All requests are subject to the annual (25 days) and lifetime (75 days) maximums.

## What does not qualify for Leave Bank?

- Bereavement / Funerals
- Personal business
- Family emergency
- Workers' compensation
- Paternity
- Adoption
- Absences shorter than 5 full consecutive work days
- Absences already docked on your paycheck
- Requests for which complete documentation is not provided
- Any maternity leave taken beyond duration limit in administrative guidelines
- Any absence in excess of the annual (25 days) or lifetime (75 days) maximums

## How do I request days from the Leave Bank?

Turn in the "Request for Leave Bank Days" form and supporting medical documentation to the benefits office before your paycheck is docked for the absences.

## Leave Bank Administrative Guidelines

1. An employee must be absent, or expect to be absent five or more consecutive full work days for the same reason, in order to apply for leave bank days. Appropriate medical certification showing the qualifying reason for the employee's absence must accompany the request.

2. It is the employee's responsibility to request leave bank days for qualifying absences and to submit all required documentation in a timely manner. If the employee has not requested leave bank days from the Benefits and Risk Management Department before the paycheck is docked for those absences, leave bank days will not be granted.

3. All accrued leave, including vacation leave, must be exhausted or expect to be exhausted through medical certification in order to receive leave bank days.

4. Family as defined in Plano ISD Board Policy DEC(LOCAL), shall include:
    - Spouse
    - Son or daughter, including a biological, adopted, or foster child, a son- or daughter-in-law, a stepchild, a legal ward, or a child for whom the employee stands *in loco parentis*
    - Parent, stepparent, parent-in-law, or other individual who stands *in loco parentis* to the employee
    - Sibling, stepsibling, sibling-in-law
    - Grandparent and grandchild
    - Any person who may be residing in the employee's household at the time of illness

5. Intermittent absences (anything shorter than five consecutive full work days), bereavement, workers' compensation, adoption, and family emergency do not qualify for leave bank.

6. Upon notice from medical certification that an employee is eligible for or receiving hospice care, the lifetime maximum of 75 days may be granted.

7. Any accrued local leave left by employees resigning or retiring is donated to the leave bank.

8. Employees who end employment before the end of their work year, and who have used more local leave than they earned, are docked to re-coupe these days. Leave bank will not be used to cover this docked pay.

9. Should the leave bank balance fall below 1/6 of the annual contribution by April 1, the district may need to reduce the number of leave bank days available to leave bank members.

10. All full time employees are required to submit a leave bank selection, either accepting or declining participation. Leave bank enrollment selections are required by the end of the annual open enrollment period (date to be determined each fiscal year and published in enrollment materials). If an employee has never made a leave bank selection, and does not submit a selection by the date specified in the enrollment materials, he or she will not be allowed to participate in the leave bank for the upcoming fiscal year. He or she will be required to submit a leave bank selection at the next open enrollment period for the following fiscal year.

11. New employees are required to submit a leave bank selection when they make their other health benefit plan selections. New employees will be allowed to submit a leave bank selection within the first 31 calendar days of employment. If a leave bank selection is not received by the deadline, the employee will not be allowed to participate in the leave bank until the next fiscal year. During the next open enrollment period, the employee must submit a leave bank selection, either accepting or declining participation.

12. Leave bank days during maternity leave may only be granted during medically necessary bed rest or during the first 6 calendar weeks after delivery. Requests for leave bank days beyond the 6-week period may be considered with additional documentation from the physician regarding medical necessity.

Section 6

# Required Notices

## Notice of ACA Health Insurance Marketplace

**PART A: General Information**

Key parts of the Affordable Care Act created a new way to buy health insurance: the Health Insurance Marketplace. To assist as you evaluate options for you and your family, this notice provides some basic information about the Marketplace as well as employment-based health coverage offered by your employer.

**What is the Health Insurance Marketplace?**

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

**Can I Save Money on my Health Insurance Premiums in the Marketplace?**

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

**Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than approximately 9.6% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.*

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

**How Can I Get More Information?**

For more information about your coverage offered by your employer, please check your summary plan description or contact the Plano ISD Benefits and Risk Management Department at (469)752-8138 or email benefits@pisd.edu.

