

EMPLOYEE SERVICES - BENEFITS

Health Insurance Option for New Substitutes and Temporary Employees

Lewisville ISD will offer health insurance to substitute and temporary employees who have a reasonable expectation of working a minimum of 10 hours per week. Because substitutes and temporary employees are not members of TRS, the district contribution will **not** apply to the health insurance. Subs and temps who elect this coverage must pay 100 percent of the health premiums in advance each month. See “Substitute & Temporary Employee TRS-ActiveCare Premiums for 2019-20” for rate and plan summary information.

ALL subs & temps must either enroll in a Lewisville ISD health plan or decline the coverage. This is done within 31 days of your hire date for your NEW HIRE ENROLLMENT. If you are not enrolling in the Lewisville ISD health insurance, you must decline.

To enroll in the LISD health insurance, you must complete enrollment in the LISD Benefits Office during your enrollment opportunity. The Benefits Office is located in the Lewisville ISD Administrative Center at 1565 A W. Main – Room 209, Lewisville, TX 75067. Payment for the first month will be due at the time of initial enrollment, payable by cash or check made out to Lewisville ISD.

Substitute and Temporary employee enrollees in the health plan will not receive a monthly bill, invoice or payment reminder. Upon enrollment, health insurance rates will be determined by the plan you select.

**LEWISVILLE INDEPENDENT SCHOOL DISTRICT
ACKNOWLEDGEMENT OF WAIVER OF
TRS ACTIVECARE MEDICAL PLAN BENEFITS**

I acknowledge that I have been given the opportunity to enroll in the Lewisville Independent School District (LISD) group medical benefit program (TRS ActiveCare Medical Plan), which is comprised of an ActiveCare Plan 1 HD, ActiveCare Plan 2, ActiveCare Select Plan and Baylor Scott & White HMO Plan. I elected to waive coverage in all plans. I understand that this waiver does not qualify me as having medical coverage under the Patient Protection and Affordable Care Act (PPACA); therefore, does not meet the Act's regulatory requirements for all individuals to have health care coverage effective 1-1-14. I am also aware that not meeting my coverage obligations under PPACA may subject me to an IRS penalty.

Lewisville ISD has a Section 125 Cafeteria Plan, which means that I may not have another opportunity to enroll until the next open enrollment period or until I have a specific change in status, called a "Family Status Change," as allowed by the IRS for Section 125 plans. This WAIVER will become part of my permanent records at LISD until otherwise revoked by me through enrolling in one of the four TRS ActiveCare medical options (ActiveCare 1 HD, ActiveCare 2, ActiveCare Select or Baylor Scott & White HMO) provided by the district.

Print Name

Emp ID#

Signature

Date

LEWISVILLE ISD
Substitute & Temporary Employee
TRS-ActiveCare Premiums for 2019-20

Provider	Plan	TRS Monthly Rate
Aetna	TRS-ActiveCare Plan 1-HD	
	Employee Only	\$378.00
	Employee & Spouse	\$1,066.00
	Employee & Child(ren)	\$722.00
	Employee & Family	\$1,415.00
Aetna	TRS-ActiveCare Plan 2	
	Employee Only	\$852.00
	Employee & Spouse	\$2,020.00
	Employee & Child(ren)	\$1,267.00
	Employee & Family	\$2,389.00
Aetna	TRS-ActiveCare Select EPO - No out-of-network benefits paid	
	Employee Only	\$556.00
	Employee & Spouse	\$1,367.00
	Employee & Child(ren)	\$902.00
	Employee & Family	\$1,718.00
Baylor Scott & White	Baylor Scott & White HMO - No out-of-network benefits paid	
	Employee Only	\$558.54
	Employee & Spouse	\$1,306.58
	Employee & Child(ren)	\$876.76
	Employee & Family	\$1,457.28

The first month's payment is due at the time of enrollment. You may pay by cash or check payable to Lewisville ISD.

