2022 - 2023 Plan Year

LEWISVILLE ISD

BENEFIT GUIDE

EFFECTIVE: 09/01/2022 - 8/31/2023

WWW.LISD.NET/BENEFITS

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PG. 12 YOUR BENEFITS

Benefit Contact Information

BENEFITS CARELINE	TELEHEALTH	DENTAL
Financial Benefit Services (833) 453-1680 www.mybenefitshub.com/lewisvilleisd	MDLIVE (888) 365-1663 www.mdlive.com/fbsbh	Metlife Group #141096 (800) 638-5433 www.metlife.com
MEDICAL: TRS ACTIVECARE	**VISION**	**FLEXIBLE SPENDING ACCOUNT**
BCBSTX (866) 355-5999 www.bcbstx.com/trsactivecare	UnitedHealthcare Group #755429 (800) 638-3120 www.myuhcvision.com	National Benefit Services (855) 399-3035 www.nbsbenefits.com
MEDICAL: HMO	**DISABILITY**	**HEALTHCARE SAVINGS ACCOUNT**
North and Central Texas Scott & White HMO (844) 633-5325 www.trs.swhp.org	New York Life Group #SLH100028 (888) 842-4462 www.myNYLGBS.com	EECU (817) 882-0800 www.eecu.org
HOSPITAL INDEMNITY	**EMERGENCY MEDICAL TRANSPORTATION**	**COBRA (DENTAL & VISION)**
Aflac Group #CTR0000078088 (800) 992-3522 www.aflacgroupinsurance.com	MASA MTS Group# B2BLEWIS (800) 423-3226 www.masamts.com	National Benefit Services (800) 274-0503 www.nbsbenefits.com
CRITICAL ILLNESS	**INDIVIDUAL LIFE**	**COBRA (TRS MEDICAL)**
Cigna Group #CI961740 (800) 244-6224 www.cigna.com	Texas Life (800) 283-9233 www.texaslife.com	bswift (833) 682-8972 TRS-Care Standard for Non-Medicare Retirees: https://www.trs.texas.gov/Pages/healthcare_trs_care.aspx TRS-Care for Medicare Retirees: https://www.trs.texas.gov/Pages/healthcare_trs_care_medicare.aspx
LEGAL SERVICES	**LIFE AND AD&D**	
LegalEase (888) 416-4313 https://www.legaleaseplan.com/lisd	Unum Group #547646 (800) 445-0402 www.unum.com	

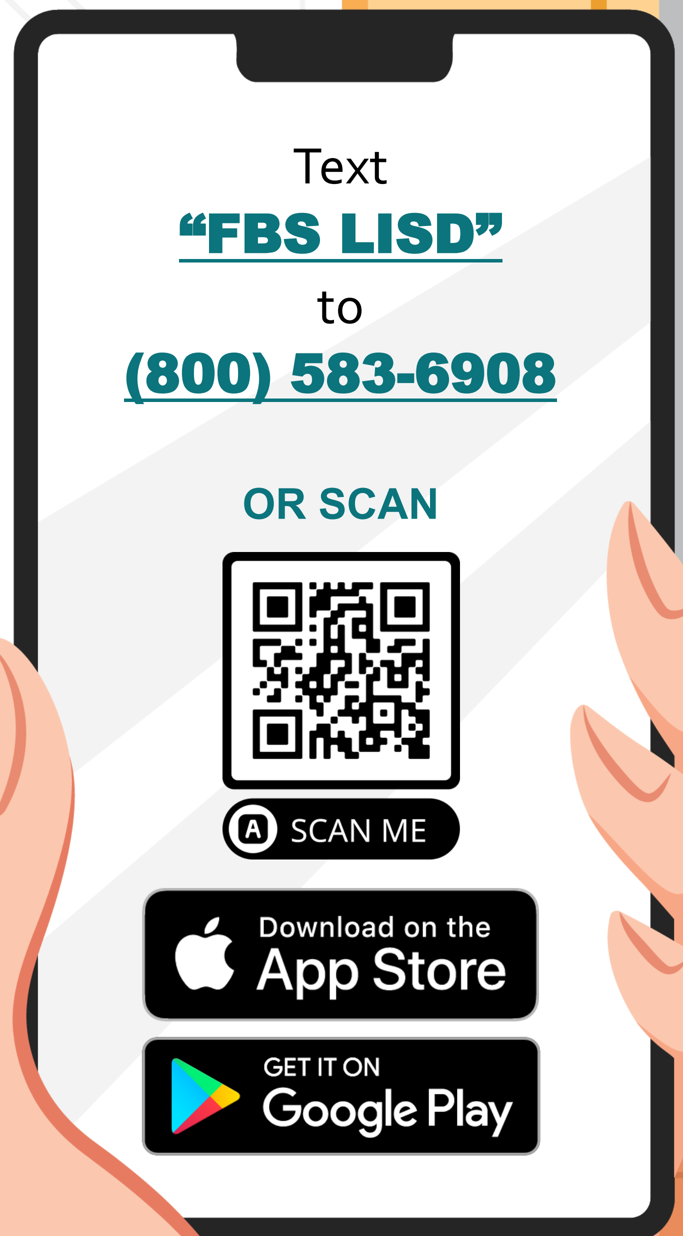
All Your Benefits - One App

Employee benefits made easy through the ***FBS Benefits App!***

Text **"FBS LISD"**
to **(800) 583-6908**
and get access to everything you need to complete your benefits enrollment:

- Benefit Resources
- Online Enrollment
- Interactive Tools
- And more!

App Group #:
FBSLISD



How to Log In

Login Instructions:

1) Go to: www.LISD.net/Benefits
2) Click the "My Benefits Logo" or under the "Access Online" box in blue click on "click here to use the Online Benefit System"
3) Enter your LISD username and password
4) Select THE*benefits*HUB icon

If you have difficulty accessing the system please contact (469) 948-8104 or email: benefits@lisd.net

Username:

District Username

Default Password:

District Password

Annual Benefit Enrollment

Annual Enrollment

During your annual enrollment period, you have the opportunity to review, change or continue benefit elections each year. Changes are not permitted during the plan year (outside of annual enrollment) unless a Section 125 qualifying event occurs.

- Changes, additions or drops may be made only during the annual enrollment period without a qualifying event.
- Employees must review their personal information and verify that dependents they wish to provide coverage for are included in the dependent profile. Additionally, you must notify your employer of any discrepancy in personal and/or benefit information.
- Employees must confirm on each benefit screen (medical, dental, vision, etc.) that each dependent to be covered is selected in order to be included in the coverage for that particular benefit.

New Hire Enrollment

All new hire enrollment elections must be completed in the online enrollment system within the first 31 days of benefit eligible employment. Failure to complete elections during this timeframe will result in the forfeiture of coverage.

Q&A

Who do I contact with Questions?

For benefit questions, you can contact your LISD Benefits Office or you can call Financial Benefit Services at (866) 914-5202 for assistance.

Where can I find forms?

For benefit summaries and claim forms, go to your benefits website www.lisd.net/benefits and click on Benefit Plans. Select "Benefits Portal – Detailed Plan Information" from the drop down list. Click the Benefits Portal link and find details about each benefit on the left hand side. Select the benefit desired and locate plan summaries and forms on the page bottom.

How can I find a Network Provider?

To locate providers in the network, go to your benefits website www.lisd.net/benefits and click on Benefit Plans. Select "Benefits Portal – Detailed Plan Information" from the drop down list. Click the Benefits Portal link and find details about each benefit on the left hand side. Select the benefit desired and the Provider Search is located under Quick Links on the page bottom.

When will I receive ID cards?

If the insurance carrier provides ID cards, you can expect to receive those 3-4 weeks after your effective date. For most dental and vision plans, you can login to the carrier website and print a temporary ID card or simply give your provider the insurance company's phone number and they can call and verify your coverage if you do not have an ID card at that time. If you do not receive your ID card, you can call the carrier's customer service number to request another card.

If the insurance carrier provides ID cards, but there are no changes to the plan, you typically will not receive a new ID card each year.

Section 125 Cafeteria Plan Guidelines

A Cafeteria plan enables you to save money by using pre-tax dollars to pay for eligible group insurance premiums sponsored and offered by your employer. Enrollment is automatic unless you decline this benefit. Elections made during annual enrollment will become effective on the plan effective date and will remain in effect during the entire plan year.

Changes in benefit elections can occur only if you experience a qualifying event. You must present proof of a qualifying event to your Benefit Office within 31 days of your qualifying event and meet with LISD Benefits Office to complete and sign the necessary paperwork in order to make a benefit election change. Benefit changes must be consistent with the qualifying event.

CHANGES IN STATUS (CIS):	QUALIFYING EVENTS
Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid change in status event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain/Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital or employment status. Proof of event change is required in order for change to be made to coverage.
Judgment/Decree/ Order	If a judgment, decree, or order from a divorce, annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Eligibility for Government Programs	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.

Helpful Definitions

Actively-at-Work

You are performing your regular occupation for the employer on a full-time basis, either at one of the employer's usual places of business or at some location to which the employer's business requires you to travel. If you will not be actively at work beginning 9/1/2022 please notify your benefits administrator.

Annual Enrollment

The period during which existing employees are given the opportunity to enroll in or change their current elections.

Annual Deductible

The amount you pay each plan year before the plan begins to pay covered expenses.

Calendar Year

January 1st through December 31st

Co-insurance

After any applicable deductible, your share of the cost of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service.

Guaranteed Coverage

The amount of coverage you can elect without answering any medical questions or taking a health exam. Guaranteed coverage is only available during initial eligibility period. Actively-at-work and/or pre-existing condition exclusion provisions do apply, as applicable by carrier.

In-Network

Doctors, hospitals, optometrists, dentists and other providers who have contracted with the plan as a network provider.

Out-of-Pocket Maximum

The most an eligible or insured person can pay in co-insurance for covered expenses.

Plan Year

September 1st through August 31st

Pre-Existing Conditions

Applies to any illness, injury or condition for which the participant has been under the care of a health care provider, taken prescription drugs or is under a health care provider's orders to take drugs, or received medical care or services (including diagnostic and/or consultation services).

Employee Eligibility Requirements

Supplemental benefits excluding medical coverage: Eligible employees must work 15 or more regularly scheduled hours each work week.