The Marketplace can help you evaluate coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

**PART B: Information About Health Coverage Offered by Your Employer**

*This section contains information about health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.*

| | | |
|---|---|---|
| 3. Employer name<br>Plano Independent School District | 4. Employer Identification Number (EIN)<br>75-6002252 | |
| 5. Employer address<br>2700 West 15th Street | 6. Employer phone number<br>(469)752-8138 | |
| 7. City<br>Plano | 8. State<br>TX | 9. Zip Code<br>75075 |
| 10. Who can we contact about employee health coverage at this job?<br>Nikki James, Coordinator for Employee Benefits | | |
| 11. Phone number (if different from above) | 12. Email address<br>Benefits@pisd.edu | |

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to most employees. Eligible employees are:
  - Employees and substitutes who are regularly scheduled to work 10 or more hours per week. Permanent full-time employees regularly scheduled to work 20 or more hours per week may also qualify for the employer contribution.
- With respect to dependents, we do offer coverage. Eligible dependents are:
  - A spouse (including a common law spouse)
  - A child under age 26 who is either a natural child, adopted child or a child who is lawfully placed for legal adoption, a stepchild, a foster child, a child under the legal guardianship of the employee
  - A grandchild under age 26 whose primary residence is the employee's household and who is a dependent of the employee for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect
  - Any other child (other than those listed above) under the age of 26 (unmarried) in a regular parent-child relationship with the employee, meeting all four of the following requirements: 1) the child's primary residence is the household of the employee; 2) the employee provides at least 50% of the child's support; 3) neither of the child's natural parents resides in that household; and 4) the employee has the legal right to make decisions regarding the child's medical care
  - An unmarried child, age 26 or over, may be eligible for dependent coverage, provided that the child is either mentally or physically incapacitated to such an extent to be dependent on the employee on a regular basis as determined by TRS, and meets other requirements as determined by TRS.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

14. Does the employer offer a health plan that meets the minimum value standard*?

☒ Yes

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):

a. How much would the employee have to pay in premiums for this plan?

☒ If eligible for the employer contribution $78.00

☒ If not eligible for the employer contribution $378.00

b. How often?

☒ Monthly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

# Notice of HIPAA Exemption

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended (HIPAA), group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than insured through a health insurance policy.

The benefits subject to this election are:

- Medical Reimbursement Plan
- Employee Assistance Program

The Plano ISD has elected to exempt the above benefits from the following requirements.

- Standards relating to benefits for mothers and newborns
- Parity in the application of certain limits to mental health benefits

The exemption from these Federal requirements will be in effect for the plan year beginning September 1, 2019, and ending August 31, 2020. The election may be renewed for subsequent years.

Even though the Plan is exempt from the above requirements, the Plan has been voluntarily amended to provide protections similar to some, but not all, of these requirements.

If you have questions or need assistance, please contact the Benefits and Risk Management Department at (469)752-8138 or e-mail benefits@pisd.edu.

# Notice of Privacy Practices

**PLANO INDEPENDENT SCHOOL DISTRICT BENEFIT PLANS**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### Effective Date and Scope of Notice

This Notice applies to all health plans maintained by Plano Independent School District (the "Employer"). All such plans are referred to in this Notice as the "Plans."

The Health Insurance Portability and Accountability Act ("HIPAA") regulates the use and disclosure of protected health information by the Plans. This Notice summarizes some of the requirements of HIPAA. It is not a contract or guarantee and does not provide any additional or other rights not expressly provided under and required by HIPAA.

This Notice does not apply to health information that does not identify an individual. Such "de-identified" information is not protected health information.

### Purpose of Notice

The Plans are required by law to take reasonable steps to maintain the privacy of protected health information and to inform you about:

- the practices of the Plans regarding use and disclosure of your protected health information;
- your privacy rights with respect to your protected health information;
- the Plans' duties with respect to your protected health information;
- your right to file a complaint with the Plans and the Secretary of the U.S. Department of Health and Human Services ("HHS"); and
- the person or office to contact for further information about the privacy practices of the Plans.

### Use and Disclosure of Protected Health Information

Disclosure to You

The Plans may disclose your protected health information to you or your personal representative.

Disclosure to HHS

The Secretary of HHS may require use and disclosure of your protected health information to investigate or determine the Plans' compliance with the privacy regulations under HIPAA.

Use and Disclosure for Treatment, Payment, and Health Care Operations and Plan Administration

The Plans and their business associates will use and disclose protected health information to carry out treatment, payment, and health care operations without your consent, authorization, or opportunity to agree or object. The Plans may also use and disclose protected health information to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. As an organized health care arrangement, the Plans may share protected health information with each other to carry out treatment, payment, or health care operations relating to the Plans.