Payments are due in the Benefits Office prior to the next month of coverage. For example, payment is due by September 30 for October coverage. Enrollees in the health plan will **not** receive a monthly bill, invoice or payment reminder. Upon enrollment, your health insurance rate will be determined by the plan/tier you sign up for. If premiums are not received by the last day of the month prior to the next month, coverage will be terminated. If the last day of the month falls on a weekend or holiday, payment is due the last working day of the month. You may pay by cash or check (checks payable to Lewisville ISD). Payment receipts will be furnished upon request.

Note: Your coverage may also be cancelled if you lose eligibility for TRS-Activecare*

*A substitute who is enrolled in TRS-Active Care and who is then removed from the substitute roster becomes ineligible for health coverage and will be provided notice regarding continuation coverage under COBRA (if eligible). Cancellation due to non-payment is considered a voluntary drop: Therefore, you would not be eligible for COBRA.

2019–20 TRS-ActiveCare Plan Highlights

Effective Sept. 1, 2019 through Aug. 31, 2020 | In-Network Level of Benefits¹



Medical Coverage	TRS-ActiveCare 1-HD	TRS-ActiveCare Select/ TRS-ActiveCare Select Whole Health <small>(Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance)</small>	TRS-ActiveCare 2 <small>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.</small>
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 \$70 copay for specialist	\$30 copay for primary \$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 \$70 copay for specialist	\$30 copay for primary \$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.trselectivecareatna.com.

2019-20 TRS-ActiveCare Plan Highlights

Prescription Coverage	TRS-ActiveCare 1-HD	TRS-ActiveCare Select/ ActiveCare Select Whole Health <small>(Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance)</small>	TRS-ActiveCare 2
	Drug Deductible (per person, per plan year)	Must meet plan-year deductible before plan pays. ²	\$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)			
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 may be 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.

Monthly Premiums

TRS-ActiveCare Monthly Premium	TRS-ActiveCare 1-HD			TRS-ActiveCare Select/ ActiveCare Select Whole Health			TRS-ActiveCare 2		
	Full monthly premium*	Premium with min. state/district contribution**	Your monthly premium***	Full monthly premium*	Premium with min. state/district contribution**	Your monthly premium***	Full monthly premium*	Premium with min. state/district contribution**	Your monthly premium***
Individual	\$378	\$153		\$556	\$331		\$852	\$627	
+Spouse	\$1,066	\$841		\$1,367	\$1,142		\$2,020	\$1,795	
+Children	\$722	\$497		\$902	\$677		\$1,267	\$1,042	
+Family	\$1,415	\$1,190		\$1,718	\$1,493		\$2,389	\$2,164	

*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.

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	
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 Does not apply to preferred generic drugs	\$150								
Ask an SWHP Pharmacy representative how to save money on your prescriptions.	<table border="1"> <thead> <tr> <th>Retail Quantity (Up to a 30-day supply)</th> <th>Maintenance Quantity (Up to a 90-day supply)</th> </tr> </thead> <tbody> <tr> <td>Preferred Generic</td> <td>\$5 copay</td> </tr> <tr> <td>Preferred Brand</td> <td>30% after Rx deductible</td> </tr> <tr> <td>Non-Preferred</td> <td>50% after Rx deductible</td> </tr> </tbody> </table>	Retail Quantity (Up to a 30-day supply)	Maintenance Quantity (Up to a 90-day supply)	Preferred Generic	\$5 copay	Preferred Brand	30% after Rx deductible	Non-Preferred	50% after Rx deductible
Retail Quantity (Up to a 30-day supply)	Maintenance Quantity (Up to a 90-day supply)								
Preferred Generic	\$5 copay								
Preferred Brand	30% after Rx deductible								
Non-Preferred	50% after Rx deductible								
Online Refills	trs.swhp.org								
Mail Order	BSWH : 1-817-388-3090 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.

¹Including all services billed with office visit

² Does not apply to wellness or preventive visits

³Includes other services, treatments, or procedures received at time of office visit

⁴\$750 maximum copay per admission and 20% after deductible

⁵35 maximum visits per year

⁶Copay waived if admitted within 24 hours