Eligible employees must be actively-at-work on the plan effective date for new benefits to be effective, meaning you are physically capable of performing the functions of your job on the first day of work concurrent with the plan effective date. For example, if your 2022 benefits become effective on September 1, 2022, you must be actively-at-work on September 1, 2022 to be eligible for your new benefits. If you are not actively at work on September 1, 2022, benefits will begin the first of the month following after you return to active status.

Dependent Eligibility Requirements

Dependent Eligibility: You can cover eligible dependent children under a benefit that offers dependent coverage, provided you participate in the same benefit, through the maximum age listed below. Dependents cannot be double covered by married spouses within the district as both employees and dependents.

PLAN	MAXIMUM AGE
Medical	26
Dental	26
Vision	26
Hospital Indemnity	26
Life and AD&D	26
Individual Life	26
Critical Illness	26
Emergency Medical Transport	26
HSA	IRS Dependent covered on your HDHP.
FSA	IRS Dependent

Please note, limits and exclusions may apply when obtaining coverage as a married couple or when obtaining coverage for dependents.

Potential Spouse Coverage Limitations: *When enrolling in coverage, please keep in mind that some benefits may not allow you to cover your spouse as a dependent if your spouse is enrolled for coverage as an employee under the same employer. Review the applicable plan documents, contact Financial Benefit Services, or contact the insurance carrier for additional information on spouse eligibility.*

FSA/HSA Limitations: *Please note, in general, per IRS regulations, married couples may not enroll in both a Flexible Spending Account (FSA) and a Health Savings Account (HSA). If your spouse is covered under an FSA that reimburses for medical expenses then you and your spouse are not HSA eligible, even if you would not use your spouse's FSA to reimburse your expenses. However, there are some exceptions to the general limitation regarding specific types of FSAs. To obtain more information on whether you can enroll in a specific type of FSA or HSA as a married couple, please reach out to the FSA and/or HSA provider prior to enrolling or reach out to your tax advisor for further guidance.*

Potential Dependent Coverage Limitations: *When enrolling for dependent coverage, please keep in mind that some benefits may not allow you to cover your eligible dependents if they are enrolled for coverage as an employee under the same employer. Review the applicable plan documents, contact Financial Benefit Services, or contact the insurance carrier for additional information on dependent eligibility.*

Disclaimer: *You acknowledge that you have read the limitations and exclusions that may apply to obtaining spouse and dependent coverage, including limitations and exclusions that may apply to enrollment in Flexible Spending Accounts and Health Savings Accounts as a married couple. You, the enrollee, shall hold harmless, defend, and indemnify Financial Benefit Services, LLC from any and all claims, actions, suits, charges, and judgments whatsoever that arise out of the enrollee's enrollment in spouse and/or dependent coverage, including enrollment in Flexible Spending Accounts and Health Savings Accounts.*

If your dependent is disabled, coverage may be able to continue past the maximum age under certain plans. If you have a disabled dependent who is reaching an ineligible age, you must provide a physician’s statement confirming your dependent’s disability. Contact your LISD Benefits Office to request a continuation of coverage.

HSA vs. FSA

	Health Savings Account (HSA) (IRC Sec. 223)	Flexible Spending Account (FSA) (IRC Sec. 125)
Description	Approved by Congress in 2003, HSAs are actual bank accounts in employee's names that allow employees to save and pay for unreimbursed qualified medical expenses tax-free.	Allows employees to pay out-of-pocket expenses for copays, deductibles and certain services not covered by medical plan, tax-free. This also allows employees to pay for qualifying dependent care tax-free.
Employer Eligibility	A qualified high deductible health plan.	All employers
Contribution Source	Employee	Employee
Account Owner	Individual	Employer
Underlying Insurance Requirement	High deductible health plan	None
Minimum Deductible	$1,400 single (2022) $2,800 family (2022)	N/A
Maximum Contribution	$3,650 single (2022) $7,300 family (2022)	$2,850 (2022)
Permissible Use Of Funds	Employees may use funds any way they wish for qualified expenses. If used for non -qualified medical expenses, subject to current tax rate plus 20% penalty.	Reimbursement for qualified medical expenses (as defined in Sec. 213(d) of IRC).
Cash-Outs of Unused Amounts (if no medical expenses)	Permitted, but subject to current tax rate plus 20% penalty (penalty waived after age 65).	Not permitted
Year-to-year rollover of account balance?	Yes, will roll over to use for subsequent year's health coverage.	No. Access to some funds may be extended if your employer's plan contains a 2 1/2-month grace period.
Does the account earn interest?	Yes	No
Portable?	Yes, portable year-to-year and between jobs.	No

FLIP TO PG. 20 FOR HSA INFORMATION

FLIP TO PG. 34 FOR FSA INFORMATION

Notes

Medical Insurance
TRS

ABOUT MEDICAL

Major medical insurance is a type of health care coverage that provides benefits for a broad range of medical expenses that may be incurred either on an inpatient or outpatient basis.

For full plan details, please visit your benefit website: **www.lisd.net/benefits**

	Monthly Premium	District Contribution	Employee Cost
TRS ActiveCare HD			
Employee Only	$429.00	$326.00	$103.00
Employee & Spouse	$1,209.00	$388.00	$821.00
Employee & Child(ren)	$772.00	$372.00	$400.00
Employee & Family	$1,445.00	$393.00	$1,052.00
TRS ActiveCare 2			
Employee Only	$1,013.00	$358.00	$655.00
Employee & Spouse	$2,402.00	$388.00	$2,014.00
Employee & Child(ren)	$1,507.00	$372.00	$1,135.00
Employee & Family	$2,841.00	$393.00	$2,448.00
TRS ActiveCare Primary			
Employee Only	$417.00	$326.00	$91.00
Employee & Spouse	$1,176.00	$388.00	$788.00
Employee & Child(ren)	$751.00	$372.00	$379.00
Employee & Family	$1,405.00	$393.00	$1,012.00
TRS ActiveCare Primary+			
Employee Only	$525.00	$358.00	$167.00
Employee & Spouse	$1,284.00	$388.00	$896.00
Employee & Child(ren)	$845.00	$372.00	$473.00
Employee & Family	$1,614.00	$393.00	$1,221.00
Central and North Texas Baylor Scott & White HMO			
Employee Only	$569.24	$358.00	$211.24
Employee & Spouse	$1,431.08	$388.00	$1,043.08
Employee & Child(ren)	$915.65	$372.00	$543.65
Employee & Family	$1,647.24	$393.00	$1,254.24

LOCAL HEALTH CARE. TEXAS-SIZED BENEFITS.

TRS-ActiveCare Plan Highlights 2022-23

From the North Texas plains to the Gulf Coast, TRS-ActiveCare is where you live and work. We have more Texas doctors than any other plan and more ways to make your health plan *yours*.

TRS-ActiveCare

REGION 11

Learn the terms.

- **Premium:** The monthly amount you pay for health care coverage.
- **Deductible:** The annual amount for medical expenses you're responsible to pay before your plan begins to pay its portion.
- **Copay:** The set amount you pay for a covered service at the time you receive it. The amount can vary by the type of service.
- **Coinsurance:** The portion you're required to pay for services after you meet your deductible. It's often a specified percentage of the costs; i.e. you pay 20% while the health care plan pays 80%.
- **Out-of-Pocket Maximum:** The maximum amount you pay each year for medical costs. After reaching the out-of-pocket maximum, the plan pays 100% of allowable charges for covered services.

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2022-23 TRS-ActiveCare Plan Highlights Sept. 1, 2022 –

How to Calculate Your Monthly Premium

Total Monthly Premium

− Your District and State Contributions

= **Your Premium**

Ask your Benefits Administrator for your district's specific premiums.

Wellness Benefits at No Extra Cost*

Being healthy is easy with:

- $0 preventive care
- 24/7 customer service
- One-on-one health coaches
- Weight loss programs
- Nutrition programs
- Ovia™ pregnancy support
- TRS Virtual Health
- Mental health benefits
- And much more!

**Available for all plans.*
See the benefits guide for more details.

Things to Know

- TRS's Texas-sized purchasing power enables access to broad networks without county boundaries.
- Specialty drug insurance means you're covered, no matter what life throws at you.

All TRS-ActiveCare participants have **three plan options**.

	TRS-ActiveCare Primary	TRS-
Plan Summary	• Lowest premium of all three plans • Copays for doctor visits before you meet your deductible • Statewide network • Primary Care Provider (PCP) referrals required to see specialists • Not compatible with a Health Savings Account (HSA) • No out-of-network coverage	• Lower deductible t • Copays for many s • Higher premium • Statewide network • PCP referrals requi • Not compatible wit • No out-of-network

Monthly Premiums	Total Premium	Your Premium	Total Premi
Employee Only	$417	$	$525
Employee and Spouse	$1,176	$	$1,284
Employee and Children	$751	$	$845
Employee and Family	$1,405	$	$1,614

Plan Features		
Type of Coverage	In-Network Coverage Only	I
Individual/Family Deductible	$2,500/$5,000	
Coinsurance	You pay 30% after deductible	Yo
Individual/Family Maximum Out of Pocket	$8,150/$16,300	
Network	Statewide Network	
PCP Required	Yes	

Doctor Visits		
Primary Care	$30 copay	
Specialist	$70 copay	

Immediate Care		
Urgent Care	$50 copay	
Emergency Care	You pay 30% after deductible	Yo
TRS Virtual Health-RediMD (TM)	$0 per medical consultation	$0
TRS Virtual Health-Teladoc®	$12 per medical consultation	$1

Prescription Drugs		
Drug Deductible	Integrated with medical	
Generics (30-Day Supply/90-Day Supply)	$15/$45 copay; $0 copay for certain generics	
Preferred Brand	You pay 30% after deductible	Yo
Non-preferred Brand	You pay 50% after deductible	Yo
Specialty	$0 if PrudentRx eligible; You pay 30% after deductible	Yo
Insulin Out-of-Pocket Costs	$25 copay for 31-day supply; $75 for 61-90 day supply	$25 copay for 3

Each includes a wide range of wellness benefits.

-ActiveCare Primary+	TRS-ActiveCare HD
han the HD and Primary plans ervices and drugs red to see specialists h a Health Savings Account (HSA) coverage	• Compatible with a Health Savings Account (HSA) • Nationwide network with out-of-network coverage • No requirement for PCPs or referrals • Must meet your deductible before plan pays for non-preventive care

This plan is closed and not accepting new enrollees. If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan.