- **Treatment** is the provision, coordination, or management of health care and related services, including consultations and referrals between one or more of your providers. For example, the Plans may disclose to a treating specialist the name of your treating provider, so that the specialist may ask for relevant medical information from your provider.
- **Payment** includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, and utilization review and preauthorization). For example, a Plan may tell a doctor whether you are eligible for coverage under the Plan. A Plan may also disclose claim information related to a covered family member (including the participating employee and the employee's spouse) to the employee or the employee's spouse. In addition to the employee and any other authorized representatives the employee designates, an employee's spouse will be considered the employee's authorized claim representative with respect to all claims the employee may have under the Plans, including claims relating to the employee and other covered family members.

- **Health Care Operations** include, but are not limited to, quality assessment and improvement; reviewing competence or qualifications of health care professionals; underwriting, premium rating, and other activities relating to insurance contracts; disease management; case management; conducting or arranging for medical review; legal services and auditing functions, including fraud and abuse compliance programs; business planning and development; business management (including business acquisition activities); and general administrative activities. For example, the Plans may use or disclose your claim information to refer you to a disease management program, project future benefit costs, or audit the accuracy of the claims processing functions of the Plans.
- **Disclosures to and Use by the Plan Sponsor.** The Plans may disclose whether you are participating in one or more of the Plans, or are enrolled in or have disenrolled from a health insurance issuer or HMO offered by the Plans. The Plans and any health insurers or HMOs with respect to the Plans may also disclose protected health information to the Employer as plan sponsor of the Plans for underwriting and for plan administration functions carried out by the Employer. For example, if the Employer sponsors a health reimbursement arrangement that is administered by the Employer through payroll, the Plans may disclose protected health information to the Employer so that it can properly review claims for reimbursement and make appropriate payment. To permit such disclosure, the Employer has amended the governing documents for the Plans as required by HIPAA. The Plans may not, however, disclose protected health information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the plan sponsor that is not a group health plan sponsored by the Employer. Additionally, federal law prohibits the Plans and the Employer from using or disclosing for underwriting purposes protected health information that is genetic information.

Use and Disclosure of Summary Health Information

The Plans may use and disclose "summary health information" to the Employer for purposes of obtaining premium bids or modifying, amending, or terminating the Plans. Summary health information is information that summarizes the claims history, claims expenses, or type of claims experienced by employees and covered family members and that does not include certain identifying information. However, neither the Plans nor the Employer may use or disclose summary health information for underwriting purposes to the extent the information is genetic information.

Use and Disclosure with Your Authorization

Except as otherwise provided in this Notice, uses and disclosures of your protected health information will be made only with your written authorization. For example, the Plans generally will not disclose your protected health information to the Employer for employment purposes or other non-health plan purposes without your authorization. You may revoke an authorization in writing unless action has been taken in reliance on such authorization. The revocation of an authorization does not apply to any disclosures already made with authorization. The Plans cannot take back and have no obligation to remedy any such prior disclosures.

Except as otherwise permitted by applicable law, the Plans must have your authorization to obtain, use or disclose any psychotherapy notes. Additionally, the Plans must also have your authorization to disclose your protected health information for purposes of marketing, except for face-to-face communications with you or your personal representative, providing promotional gifts of nominal value, and except to the extent such marketing activities constitute "treatment" or "healthcare operations," as explained above, but only if the Plans and the Employer do not receive financial remuneration for such treatment or healthcare operations marketing activities. Also, the Plans must have your authorization for any disclosure of protected health information that constitutes a "sale" of protected health information under applicable law.

Use and Disclosure Subject to Your Right to Object

The Plans may disclose your protected health information to family members, other relatives, and your close personal friends if the information is directly relevant to the family member's, relative's, or friend's involvement with your care or payment for that care, and if you are present at or prior to the disclosure and have either agreed to the disclosure or have been given an opportunity to object and not objected.

Other Permissible Uses and Disclosures

The Plans may use and disclose your protected health information without your consent, authorization, or request under the following circumstances:

- When required by federal, state, or local law.
- When permitted for purposes of public health activities. For example, protected health information may be disclosed (1) to a public health authority for the purpose of preventing or controlling disease or injury

or to report child abuse or neglect, and (2) to report product defects, to permit product recalls, and to conduct post-marketing surveillance.