TRS-ActiveCare 2
• Closed to new enrollees • Current enrollees can choose to stay in plan • Lower deductible • Copays for many services and drugs • Nationwide network with out-of-network coverage • No requirement for PCPs or referrals

um	Your Premium	Total Premium	Your Premium
	$	$429	$
	$	$1,209	$
	$	$772	$
	$	$1,445	$

Total Premium	Your Premium
$1,013	$
$2,402	$
$1,507	$
$2,841	$

n-Network Coverage Only	In-Network	Out-of-Network
$1,200/$3,600	$3,000/$6,000	$5,500/$11,000
u pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible
$6,900/$13,800	$7,050/$14,100	$20,250/$40,500
Statewide Network	Nationwide Network	
Yes	No	

In-Network	Out-of-Network
$1,000/$3,000	$2,000/$6,000
You pay 20% after deductible	You pay 40% after deductible
$7,900/$15,800	$23,700/$47,400
Nationwide Network	
No	

$30 copay	You pay 30% after deductible	You pay 50% after deductible
$70 copay	You pay 30% after deductible	You pay 50% after deductible

$30 copay	You pay 40% after deductible
$70 copay	You pay 40% after deductible

$50 copay	You pay 30% after deductible	You pay 50% after deductible
u pay 20% after deductible	You pay 30% after deductible	
) per medical consultation	$30 per medical consultation	
2 per medical consultation	$42 per medical consultation	

$50 copay	You pay 40% after deductible
You pay a $250 copay plus 20% after deductible	
$0 per medical consultation	
$12 per medical consultation	

$200 brand deductible	Integrated with medical
$15/$45 copay	You pay 20% after deductible; $0 coinsurance for certain generics
u pay 25% after deductible	You pay 25% after deductible
u pay 50% after deductible	You pay 50% after deductible
$0 if PrudentRx eligible; u pay 30% after deductible	You pay 20% after deductible
1-day supply; $75 for 61-90 day supply	You pay 25% after deductible

$200 brand deductible
$20/$45 copay
You pay 25% after deductible ($40 min/$80 max)/ You pay 25% after deductible ($105 min/$210 max)
You pay 50% after deductible ($100 min/$200 max)/ You pay 50% after deductible ($215 min/$430 max)
$0 if PrudentRx eligible; You pay 30% after deductible ($200 min/$900 max)/ No 90-day supply of specialty medications
$25 copay for 31-day supply; $75 for 61-90 day supply

What's New and What's Changing

This table shows you the changes between 2021-22 statewide premium price and this year's 2022-23 regional price for your Education Service Center.

		2021-22 Total Premium	New 2022-23 Total Premium	Change in Dollar Amount	Key Plan Changes
TRS-ActiveCare Primary	Employee Only	$417	$417	**$0**	• Member Rewards was expanded to include more than 100 new procedures • Copay for Teladoc® rose from $0 to $12 • Maximum out of pocket for insulin capped at $25/31-day supply; $75/61-90 day supply
	Employee and Spouse	$1,176	$1,176	**$0**	
	Employee and Children	$751	$751	**$0**	
	Employee and Family	$1,405	$1,405	**$0**	
TRS-ActiveCare HD	Employee Only	$429	$429	**$0**	• In-network maximum rose by $50/individual; $100/families • The Member Rewards program is now available for HD participants - Rewards are paid through a limited-purpose Health Care Account (HCA) and can be used toward dental and vision expenses • Consult fee for Teladoc rose from $30 to $42
	Employee and Spouse	$1,209	$1,209	**$0**	
	Employee and Children	$772	$772	**$0**	
	Employee and Family	$1,445	$1,445	**$0**	
TRS-ActiveCare Primary+	Employee Only	$542	$525	**($17)**	• Member Rewards was expanded to include more than 100 new procedures • Copay for Teladoc rose from $0 to $12 • Maximum out of pocket for insulin capped at $25/31-day supply; $75/61-90 day supply
	Employee and Spouse	$1,334	$1,284	**($50)**	
	Employee and Children	$879	$845	**($34)**	
	Employee and Family	$1,675	$1,614	**($61)**	
TRS-ActiveCare 2 (closed to new enrollees)	Employee Only	$1,013	$1,013	**$0**	• Copay for Teladoc rose from $0 to $12 • Maximum out of pocket for insulin capped at $25/31-day supply; $75/61-90 day supply • This plan is still closed to new enrollees
	Employee and Spouse	$2,402	$2,402	**$0**	
	Employee and Children	$1,507	$1,507	**$0**	
	Employee and Family	$2,841	$2,841	**$0**	

At a Glance

	Primary	HD	Primary+
Premiums	Lowest	Lower	Higher
Deductible	Mid-range	High	Low
Copays	Yes	No	Yes
Network	Statewide network	Nationwide network	Statewide network
PCP Required?	Yes	No	Yes
HSA-eligible?	No	Yes	No

Effective: Sept. 1, 2022

Compare Prices for Common Medical Services

REMEMBER: Log into Blue Access for Members[SM] at **www.bcbstx.com/trsactivecare** to use the cost estimator tool. This will help you find the best prices through different providers.

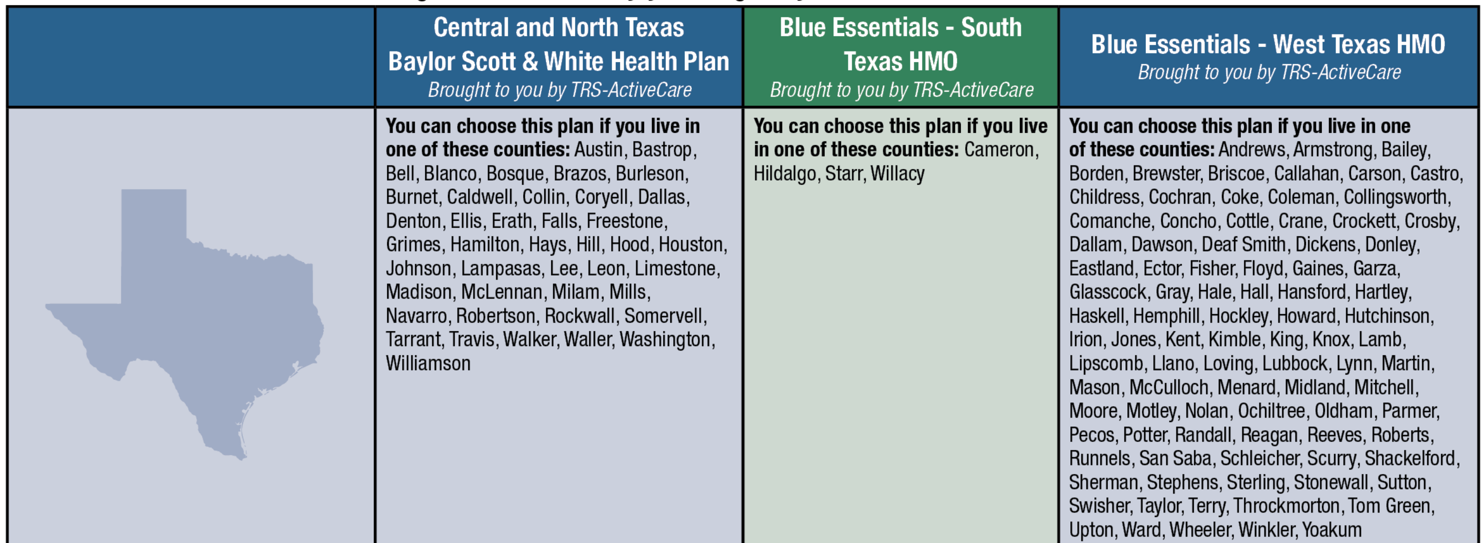
Benefit	TRS-ActiveCare Primary	TRS-ActiveCare Primary+	TRS-ActiveCare HD		TRS-ActiveCare 2	
	In-Network Only	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Labs*	Office/Indpendent Lab: You pay $0 Outpatient: You pay 30% after deductible	Office/Indpendent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	Office/Indpendent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 40% after deductible
High-Tech Radiology	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible + $100 copay per procedure	You pay 40% after deductible + $100 copay per procedure
Outpatient Costs	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible ($150 facility copay per incident)	You pay 40% after deductible ($150 facility copay per incident)
Inpatient Hospital Costs	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible ($500 facility per day maximum)	You pay 20% after deductible ($150 facility copay per day)	You pay 40% after deductible ($500 facility per day maximum)
Freestanding Emergency Room	You pay $500 copay + 30% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 30% after deductible	You pay $500 copay + 50% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 40% after deductible
Bariatric Surgery	Facility: You pay 30% after deductible Professional Services: You pay $5,000 copay + 30% after deductible Only covered if rendered at a BDC+ facility	Facility: You pay 20% after deductible Professional Services: You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility	Not Covered	Not Covered	Facility: You pay 20% after deductible ($150 facility copay per day) Professional Services: You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility	Not Covered
Annual Vision Exam (one per plan year; performed by an ophthalmologist or optometrist)	You pay $70 copay	You pay $70 copay	You pay 30% after deductible	You pay 50% after deductible	You pay $70 copay	You pay 40% after deductible
Annual Hearing Exam (one per plan year)	$30 PCP copay $70 specialist copay	$30 PCP copay $70 specialist copay	You pay 30% after deductible	You pay 50% after deductible	$30 PCP copay $70 specialist copay	You pay 40% after deductible

Pre-certification for genetic and specialty testing may apply. Contact a Personal Health Guide at **1-866-355-5999 with questions.*

2022-23 Health Maintenance Organization (HMO) Plans and Premiums for Select Regions of the State

REMEMBER: Remember that when you choose an HMO, you're choosing a regional network.

TRS also contracts with HMOs in certain regions of the state to bring participants in those areas additional options. Not all HMOs are available in all regions. Please verify your eligibility.



	Central and North Texas Baylor Scott & White Health Plan *Brought to you by TRS-ActiveCare*	Blue Essentials - South Texas HMO *Brought to you by TRS-ActiveCare*	Blue Essentials - West Texas HMO *Brought to you by TRS-ActiveCare*
	You can choose this plan if you live in one of these counties: Austin, Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Collin, Coryell, Dallas, Denton, Ellis, Erath, Falls, Freestone, Grimes, Hamilton, Hays, Hill, Hood, Houston, Johnson, Lampasas, Lee, Leon, Limestone, Madison, McLennan, Milam, Mills, Navarro, Robertson, Rockwall, Somervell, Tarrant, Travis, Walker, Waller, Washington, Williamson	**You can choose this plan if you live in one of these counties:** Cameron, Hildalgo, Starr, Willacy	**You can choose this plan if you live in one of these counties:** Andrews, Armstrong, Bailey, Borden, Brewster, Briscoe, Callahan, Carson, Castro, Childress, Cochran, Coke, Coleman, Collingsworth, Comanche, Concho, Cottle, Crane, Crockett, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Eastland, Ector, Fisher, Floyd, Gaines, Garza, Glasscock, Gray, Hale, Hall, Hansford, Hartley, Haskell, Hemphill, Hockley, Howard, Hutchinson, Irion, Jones, Kent, Kimble, King, Knox, Lamb, Lipscomb, Llano, Loving, Lubbock, Lynn, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Parmer, Pecos, Potter, Randall, Reagan, Reeves, Roberts, Runnels, San Saba, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Taylor, Terry, Throckmorton, Tom Green, Upton, Ward, Wheeler, Winkler, Yoakum

Total Monthly Premiums	Total Premium	Your Premium	Total Premium	Your Premium	Total Premium	Your Premium
Employee Only	$569.24	$	N/A	$	N/A	$
Employee and Spouse	$1,431.08	$	N/A	$	N/A	$
Employee and Children	$915.65	$	N/A	$	N/A	$
Employee and Family	$1,647.24	$	N/A	$	N/A	$

Plan Features			
Type of Coverage	In-Network Coverage Only	N/A	N/A
Individual/Family Deductible	$1,900/$4,750	N/A	N/A
Coinsurance	You pay 20% after deductible	N/A	N/A
Individual/Family Maximum Out of Pocket	$8,000/$15,000	N/A	N/A

Doctor Visits			
Primary Care	$15 copay	N/A	N/A
Specialist	$70 copay	N/A	N/A

Immediate Care			
Urgent Care	$45 copay	N/A	N/A
Emergency Care	$500 copay after deductible	N/A	N/A

Prescription Drugs			
Drug Deductible	$200 (excl. generics)	N/A	N/A
Days Supply	30-day supply/90-day supply	N/A	N/A
Generics	$12/$30 copay	N/A	N/A
Preferred Brand	You pay 30% after deductible	N/A	N/A
Non-preferred Brand	You pay 50% after deductible	N/A	N/A
Specialty	You pay 25%/35% after deductible (perferred/non-preferred)	N/A	N/A

Revised 05/03/22

Telehealth

MDLIVE

EMPLOYEE BENEFITS

ABOUT TELEHEALTH

Telehealth provides 24/7/365 access to board-certified doctors via telephone or video consultations that can diagnose, recommend treatment and prescribe medication. Telehealth makes care more convenient and accessible for non-emergency care when your primary care physician is not available.

For full plan details, please visit your benefit website:
www.lisd.net/benefits

Alongside your medical coverage is access to quality telehealth services through **MDLIVE**. Connect anytime day or night with a board-certified doctor via your mobile device or computer. While **MDLIVE** does not replace your primary care physician, it is a convenient and cost-effective option when you need care and:

- Have a non-emergency issue and are considering a convenience care clinic, urgent care clinic or emergency room for treatment
- Are on a business trip, vacation or away from home
- Are unable to see your primary care physician

When to Use MDLIVE:

At a cost that is the same or less than a visit to your physician, use telehealth services for minor conditions such as:

- Sore throat
- Headache
- Stomachache
- Cold
- Flu
- Allergies
- Fever
- Urinary tract infections

Do not use telemedicine for serious or life-threatening emergencies.

MDLIVE Behavioral Health:

Managing stress or life changes can be overwhelming but it's easier than ever to get help right in the comfort of your own home. Visit a counselor or psychiatrist by phone, secure video, or MDLIVE App.

- Talk to a licensed counselor or psychiatrist from your home, office, or on the go!
- Affordable, confidential online therapy for a variety of counseling needs.
- The MDLIVE app helps you stay connected with appointment reminders, important notifications and secure messaging.

Registration is Easy

- Register with **MDLIVE** so you are ready to use this valuable service when and where you need it.
- Online – www.mdlive.com/fbsbh
- Phone – **(888) 365-1663**
- Mobile – download the MDLIVE mobile app to your smartphone or mobile device
- Select –"MDLIVE as a benefit" and "FBS" as your Employer/Organization when registering your account.

Telehealth	
Employee	$8.00
Employee and Family	$12.00

Health Savings Account (HSA)

EECU

EMPLOYEE BENEFITS

ABOUT HSA

A Health Savings Account (HSA) is a personal savings account where the money can only be used for eligible medical expenses. Unlike a flexible spending account (FSA), the money rolls over year to year however only those funds that have been deposited in your account can be used. Contributions to a Health Savings Account can only be used if you are also enrolled in a High Deductible Health Care Plan (HDHP).

For full plan details, please visit your benefit website:
www.lisd.net/benefits

A Health Savings Account (HSA) is more than a way to help you and your family cover health care costs – it is also a tax-exempt tool to supplement your retirement savings and cover health expenses during retirement. An HSA can provide the funds to help pay current health care expenses as well as future health care costs.

A type of personal savings account, an HSA is always yours even if you change health plans or jobs. The money in your HSA (including interest and investment earnings) grows tax-free and spends tax-free if used to pay for qualified medical expenses. There is no "use it or lose it" rule — you do not lose your money if you do not spend it in the calendar year — and there are no vesting requirements or forfeiture provisions. The account automatically rolls over year after year.

HSA Eligibility

You are eligible to open and contribute to an HSA if you are:

- Enrolled in an HSA-eligible HDHP
- Not covered by another plan that is not a qualified HDHP, such as your spouse's health plan
- Not enrolled in a Health Care Flexible Spending Account
- Not eligible to be claimed as a dependent on someone else's tax return
- Not enrolled in Medicare or TRICARE
- Not receiving Veterans Administration benefits

You can use the money in your HSA to pay for qualified medical expenses now or in the future. You can also use HSA funds to pay health care expenses for your dependents, even if they are not covered by the HDHP.

Maximum Contributions

Your HSA contributions may not exceed the annual maximum amount established by the Internal Revenue Service. The annual contribution maximum for 2022 is based on the coverage option you elect:

- Individual – $3,650
- Family (filing jointly) – $7,300

You decide whether to use the money in your account to pay for qualified expenses or let it grow for future use. If you are 55 or older, you may make a yearly catch-up contribution of up to $1,000 to your HSA. If you turn 55 at any time during the plan year, you are eligible to make the catch-up contribution for the entire plan year.

Opening an HSA

If you meet the eligibility requirements, you may open an HSA administered by EECU. You will receive a debit card to manage your HSA account reimbursements. Keep in mind, available funds are limited to the balance in your HSA.

Important HSA Information

- Always ask your health care provider to file claims with your medical provider so network discounts can be applied. You can pay the provider with your HSA debit card based on the balance due after discount.
- You, not your employer, are responsible for maintaining ALL records and receipts for HSA reimbursements in the event of an IRS audit.
- You may open an HSA at the financial institution of your choice, but only accounts opened through EECU are eligible for automatic payroll deduction and company contributions.

How to Use your HSA

- Online/Mobile: Sign-in for 24/7 account access to check your balance, pay bills and more.
- Call/Text: (817) 882-0800. EECU's dedicated member service representatives are available to assist you with any questions. Their hours of operation are Monday through Friday from 8:00 a.m. to 7:00 p.m. CT, Saturday 9:00 a.m. – 1:00 p.m. CT and closed on Sunday.
- Lost/Stolen Debit Card: Call the 24/7 debit card hotline at (800) 333-9934
- Stop by a local EECU financial center for in-person assistance: www.eecu.org/locations.

Hospital Indemnity

Aflac

EMPLOYEE BENEFITS

ABOUT HOSPITAL INDEMNITY

This is an affordable supplemental plan that pays you should you be in-patient hospital confined. This plan complements your health insurance by helping you pay for costs left unpaid by your health insurance.

For full plan details, please visit your benefit website:
www.lisd.net/benefits

The plan that can help with expenses and protect your savings.

Does your major medical insurance cover all your bills? Even a minor trip to the hospital can present you with unexpected expenses and medical bills. And even with major medical insurance, your plan may only pay a portion of your entire stay. That's how the Aflac Group Hospital Indemnity plan can help. It provides financial assistance to enhance your current coverage. So you may be able to avoid dipping into savings or having to borrow to address out-of-pocket-expenses major medical insurance was never intended to cover. Like transportation and meals for family members, help with childcare, or time away from work, for instance.

In order to receive benefits for accidental injuries due to a covered accident, an insured must be admitted within six months of the date of the covered accident (in Washington, twelve months).

Hospital Indemnity	
Employee	$17.44
Employee + Spouse	$33.09
Employee + Child(ren)	$26.78
Family	$42.43

Benefit	Amount
HOSPITAL ADMISSION BENEFIT per confinement (once per covered sickness or accident per calendar year for each insured) Payable when an insured is admitted to a hospital and confined as an in-patient because of a covered accidental injury or covered sickness. We will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment. We will not pay benefits for admission of a newborn child following his birth; however, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a covered accidental injury or covered sickness (including congenital defects, birth abnormalities, and/or premature birth).	$1,000
HOSPITAL CONFINEMENT per day (maximum of 31 days per confinement for each covered sickness or accident for each insured) Payable for each day that an insured is confined to a hospital as an in-patient as the result of a covered accidental injury or covered sickness. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.	$100
HOSPITAL INTENSIVE CARE BENEFIT per day (maximum of 10 days per confinement for each covered sickness or accident for each insured) Payable for each day when an insured is confined in a Hospital Intensive Care Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in a Hospital's Intensive Care Unit at a time. Once benefits are paid, if an insured becomes confined to a Hospital's Intensive Care Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable in addition to the Hospital Confinement Benefit.	$200
HEALTH SCREENING BENEFIT The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for each insured. Residents of Massachusetts are not eligible for the Health Screening Benefit.	$50 per calendar year
SUCCESSOR INSURED BENEFIT If spouse coverage is in force at the time of the employee's death, the surviving spouse may elect to continue coverage. Coverage would continue according to the existing plan and would also include any dependent child coverage in force at the time.	