- When required or authorized by law to report information about abuse, neglect, or domestic violence to public authorities if a reasonable belief exists that the individual may be a victim of abuse, neglect, or domestic violence.
- For health oversight activities authorized by law. This includes uses or disclosures in civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required in the course of any judicial or administrative proceeding. For example, the Plans may disclose protected health information in response to a court order. The Plans may also disclose such information in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that the Plans be provided satisfactory assurances that the requesting party has made a good faith attempt to provide written notice to you, the notice provided sufficient information about the proceeding to permit you to raise an objection, and no objections were raised or were resolved in favor of disclosure by the court or administrative tribunal.
- For law enforcement purposes. For example, if required by law the Plans may disclose protected health information to report certain types of wounds. The Plans may also disclose certain protected health information in response to a law enforcement request for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or for certain purposes relating to the victim of a crime.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. Also, disclosure is permitted to a funeral director, consistent with applicable law, as necessary to carry out the duties of the director with respect to the decedent.
- For the purpose of facilitating organ, eye, or tissue donation and transplantation.
- For research purposes, subject to certain conditions.
- When consistent with applicable law if the Plans, in good faith, believe the use or disclosure is necessary (1) to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, or (2) is necessary for law enforcement authorities to identify or apprehend an individual. The Plans may also disclose protected health information to federal, state, or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.
- For purposes of certain specialized government functions, including military and veteran's activities, national security and intelligence activities, certain protective services, and activities of correctional institutions.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

- With respect to psychotherapy notes, to defend the Plan or the Employer in its capacity as plan sponsor in a legal action or other proceeding brought by you or your personal representative.

**Privacy Rights**

Right to Request Restriction on Protected Health Information Use and Disclosure

You may request that the Plans restrict use and disclosure of your protected health information to carry out treatment, payment, or health care operations or restrict use and disclosure to family members, relatives, or friends identified by you who are involved in your care or payment for your care. **The Plans are not required to agree to your requests.** The Plans may accommodate your request to receive communications of protected health information by alternative means or at alternative locations if you notify the Plans that communication in another manner may endanger you.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your protected health information or alternative communications of your protected health information. Such requests must be submitted to the attention of "Protected Health Information Restriction Request" c/o the Privacy Officer (see the "Contact Information" at the end of this section).

Right to Inspect and Copy Your Protected Health Information

You have the right to inspect and obtain a copy of your protected health information contained in a "designated record set" for as long as the Plans maintain such protected health information. A "designated record set" includes enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for the Plans and used to make decisions about individuals. However, certain types of protected health information will not be made available for inspection and copying, including psychotherapy notes and protected health information collected by the Plans in connection with or in reasonable anticipation of any claim or legal proceeding. The requested information will be provided within 30 days if the information is maintained on-site or within 60 days if the information is maintained off-site. A single 30-day extension is allowed if the Plans are unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to your protected health information in a designated record set. Such requests must be submitted to the attention of "Protected Health Information Inspection Request" c/o the Privacy Officer (see the contact information at the end of this section). If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights, and a description of how you may complain to the Secretary of the HHS.

Right to Amend Your Protected Health Information

You have the right to request that the Plans amend your protected health information or a record about you contained in a designated record set for as long as the information is maintained in the designated record set. The Plans may deny your request if it is not in writing or does not include a reason that supports the request. In addition, the Plans may deny your request if you request to amend protected health information that is accurate and complete; was not created by the Plans, unless the person or entity that created the protected health information is no longer available to make the amendment; is not part of a designated record set kept by or for the Plans; or is not part of the protected health information which you would be permitted to inspect and copy. The Plans have 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plans are unable to comply with such deadline.

You or your personal representative will be required to complete a form to request an amendment of your records or protected health information in a designated record set. Such requests must be submitted to the attention of "Protected Health Information Amendment Request" c/o the Privacy Officer (see the contact information at the end of this section). If the request is denied in whole or in part, the Plans must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of such protected health information.

Right to an Accounting of Protected Health Information Disclosures

The Plans will provide you with an accounting of the Plans' disclosures of your protected health information during the six-year period prior to the date of your request (or the time specified by your request, if less). However, such accounting need not and will not include disclosures made: (1) to carry out treatment, payment, or health care operations; (2) to individuals about their own protected health information; (3) prior to April 14, 2003; (4) for national security purposes or certain law enforcement purposes; (5) as part of a limited data set; or (6) pursuant to your written authorization.

You or your personal representative will be required to complete a form to request an accounting of disclosures of your protected health information. Such requests must be submitted to the attention of "Protected Health Information Accounting" c/o the Privacy Officer (see the contact information at the end of this section). If the accounting cannot be provided within 60 days after your request, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each additional accounting beyond the first.

Right to a Paper Copy of this Notice

To obtain a paper copy of this Notice, submit a request to the attention of "Privacy Notice Request" c/o the Privacy Officer (see the contact information at the end of this section).

Your Personal Representatives

You may exercise your rights under this Notice through a personal representative. Your personal representative may be required to produce evidence of authority to act on your behalf before the representative will be given access to your protected health information or allowed to take any action for you. Proof of such authority may include a parental relationship, a duly notarized power of attorney for health care purposes, or a court order of appointment of the representative as the conservator or guardian of the individual. The Plans

retain the discretion to deny access to your protected health information to a personal representative to the extent permitted by applicable regulations.

### Duties of the Plans

The Plans are required by HIPAA to maintain the privacy of protected health information and to provide covered employees and covered family members with this Notice of the privacy practices of the Plans, and to notify affected individuals following a breach of unsecured protected health information. The Plans will comply with mandatory requirements of applicable state laws regarding the use and disclosure of health information to the extent such laws are more restrictive than and are not preempted by applicable federal laws.

Each Plan is required to abide by the terms of the Notice currently in effect. However, the Plans reserve the right to change their privacy practices at any time and to apply the changes to any protected health information received or maintained by the Plans prior to the date such change is adopted. If a privacy practice is changed, a revised version of this Notice will be provided to all past and present covered employees and covered family members for whom the Plan still maintains protected health information. Such revised Notice will be provided via hand delivery, mail, or, to the extent permissible, e-mail. The exact method of delivery will be determined by the Plans and may be different for different individuals. Any revised version of this Notice will be distributed within 60 days after the effective date of any material change to the permissible uses or disclosures, an individual's rights, the duties of the Plans, or other privacy practices set forth in this Notice.