Terms you need to know:

Covered Accident is an accident that occurs on or after an insured's effective date while coverage is in force, and that is not specifically excluded by the plan.

Dependent means your spouse or dependent children, as defined in the applicable rider, who have been accepted for coverage.

Spouse is your legal wife, husband, or partner in a legally recognized union. Refer to your certificate for details.

Dependent Children are your or your spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children (in Texas, adopted children), or children placed for adoption. Newborn children are automatically covered from the moment of birth for 60 days. Newly adopted children are automatically covered for 60 days also. Dependent children must be younger than age 26 (In Arizona, on the effective date of coverage and in Louisiana and Illinois, unmarried). See certificate for details.

You May Continue Your Coverage Your coverage may be continued with certain stipulations. See certificate for details. Termination of Coverage Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force. See certificate for details.

A Covered Sickness is one that is not excluded by name, specific description, or any other provision in this plan. For a benefit to be payable, loss arising from the covered sickness must occur while the applicable insured's coverage is in force (except in Montana). Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does not include telemedicine services (except in Kansas).

A **Hospital Intensive Care Unit** is not any of the following step-down units: a progressive care unit; a sub-acute intensive care unit; an intermediate care unit; a private monitored room; a surgical recovery room; an observation unit; or any facility not meeting the definition of a Hospital Intensive Care Unit as defined in the certificate Sickness means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury (In Maine, illness or disease of an insured).

A **Hospital** is not a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a rehabilitation facility; a facility for the treatment of alcoholism or drug addiction (except in Vermont); an assisted living facility; or any facility not meeting the definition of a Hospital as defined in the certificate.

Dental Insurance

MetLife

ABOUT DENTAL

Dental insurance is a coverage that helps defray the costs of dental care. It insures against the expense of routine care, dental treatment and disease.

For full plan details, please visit your benefit website:
www.lisd.net/benefits

MetLife Preferred Dentist Program #141096	Plan Option 1 Standard		Plan Option 2 Basic	
	In-Network[1] % of Negotiated Fee[2]	Out-of-Network % Maximum Allowable Charge*	In-Network[1] % of Negotiated Fee[2]	Out-of-Network % Maximum Allowable Charge*
Type A: Preventive (cleanings, exams, X-rays)	100%	100%	50%	50%
Type B: Basic Restorative (fillings, extractions)	80%	80%	50%	50%
Type C: Major Restorative (bridges, dentures)	50%	50%	50%	50%
Type D: Orthodontia	50%	50%	Not Covered	Not Covered
Deductible†				
Individual	$50	$50	N/A	N/A
Family	$150	$150	N/A	N/A
Annual Maximum				
Per Person	$1,500	$1,500	$1,000	$1,000
Orthodontia Lifetime Maximum				
Per Person	$1,500	$1,500	Not Covered	Not Covered

1 "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.

2 Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

* Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife.

† Applies only to Type B & C Services in the Standard Plan. Does not apply to Basic Plan.

How do I find a participating dentist?
Visit Dental Insurance Plans: Healthy Smiles Ahead | MetLife or call (800) 942-0854 to have a list faxed or mailed to you.

Dental		
	Standard Plan	Basic Plan
Employee	$42.68	$22.46
Employee + Spouse	$85.38	$44.90
Employee + Child(ren)	$87.10	$45.82
Family	$129.80	$68.28

Do I need an ID Card?
No. You do not need to present an ID Card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Dental Insurance

MetLife

Type A - Preventive	Plan Option 1 - Standard	Plan Option 2 - Basic
Prophylaxis (cleanings)	Two per year	
Oral Examinations	Two exams per year	
Topical Fluoride Applications	One fluoride treatment per year for dependent children up to his/her 16th birthday	
X-rays	Full mouth X-rays; one per 36 months Bitewing X-rays; two sets per year	
Sealants	One application of sealant material every 36 months for each non-restored, non-decayed, 1st and 2nd molar of dependent child up to his/her 17th birthday	
Type B - Basic Restorative		
Fillings		
Simple Extractions		
Crown, Denture and Bridge Repair/Recementations	One replacement for the same tooth surface, every 60 months	
Oral Surgery		N/A
Endodontics	Root canal treatment limited to once per tooth per 24 months	Root canal treatment limited to once per tooth per 24 months
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services.	
Periodontics	Periodontal scaling and root planning for covered person over age 14 once per quadrant, every 24 months Periodontal surgery once per quadrant, every 36 months Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year	N/A
Space Maintainers	Space maintainers for dependent children up to his/her 14th birthday, once per lifetime per tooth area	
Type C - Major Restorative		
Bridges and Dentures	Initial placement to replace one or more natural teeth for covered person over age 14, which are lost while covered by the plan Dentures and bridgework replacement; once every 60 months Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed	
Crown, Denture and Bridge Repair/Recementations	One replacement for the same tooth surface, every 60 months Repairs once a 12-month period Re-cementation once a 12-month period	
Implants	Repair once every 12 months Replacement once every 60 months	
Crowns, Inlays and Onlays	Replacement once every 60 months for covered person over age 14	
Oral Surgery	N/A	
Periodontics	N/A	Periodontal scaling and root planning for covered person over age 14 once per quadrant, every 24 months Periodontal surgery once per quadrant every 36 month Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year
Type D - Orthodontia	You, your spouse, and your children, up to age 25, are covered while Dental insurance is in effect. All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. Payments are on a repetitive basis 20% of the Orthodontia Lifetime Maximum will be considered at the initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as identified in the plan summary Orthodontic benefits end at cancellation of coverage	Not Covered

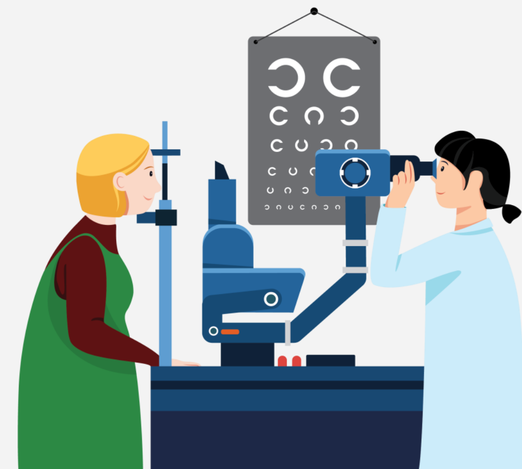
Vision Insurance

UnitedHealthcare

EMPLOYEE BENEFITS

ABOUT VISION

Vision insurance provides coverage for routine eye examinations and can help with covering some of the costs for eyeglass frames, lenses or contact lenses.



For full plan details, please visit your benefit website:
www.lisd.net/benefits

Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Eyeglass Lenses	Once every 12 months
Frames	Once every 24 months
Contact lens instead of Eyeglasses	Once every 12 months

Copays	
Exam(s)	$10
Eyeglasses (lenses and frame)	$25
Contact lens instead of Eyeglasses	$25

Vision	
Employee	$8.38
Employee + Spouse	$15.33
Employee + Child(ren)	$16.06
Family	$24.78

In-Network Services	
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[1]	
Private Practice Provider	$130 retail frame allowance
Retail Chain Provider	$130 retail frame allowance
Lens Options: Standard Scratch-resistant Coating, Polycarbonate Lenses for Adults, Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full.	
Contact Lens Benefit[2] (Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Non-Formulary. A copy of the list can be found at www.myuhcvision.com).	
Formulary contact lenses: The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.	If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider.
Non-Formulary contact lenses: An allowance is applied toward the purchase of contact lenses outside the Formulary. Contact lens copay is waived.	$125.00
Necessary contact lenses	Covered in full after copay (if applicable).
Children's and Maternity Eye Care Benefit Members aged 0-12 and members pregnant or breastfeeding are eligible for a 2nd exam. Members aged 0-12 and pregnant or breastfeeding are also eligible for a replacement frame and lenses if they have a prescription change of 0/5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame, and lens benefits.	

1. 30% discount available at most participating in-network provider locations. May exclude certain frame manufactures. Please verify all discounts with your provider.
2. Contact lenses are instead of eyeglass lenses and/or eyeglass frames. Coverage for Formulary contact lenses does not apply at all in-network providers. The allowance for Non-Formulary contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.
3. Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular comeal/astigmatism, aphakia, pathological myopia, aniseikonia, aniridia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vsion confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to $40
Frames	Up to $45
Single Vision Lenses	Up to $40
Lined Bifocal and Progressive Lenses	Up to $60
Lined Trifocal Lenses	Up to $80
Lenticular Lenses	Up to $80
Elective Contacts instead of Eyeglasses[2]	Up to $125
Necessary Contacts instead of Eyeglasses[3]	Up to $210

Refractive surgery
UnitedHealthcare has partnered with QUalSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction providers. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at $945 per eye for Traditional LASIK and $1,395 per eye for Custom LASIK. Discounts are also provided on the newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit www.myuhcvision.com.

Additional Material
At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please not that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.

Hearing Aids
As a UnitedHealthcare vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to www.UHCHearing.com.

Disability Insurance

New York Life

ABOUT DISABILITY

Disability insurance protects one of your most valuable assets, your paycheck. This insurance will replace a portion of your income in the event that you become physically unable to work due to sickness or injury for an extended period of time.

For full plan details, please visit your benefit website:
www.lisd.net/benefits

Who is eligible? If you are an active employee in the United States working a minimum of 15 hours per week. You are eligible on the first day of the month following date of hire.

When Coverage Takes Effect: Your coverage takes effect on the later of the policy's effective date, the date you become eligible, the date we receive your completed enrollment form, or the date you authorize any necessary payroll deductions. If you're not actively at work on the date your coverage would otherwise take effect, your coverage will take effect on the date you return to work. If you have to submit evidence of good health, your coverage takes effect on the date we agree, in writing, to cover you.

Disability: "Disability" or "Disabled" means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to earn 80% or more of your indexed earnings from working in your regular occupation. After benefits have been payable for 24 months, you are considered disabled if solely due to your injury or sickness, you are unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience, and you are unable to earn 60% or more of your indexed earnings. We will require proof of earnings and continued disability.

Covered Earnings: "Covered Earnings" means your wages or salary, not including bonuses, commissions, and other extra compensation

When Benefits Begin: The elimination period is the length of time you must be continuously disabled before you can receive benefits.

Elimination Period Options:
Option 1: 14 days/14 days first day hospital
Option 2: 30 days/30 days first day hospital
Option 3: 60 days/60 days
Option 4: 90 days/90 days

You must be continuously Disabled for your elected benefit waiting period before benefits will be payable for a covered Disability. For any selected Benefit Waiting Period of 30 days or less, the Benefit Waiting Period will end on the date you are admitted as an inpatient in a hospital if that date is before the end of the time period specified.

What is my maximum Monthly Benefit? You may select a benefit amount between $200 and $8,000 in increments of $100 not to exceed 70% of your current monthly earnings.

What is my maximum Benefit Period? Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit or until you no longer qualify for benefits, whichever occurs first. Should you remain Disabled, your benefits continue according to one of the following schedules, depending on your age at the time you become Disabled and the plan you select.

Premium Plan	
Age at Start of Disability	Maximum Benefit Duration
Age 62 or younger	the Employee's 65th birthday or the 42nd monthly disability benefit
Age 63	the 36th monthly disability benefit
Age 64	the 30th monthly disability benefit
Age 65	the 24th monthly disability benefit
Age 66	the 21st monthly disability benefit
Age 67	the 18th monthly disability benefit
Age 68	the 15th monthly disability benefit
Age 69 and older	the 12th monthly disability benefit

Select Plan	
Age at Start of Disability - Sickness	Duration of Payments
18-65	60 months
65 - 69	To age 70, but not less than 12 months
70+	12 Months
Age at Start of Disability - Injury	Maximum Benefit Duration
age 62 or younger	the Employee's 65th birthday or the 42nd monthly disability benefit
age 63	the 36th monthly disability benefit
age 64	the 30th monthly disability benefit
age 65	the 24th monthly disability benefit
age 66	the 21st monthly disability benefit
age 67	the 18th monthly disability benefit
age 68	the 15th monthly disability benefit
Age 69 and older	the 12th monthly disability benefit

Benefit Reductions, Conditions, and Limitations:

Effects of Other Income: Benefits This plan is structured to prevent your total benefits and post-disability earnings from equaling or exceeding pre-disability earnings. Therefore, we reduce this plan's benefits by Other Income Benefits payable to you, your dependents, or a qualified third party on behalf of you or your dependents. Disability benefits may be reduced by amounts received through Social Security disability benefits payable to you, your dependents, or a qualified third party on behalf of you or your dependents. Your disability benefits will not be reduced by any Social Security disability benefits you are not receiving as long as you cooperate fully in efforts to obtain them and agree to repay any overpayment when and if you do receive them. Disability benefits will also be reduced by amounts received through other government programs, sick leave, employer's sabbatical leave, employer's assault leave plan, employer funded retirement benefits, workers' compensation, franchise/group insurance, auto no-fault, and damages for wage loss. For details, see your outline of coverage, policy certificate, or your employer's summary plan description. Note: Some of the Other Income Benefits, as defined in the group policy, will not be considered until after disability benefits are payable for 6 months.

Earnings While Disabled: During the first 24 months that benefits are payable, benefits will be reduced if benefits plus income from employment exceeds 100% of pre-disability Covered Earnings. After that, benefits will be reduced by 50% of earnings from employment.

Limited Benefit Period: Disabilities caused by or contributed to by any one or more of the following conditions are subject to a lifetime limit of 24 months for outpatient treatment: Anxiety-disorders, delusional (paranoid) or depressive disorders, eating disorders, mental illness, somatoform disorders (including psychosomatic illnesses) ,alcoholism, drug addiction or abuse. Benefits are payable during periods of hospital confinement for these conditions for hospitalizations lasting more than 14 consecutive days that occur before the 24-month lifetime outpatient limit is exhausted.

Pre-existing Condition Limitation: Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures,) during the 3 months just prior to the most recent effective date of insurance. Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance.

Guarantee issue open enrollment every year Waiver of elimination period upon hospitalization with 30 day elimination period or less

Pregnancy covered same as any illness - 12 month pre-existing limitation

Can elect up to 70% of salary to a max of $8,000

Premium Plan - pays sickness & injury to age 65

Elimination (waiting)	Rate per month per period $100 of coverage
14 day	$2.74
30 day	$2.32
60 day	$1.50
90 day	$1.30

Select Plan - pays sickness for 5 years & injury to age 65

Elimination (waiting)	Rate per month per period $100 of coverage
14 day	$2.42
30 day	$2.08
60 day	$1.35
90 day	$1.16

Critical Illness Insurance

Cigna

ABOUT CRITICAL ILLNESS

Critical illness insurance can be used towards medical or other expenses. It provides a lump sum benefit payable directly to the insured upon diagnosis of a covered condition or event, like a heart attack or stroke. The money can also be used for non-medical costs related to the illness, including transportation, child care, etc.

For full plan details, please visit your benefit website:
www.lisd.net/benefits

What are the Critical Illness coverage amounts? For you: Select one of the following Choices $10,000, $20,000 or $30,000; For your Dependent(s): 100% of employee coverage amount.

Who is eligible? Employees in active employment in the United States working at least 15 hours per week and their eligible spouses and children (to age 26).

	Benefit Amount	Guaranteed Issue Amount
Employee	$10,000, $20,000, $30,000	Up to $30,000
Spouse	100% of employee amount	Up to $30,000
Children	100% of employee amount, including Childhood conditions	All guaranteed issue
Covered Conditions		
Cancer Conditions		
Skin Cancer*	$250 1x per lifetime	
Covered Conditions	**Initial Benefit Amount %**	**Recurrence % of Initial Benefit Amount**
Invasive Cancer	100%	100%
Carcinoma in Situ	25%	25%
Vascular Conditions		
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	100%	100%
Nervous System Conditions		
Advanced Stage Alzheimer’s Disease	25%	Not Available
Amyotrophic Lateral Sclerosis (ALS)	25%	Not Available
Parkinson’s Disease	25%	Not Available
Multiple Sclerosis	25%	Not Available
Mid Stage Alzheimer’s Disease	25%	Not Available
Huntington’s Disease	25%	Not Available
Myasthenia Gravis	25%	25%
Infectious Conditions		
Bacterial Meningitis	25%	25%
Malaria	25%	25%
Tuberculosis	25%	25%
Necrotizing Fasciitis	25%	25%
Osteomyelitis	25%	25%

Critical Illness Insurance

Cigna

EMPLOYEE BENEFITS

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
Childhood Conditions		
Cerebral Palsy	25%	Not Available
Cystic Fibrosis	25%	Not Available
Muscular Dystrophy	25%	Not Available
Poliomyelitis	25%	Not Available
Other Specific Conditions		
Benign Brain Tumor	100%	100%
Blindness	100%	Not Available
Coma	25%	25%
End-Stage Renal (Kidney) Disease	100%	100%
Major Organ Failure	100%	100%
Paralysis	100%	100%
Loss of Hearing	100%	Not Available
Loss of Speech	100%	Not Available
Systemic Lupus	25%	25%
Systemic Sclerosis	25%	25%

**Please refer to the policy for complete definitions of covered conditions.*

To file a claim call Cigna at (800) 754-3207 or find claim form at www.mybenefitshub.com/lewisvilleisd.

Critical Illness					
	Age	Employee	Employee + Spouse	Employee + Children	Employee + Family
Benefit Amount: $10,000	<29	$2.05	$4.19	$4.74	$6.88
	30 to 39	$4.04	$7.82	$6.72	$10.50
	40 to 49	$6.75	$13.35	$9.04	$15.63
	50 to 59	$11.92	$26.54	$14.15	$28.78
	60 to 69	$19.91	$46.09	$22.32	$48.51
	70 to 79	$34.11	$75.47	$36.52	$77.89
	80 to 89	$69.99	$126.98	$72.54	$129.53
	90+	$69.99	$126.98	$72.54	$129.53
	Age	Employee	Employee + Spouse	Employee + Children	Employee + Family
Benefit Amount: $20,000	<29	$4.10	$8.38	$9.48	$13.76
	30 to 39	$8.08	$15.64	$13.44	$21.00
	40 to 49	$13.50	$26.70	$18.08	$31.26
	50 to 59	$23.84	$53.08	$28.30	$57.56
	60 to 69	$39.82	$92.18	$44.64	$97.02
	70 to 79	$68.22	$150.94	$73.04	$155.78
	80 to 89	$139.98	$253.96	$145.08	$259.06
	90+	$139.98	$253.96	$145.08	$259.06
	Age	Employee	Employee + Spouse	Employee + Children	Employee + Family
Benefit Amount: $30,000	<29	$6.15	$12.57	$14.22	$20.64
	30 to 39	$12.12	$23.46	$20.16	$31.50
	40 to 49	$20.25	$40.05	$27.12	$46.89
	50 to 59	$35.76	$79.62	$42.45	$86.34
	60 to 69	$59.73	$138.27	$66.96	$145.53
	70 to 79	$102.33	$226.41	$109.56	$233.67
	80 to 89	$209.97	$380.94	$217.62	$388.59
	90+	$209.97	$380.94	$217.62	$388.59

Costs are subject to change. Actual per pay period premiums may differ slightly due to rounding.
The policy's rate structure is based on attained age, which means the premium can increase due to the increase in your age.

Life and AD&D

Unum

EMPLOYEE BENEFITS

ABOUT LIFE AND AD&D

Group term life is the most inexpensive way to purchase life insurance. You have the freedom to select an amount of life insurance coverage you need to help protect the well-being of your family.

Accidental Death & Dismemberment is life insurance coverage that pays a death benefit to the beneficiary, should death occur due to a covered accident. Dismemberment benefits are paid to you, according to the benefit level you select, if accidentally dismembered.

For full plan details, please visit your benefit website:
www.lisd.net/benefits

Who is eligible? For Basic Life all actively employed employees working at least 15 hours each week for your employer in the U.S. For Voluntary Life and AD&D products employees working at least 15 hours and their eligible spouses and children to age 26.