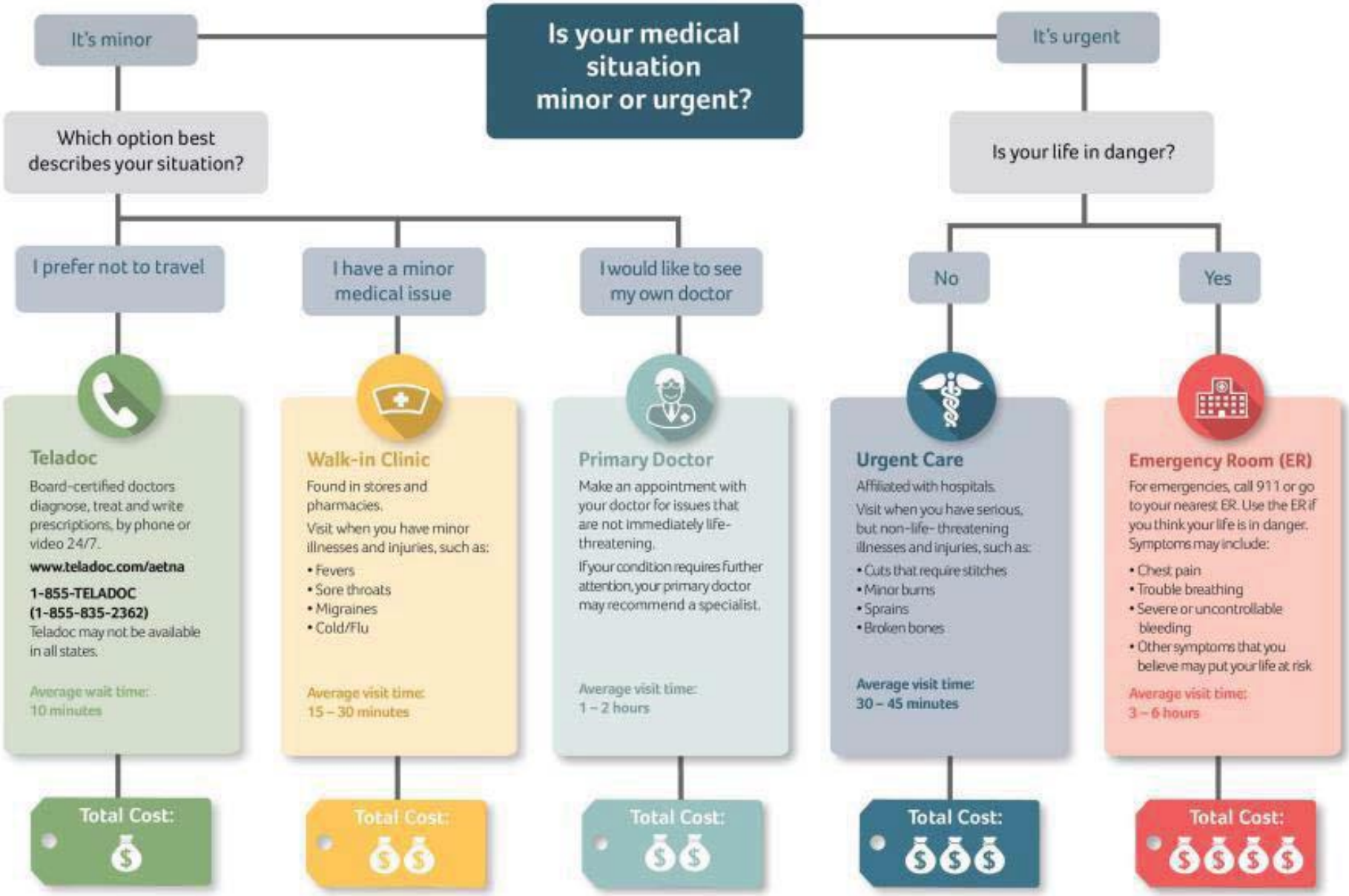
When using or disclosing protected health information or when requesting protected health information from another covered entity, the Plans will make reasonable efforts not to use, disclose, or request more than the minimum amount of protected health information reasonably necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. However, this "minimum necessary" standard will not apply in the following situations: (1) disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the individual or a personal representative; (3) disclosures made to HHS; (4) uses or disclosures that are required by law; (5) uses or disclosures made pursuant to an authorization; and (6) uses or disclosures that are required for compliance with HIPAA regulations.

### Complaints

If you believe that your privacy rights have been violated, you may complain to the Plans in care of the Privacy Officer: Director of Benefits and Risk Management, Plano Independent School District, 6301 Chapel Hill Blvd., Plano, TX 75093, benefits@pisd.edu. You may also file a complaint with the Secretary of HHS, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint. An individual cannot sue or bring a claim or other action against any of the Plans or any other person to enforce any of the requirements of HIPAA.

### Contact Information

If you have any questions regarding this Notice or the subjects described in it, you may contact the Privacy Officer listed above.



## Benefits and Risk Management Department

**benefits@pisd.edu** **(469)752-8138**

### Let us help you with:

Enrollment issues

General coverage questions

Life insurance

Mid-year changes

### Get information anytime

www.pisd.edu/benefits

### TEAMS Employee Service Center

http://esc.pisd.edu

view paychecks & benefits

view leave balances & report absences

| Benefit Plan | Company | Phone | Web Site |
|---|---|---|---|
| Medical | | | |
| ActiveCare 1-HD<br>ActiveCare Select<br>ActiveCare 2 | Aetna (med)<br>CareMark (rx) | 1-800-222-9205 | www.trsactivecareaetna.com |
| | Teladoc | 1-855-835-2362 | |
| | Nurse Line | 1-800-556-1555 | |
| Scott & White HMO | Scott & White | 1-800-321-7947 | trs.swhp.org |
| | Nurse Line | 1-877-505-7947 | |
| Dental | Delta Dental | 1-800-521-2651 | deltadentalins.com |
| Vision | VSP | 1-800-877-7195 | www.vsp.com |
| | Davis | 1-800-999-5431 | www.davisvision.com |
| EAP (free counseling) | ComPsych | 1-800-272-7255 | www.guidanceresources.com<br>Web ID: PLANOISD |
| Disability Insurance | Cigna | 1-800-362-4462 | www.mycigna.com |
| FSA & HSA | FBA | 1-800-437-3539 | www.flex-admin.com<br>Employer ID: FBAPISD |