What are the Basic Life coverage amounts? Your employer is providing you with $15,000 of term life and accidental death and dismemberment insurance.

What are the Voluntary Life coverage amounts? Employees may elect up to 7 times salary in increments of $10,000 not to exceed $750,000 for themselves. Employees may elect up to 50% of employee amount in increments of $5,000, not to exceed $250,000. Employees may elect up to 50% of employee amount in increments of $2,000, not to exceed $10,000. The maximum death benefit for a child between the ages of live birth and six months is $100.

What are the AD&D coverage amounts? Employees may elect up to 7 times salary in increments of $10,000 not to exceed $750,000 for themselves. Employees may elect up to 50% of employee amount in increments of $5,000, not to exceed $250,000. Employees may elect up to 50% of employee amount in increments of $2,000, not to exceed $10,000. The maximum death benefit for a child between the ages of live birth and six months is $100.

Do my life insurance benefits decrease with age? Coverage amounts will reduce according to the following schedule:

Age:	Insurance amount reduces to:
70	65% of original amount

Coverage may not be increased after a reduction.

When is coverage effective? Please see your plan administrator for your effective date. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. For your dependent spouse and children, insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Totally disabled means that as a result of an injury, sickness or disorder, your dependent spouse and children: are confined in a hospital or similar institution; are confined at home under the care of a physician for a sickness or injury; or your spouse has a life-threatening condition. Exception: Infants are insured from live birth.

Is this coverage portable (can I keep it when I leave my employer)? If you retire, reduce your hours, or leave your employer, you can continue coverage for yourself your spouse and your dependent children at the group rate. Portability is not available for people who have a medical condition that could shorten their life expectancy — but they may be able to convert their term life policy to an individual life insurance policy.

Are there any life insurance exclusions or limitations? Life insurance benefits will not be paid for deaths caused by suicide within the first 24 months after the date your coverage becomes effective. If you increase or add coverage, these enhancements will not be paid for deaths caused by suicide within the first 24 months after you make these changes.

Voluntary Group Life and AD&D		
Age	Employee (per $10,000)	Spouse (per $5,000)
<25	$0.36	$0.18
25-29	$0.36	$0.18
30-34	$0.45	$0.23
35-39	$0.63	$0.32
40-44	$0.99	$0.50
45-49	$1.71	$0.86
50-54	$2.97	$1.49
55-59	$4.23	$2.12
60-64	$5.04	$2.52
65-69	$9.00	$4.50
70-74	$15.39	$7.70
75+	$30.87	$15.44
Voluntary Group Life - Child(ren) (per $10,000 in coverage)		
0-26	$2.00	
Spouse rates based on Employee's age.		

Individual Life Insurance
Texas Life

EMPLOYEE BENEFITS

ABOUT INDIVIDUAL LIFE

Individual insurance is a policy that covers a single person and is intended to meet the financial needs of the beneficiary, in the event of the insured's death. This coverage is portable and can continue after you leave employment or retire.

For full plan details, please visit your benefit website:
www.lisd.net/benefits

Individual Life Insurance Highlights for the Employee

Voluntary permanent life insurance can be an ideal complement to the group term and optional term your employer might provide. Designed to be in force when you die, this voluntary universal life product is yours to keep, even when you change jobs or retire, as long as you pay the necessary premium. Group and voluntary term, on the other hand, typically are not portable if you change jobs and, even if you can keep them after you retire, usually cost more and decline in death benefit.

The policy, PureLife-plus, is underwritten by Texas Life Insurance Company, and it has the following features:
High Death Benefit. With one of the highest death benefits available at the worksite,1 PureLife-plus gives your loved ones peace of mind, knowing there will be life insurance in force when you die.

Refund of Premium. Unique in the marketplace, PureLife-plus offers you a refund of 10 years' premium, should you surrender the contract if the premium you pay when you buy the contract ever increases. (Conditions apply.)

Accelerated Death Benefit Due to Terminal Illness Rider. Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92% of the death benefit, minus a $150 ($100 in Florida) administrative fee. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take much of your death benefit while still alive. (Conditions apply.)

Accelerated Death Benefit for Chronic Illness Rider Included for employees at a small extra cost, this rider will be triggered by the loss of two activities of daily living3 or permanent cognitive impairment. It pays the insured 92% of the death benefit minus a small administrative fee, should the insured decide to exercise it. This valuable living benefit can help offset the cost of either in-home care or care in a resident facility. (Conditions apply.)

Additional Features

Minimal Cash Value. Designed to provide a high death benefit at a reasonable premium, PureLife-plus provides peace of mind for you and your beneficiaries while freeing investment dollars to be directed toward such tax-favored retirement plans as 403(b), 457 and 401(k).

Long Guarantees. Enjoy the assurance of a contract that has a guaranteed death benefit to age 121 and level premium that guarantees coverage for a significant period (after the guaranteed period, premiums may go down, stay the same, or go up).[4]
You may apply for this permanent coverage, not only for yourself, but also for your spouse, children, and grandchildren.[5]

Three Quick Questions

You can qualify by answering just 3 questions – no exams or needles.
During the last six months, has the proposed insured:
1. Been actively at work on a full-time basis, performing usual duties?
2. Been absent from work due to illness or medical treatment for a period of more than 5 consecutive working days?
3. Been disabled or received tests, treatment, or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation, dialysis treatment, or treatment for alcohol or drug abuse?

1. Voluntary Whole and Universal Life Products, Eastbridge Consulting Group, December 2018
2. Chronic Illness Rider available for an additional cost for employees only. Conditions apply. Form ICC15-ULABR-CI-15 or Form Series ULABR-CI-15.
3. Six Activities of Daily Living include: bathing, continence, dressing, eating, toileting, and transferring. Severe Cognitive Impairment means a deterioration or loss in intellectual capacity that: places the Insured in jeopardy of harming him/herself or others and, therefore, the Insured requires Substantial Supervision by another individual; and is measured by clinical evidence and standardized tests which reliably measure impairment in: short or long-term memory; orientation to people, places, or time; and (c) deductive or abstract reasoning.
4. Guarantees are subject to product terms, limitations, exclusions, and the insurer's claims paying ability and financial strength
5. Coverage not available on children in WA or on grandchildren in WA or MD. In MD, children must reside with the applicant to be eligible for coverage.

Emergency Medical Transport
MASA

EMPLOYEE BENEFITS

ABOUT MEDICAL TRANSPORT

Medical Transport covers emergency transportation to and from appropriate medical facilities by covering the out-of-pocket costs that are not covered by insurance. It can include emergency transportation via ground ambulance, air ambulance and helicopter, depending on the plan.

For full plan details, please visit your benefit website:
www.lisd.net/benefits

A MASA MTS Membership provides the ultimate peace of mind at an affordable rate for emergency ground and air transportation service within the United States and Canada, regardless of whether the provider is in or out of a given group healthcare benefits network. If a member has a high deductible health plan that is compatible with a health savings account, benefits will become available under the MASA membership for expenses incurred for medical care (as defined under Internal Revenue Code ("IRC") section 213 (d)) once a member satisfies the applicable statutory minimum deductible under IRC section 223(c) for high-deductible health plan coverage that is compatible with a health savings account.

Emergent Air Transportation In the event of a serious medical emergency, Members have access to emergency air transportation into a medical facility or between medical facilities.

Emergent Ground Transportation In the event of a serious medical emergency, Members have access to emergency ground transportation into a medical facility or between medical facilities.

Non-Emergency Inter-Facility Transportation In the event that a member is in stable condition in a medical facility but requires a heightened level of care that is not available at their current medical facility, Members have access to non-emergency air or ground transportation between medical facilities.

Repatriation/Recuperation Suppose you or a family member is hospitalized more than 100-miles from your home. In that case, you have benefit coverage for air or ground medical transportation into a medical facility closer to your home for recuperation.

Should you need assistance with a claim contact MASA at (800) 643-9023. You can find full benefit details www.mybenefitshub.com/lewisvilleisd.

Emergency Transportation	
Employee and Family	$14.00

Flexible Spending Account (FSA)

NBS

EMPLOYEE BENEFITS

ABOUT FSA

A Flexible Spending Account allows you to pay for eligible healthcare expenses with a pre-loaded debit card. You choose the amount to set aside from your paycheck every plan year, based on your employer's annual plan limit. This money is use it or lose it within the plan year (LISD offers a 75-day grace period).

For full plan details, please visit your benefit website:
www.lisd.net/benefits

Health Care FSA

The Health Care FSA covers qualified medical, dental and vision expenses for you or your eligible dependents. You may contribute up to $2,850 annually to a Health Care FSA and you are entitled to the full election from day one of your plan year. Eligible expenses include:

- Dental and vision expenses
- Medical deductibles and coinsurance
- Prescription copays
- Hearing aids and batteries

You may NOT contribute to a Health Care FSA if you are contributing to Health Care HSA.

How the Health Care FSAs Work

You can access the funds in your Health Care FSA two different ways:

- Use your NBS Debit Card to pay for qualified expenses, doctor visits and prescription copays.
- Pay out-of-pocket and submit your receipts for reimbursement:
    - ◊ Fax – (844) 438-1496
    - ◊ Email – service@nbsbenefits.com
    - ◊ Online – my.nbsbenefits.com
    - ◊ Call for Account Balance: (855) 399-3035
    - ◊ Lost or Stolen Debit Cards Replacement Fee $5.00 (taken from account balance)
    - ◊ Mail: PO Box 6980
West Jordan, UT 84084

Contact NBS

- Hours of Operation: 6:00 AM – 6:00 PM MST, Mon-Fri
- Phone: (800) 274-0503
- Email: service@nbsbenefits.com
- Mail: PO Box 6980
West Jordan, UT 84084

Dependent Care FSA

This account helps pay for expenses associated with caring for elder or child dependents so you or your spouse can work or attend school full time. You can use the account to pay for day care or baby sitter expenses for your children under age 13 and qualifying older dependents, such as dependent parents.

Reimbursement from your Dependent Care FSA is limited to the total amount deposited in your account at that time. To be eligible, you must be a single parent or you and your spouse must be employed outside the home, disabled or a full-time student.

Dependent Care FSA Guidelines

- Overnight camps are not eligible for reimbursement (only day camps can be considered).
- If your child turns 13 midyear, you may only request reimbursement for the part of the year when the child is under age 13.
- You may request reimbursement for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.
- You will not receive a debit card for the Dependent Care FSA, paper claim for reimbursement are required to be filed with National Benefit Services.

Important FSA Rules

The maximum per plan year you can contribute to a Health Care FSA is $2,850. The maximum per plan year you can contribute to a Dependent Care FSA is $5,000 when filing jointly or head of household and $2,500 when married filing separately.

- You cannot change your election during the year unless you experience a specific Qualifying Life Event.
- You can continue to file claims incurred during the plan year for another 30 days (up until date).
- Your Health Care FSA debit card can be used for health care expenses only. It cannot be used to pay for dependent care expenses.

Over-the-Counter (OTC) Item Rule

Health care reform legislation requires that certain over-the-counter (OTC) items require a prescription to qualify as an eligible Health Care FSA expense. You will only need to obtain a one-time prescription for the current plan year. You can continue to purchase your regular prescription medications with your FSA debit card. However, the FSA debit card may not be used as payment for an OTC item, even when accompanied by a prescription.

Flexible Spending Accounts			
Account Type	**Eligible Expenses**	**Annual Contribution Limits**	**Benefit**
Health Care FSA	Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over-the -counter medications)	$2,850	Saves on eligible expenses not covered by insurance, reduces your taxable income
Dependent Care FSA	Dependent care expenses (such as day care, after-school programs or elder care programs) so you and your spouse can work or attend school full-time	$5,000 single $2,500 if married and filing separate tax returns	Reduces your taxable income

Legal Services
LegalEASE

ABOUT LEGAL SERVICES

Legal plans provide benefits that cover the most common legal needs you may encounter - like creating a standard will, living will, healthcare power of attorney or buying a home.

For full plan details, please visit your benefit website:
www.lisd.net/benefits

Protect your family's future with LegalEASE.

LegalEASE offers valuable benefits to shield your family and savings from unexpected personal legal issues.

What you get with a LegalEASE plan:
An attorney with expertise specific to your personal legal matter

Access to a national network of attorneys with exceptional experience that are matched to meet your needs, In- and out-of-network coverage, Concierge help navigating common individual or family legal issues. Being a member saves costly legal fees and provides coverage for:

Home & Residential:
Purchase, Sale, Refinancing of Primary Residence/Vacation or Investment Home, Tenant Dispute, Tenant Security Deposit Dispute, Landlord Despite with Tenant, Security Deposit Dispute with Tenant, Construction Defect Despite, Neighbor Dispute, Noise Reduction Dispute, Disclosure

Auto & Traffic:
Traffic Ticket, Serious Traffic Matters (Resulting in Suspension or Revocation of License), License Suspension (Administrative Proceeding), First-time Vehicle Buyer, Vehicle Repair & Lemon Law Litigation

Estate Planning & Wills:
Will or Codicil, Living Will and/or Health Care Power of Attorney, Probate of Small Estate, Living Trust Document

Financial & Consumer:
Debt Collection Defense, Bankruptcy, Tax Audit, Student Loan Refinancing/Collection Defense, Document Preparation, Consumer Dispute, Small Claims Court, Mail Order/Internet Purchase Dispute, Warranty Dispute, Healthcare Coverage Dispute, Financial Advisor, Identity Theft Defense

Family:
Separation, Divorce, Prenuptial Agreement, Name Change, Guardianship/Conservatorship, Adoptions, Juvenile Court Proceedings, Elder Law

General:
Civil Litigation Defense, Incompetency Defense, Initial Law Office Consultation, Review of Simple Documents, Mediation, Misdemeanor Defense, Identity Theft Assistance.

Limitations apply please visit:
https://www.leagleaseplan.com/lisd for specific plan benefits. To learn more, call: (888) 416-4313 and reference "Lewisville ISD" or visit: www.legaleaseplan.com/lisd

Legal Services	
Employee and Family	$15.18

Sick Leave Bank

Lewisville ISD

ABOUT SICK LEAVE BANK

The purpose of the Sick Leave Bank is to provide additional paid sick leave days to members of the Bank in the event of extended illness, surgery, or a disability due to an injury when the member is unable to perform the duties of his/her position. Benefits are for personal illness/injury of the member, and for serious illness, injury, or death of family members (as defined within the bereavement and critical care benefits).

For full plan details, please visit your benefit website:
www.lisd.net/benefits

Lewisville ISD Sick Leave Bank Rules

Membership Eligibility

Eligibility is limited to all full-time employees of the Lewisville Independent School District. Full-time shall be defined as thirty or more hours of duty per week. Eligibility for membership begins on the first official workday for eligible personnel. An employee must be able to earn at least one local personal leave day from the beginning of his/her employment to the end of that SLB year to be eligible for membership. Application for membership must be made during the enrollment period or within thirty-one (31) days of employment or eligibility for membership.

Sick Leave Bank Enrollment

A. Existing employees
   Sick Leave Bank enrollment will be conducted during the benefits open enrollment period.

B. New hires
   a. New employees will indicate their Sick Leave Bank election through the on-line benefits system
   b. New employees that fail to make an election within 31 days of their hire date will not be allowed to join the Sick Leave Bank until the following plan year.

Application Process

The Application for Sick Leave Bank Days must be submitted to the Benefits Office of the Lewisville ISD. If the member is too ill to complete the application, his or her building or area administrator may begin the process on the member's behalf. The deadline for submitting the application to the Employee Services/Benefits Office is 60 days from the first date of absence pertaining to the SLB request. Each illness or injury must be applied for separately and each must meet the criteria for approval of benefits on its own merits. This may not apply, however in certain circumstances such as recurring absences due to the same illness. See Guidelines for Benefits. The SLB Board will make the final determination of the eligibility of the member's request for days from the SLB. If all criteria are met, the SLB Board will approve a maximum number of days (up to 25) that the member may withdraw from the Bank. In no circumstance may the member withdraw any days that exceed his or her actual absence for the period covered by the approved application. The SLB Board tries to meet at regular intervals to assure that any decision will be made prior to the cutoff date for payroll determination. If the cutoff date is missed on an individual applicant, the Payroll Office will make corrections on the next payroll check as supplemental pay. You may determine the cutoff date for your position by checking with Payroll or your administrator. The Payroll Office will not be able to issue special checks.

Applicants who wish to discuss their situation may contact:

- Employee Services/Benefits Office for questions regarding SLB Board meetings
- Payroll Office for questions on pay and leave balances
- SLB Board Members for questions on SLB Board activities and responsibilities

No individual is authorized to make SLB or application decisions.

Sick Leave Bank Calendar Year

The sick bank calendar year is from July 1st through June 30th for all staff.

Note: If you were a member of the Sick Leave Bank for 21-22 and did not use any Sick Leave Bank days, you do not have to donate a local day for 22-23.

Absences at the Beginning of the Sick Leave Bank Year

Employees that are on leave of absence at the beginning of the Sick Leave Bank year will not be paid for any days awarded from the Sick Leave Bank until the employee has returned to work for a minimum of 18 days. The employee may apply for and be awarded Sick Leave Bank days for the absences at the beginning of the Sick Leave Bank year, but the employee will not be paid for these days until they have returned to work for a minimum of 18 work days.

Contribution of Days

For employees who elect to join the SLB, one local personal leave day will automatically be subtracted from the employee's personal leave balance. It becomes the permanent property of the bank and cannot be returned. Each deposit remains the property of the bank, even in the event of termination, resignation. Unused bank days carry over to the next SLB year. If a member uses any days from the bank during a bank year, the employee will be required to become a member the next bank year whether or not the employee wishes to enroll. One (1) day will be subtracted from the employee's personal leave balance during the member's next year of employment. If, as of March 1 the number of unused bank days is equal to or greater than three (3) times the number of current members then employees who continue their membership the following year do not have to donate a local personal day (provided that the employee did not use any days from the bank during the current bank year).

Withdrawal of Days

Only bank members in good standing are eligible to withdraw days. Days will be awarded only after the member has exhausted all accumulated state and local leave. The Sick Leave Bank may provide a member with benefits for serious illnesses and injuries. A member may apply for days after ten (10) consecutive days of absence for reasons of personal illness or injury. A member may apply for days for planned absences such as surgery or hospitalization in advance if it is anticipated that the absence will exceed ten (10) days. There is no 10-day waiting period for critical care or bereavement leave. A member may apply for these immediately. The ten (10) consecutive days of absence provision is modified to include school holidays for employees that elect to postpone their medical treatment/care to a school holiday but who are unable to postpone the medical treatment/ care to the summer months. The days during the holiday period that an employee would have been absent had the employee not postponed their medical treatment/care will count toward satisfying the 10-day absent rule. The ten (10) day consecutive absence requirement is waived for employees who have a minimum of 10 absences due to a serious long-term illness/injury but whose absences are not consecutive. Benefit days are retroactive to the first day of eligible absence once all other eligibility criteria are met. No benefit days will be granted unless an actual absence from normal duty occurs. No benefit days will be granted for elective absences, elective surgical or medical procedures, or procedures that could be safely and reasonably postponed to extended school breaks. If the member dies before all approved absences are used, the unused days revert to the bank. There are no survivor benefits under any circumstance.

Notes

2022 - 2023 Plan Year

Enrollment Guide General Disclaimer: This summary of benefits for employees is meant only as a brief description of some of the programs for which employees may be eligible. This summary does not include specific plan details. You must refer to the specific plan documentation for specific plan details such as coverage expenses, limitations, exclusions, and other plan terms, which can be found at the Lewisville ISD Benefits Website. This summary does not replace or amend the underlying plan documentation. In the event of a discrepancy between this summary and the plan documentation the plan documentation governs. All plans and benefits described in this summary may be discontinued, increased, decreased, or altered at any time with or without notice.

Rate Sheet General Disclaimer: The rate information provided in this guide is subject to change at any time by your employer and/or the plan provider. The rate information included herein, does not guarantee coverage or change or otherwise interpret the terms of the specific plan documentation, available at the Lewisville ISD Benefits Website, which may include additional exclusions and limitations and may require an application for coverage to determine eligibility for the health benefit plan. To the extent the information provided in this summary is inconsistent with the specific plan documentation, the provisions of the specific plan documentation will govern in all cases.

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