

HUMAN RESOURCE SERVICES - BENEFITS

Health Insurance Option for New Substitutes and Temporary Employees

Lewisville ISD will offer health insurance to substitute and temporary employees who have a reasonable expectation of working a minimum of 10 hours per week. Because substitutes and temporary employees are not members of TRS, the district contribution will **not** apply to the health insurance. Subs and temps who elect this coverage must pay 100 percent of the health premiums in advance each month. See “Substitute & Temporary Employee TRS-ActiveCare Premiums for 2017-18” for rate and plan summary information.

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

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

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

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

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

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

Print Name

Emp ID#

Signature

Date

LEWISVILLE ISD
Substitute & Temporary Employee
TRS-ActiveCare Premiums for 2017-18

Provider	Plan	TRS Monthly Rate
Aetna	TRS-ActiveCare Plan 1-HD	
	Employee Only	\$351.00
	Employee & Spouse	\$991.00
	Employee & Child(ren)	\$671.00
	Employee & Family	\$1,316.00
Aetna	TRS-ActiveCare Plan 2	
	Employee Only	\$714.00
	Employee & Spouse	\$1,694.00
	Employee & Child(ren)	\$1,062.00
	Employee & Family	\$2,004.00
Aetna	TRS-ActiveCare Select EPO - No out-of-network benefits paid	
	Employee Only	\$514.00
	Employee & Spouse	\$1,264.00
	Employee & Child(ren)	\$834.00
	Employee & Family	\$1,589.00
Baylor Scott & White	Baylor Scott & White HMO - No out-of-network benefits paid	
	Employee Only	\$561.04
	Employee & Spouse	\$1,263.08
	Employee & Child(ren)	\$888.42
	Employee & Family	\$1,400.98

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

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

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

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

2017 – 2018 TRS-ActiveCare Plan Highlights

Effective September 1, 2017 through August 31, 2018 | In-Network Level of Benefits*



Medical Coverage	ActiveCare 1-HD	ActiveCare Select or ActiveCare Select Whole Health (Baptist Health System and HealthTexas Medical Group; Baylor Scott & White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance)	ActiveCare 2
Deductible (per plan year) In-Network Out-of-Network	\$2,500 employee only/\$5,000 family \$5,000 employee only/\$10,000 family	\$1,200 individual/\$3,600 family Not applicable. This plan does not cover out-of-network services except for emergencies.	\$1,000 individual/\$3,000 family \$2,000 individual/\$6,000 family
Out-of-Pocket Maximum (per plan year; medical and prescription drug deductibles, copays, and coinsurance count toward the out-of-pocket maximum) In-Network Out-of-Network	The individual out-of-pocket maximum only includes covered expenses incurred by that individual. \$6,550 individual/\$13,100 family \$13,100 individual/\$26,200 family	\$7,150 individual/\$14,300 family Not applicable. This plan does not cover out-of-network services except for emergencies.	\$7,150 individual/\$14,300 family \$14,300 individual/\$28,600 family
Coinsurance In-Network Participant pays (after deductible) Out-of-Network Participant pays (after deductible)	20% 40% of allowed amount	20% Not applicable. This plan does not cover out-of-network services except for emergencies.	20% 40% of allowed amount
Office Visit Copay Participant pays	20% after deductible	\$30 copay for primary \$60 copay for specialist	\$30 copay for primary \$50 copay for specialist
Diagnostic Lab Participant pays	20% after deductible	Plan pays 100% (deductible waived) if performed at a Quest facility; participant pays 20% after deductible at other facility	Plan pays 100% (deductible waived) if performed at a Quest facility; participant pays 20% after deductible at other facility
Preventive Care See below for examples	Plan pays 100%	Plan pays 100%	Plan pays 100%
Teladoc® Physician Services	\$40 consultation fee (counts toward deductible and out-of-pocket maximum)	Plan pays 100%	Plan pays 100%
High-Tech Radiology (CT scan, MRI, nuclear medicine) Participant pays	20% after deductible	\$100 copay plus 20% after deductible	\$100 copay plus 20% after deductible
Inpatient Hospital (preauthorization required) (facility charges) Participant pays	20% after deductible	\$150 copay per day plus 20% after deductible (\$750 maximum copay per admission)	\$150 copay per day plus 20% after deductible (\$750 maximum copay per admission; \$2,250 maximum copay per plan year)
Emergency Room (true emergency use) Participant pays	20% after deductible	\$200 copay plus 20% after deductible (copay waived if admitted)	\$200 copay plus 20% after deductible (copay waived if admitted)
Outpatient Surgery Participant pays	20% after deductible	\$150 copay per visit plus 20% after deductible	\$150 copay per visit plus 20% after deductible
Bariatric Surgery Physician charges (only covered if performed at an IOQ facility) Participant pays	\$5,000 copay (does apply to out-of-pocket maximum) plus 20% after deductible	Not covered	\$5,000 copay (does not apply to out-of-pocket maximum) plus 20% after deductible
Annual Vision Examination (one per plan year; performed by an ophthalmologist or optometrist using calibrated instruments) Participant pays	20% after deductible	\$60 copay for specialist	\$50 copay for specialist
Annual Hearing Examination Participant pays	20% after deductible	\$30 copay for primary \$60 copay for specialist	\$30 copay for primary \$50 copay for specialist

Preventive Care

Some examples of preventive care frequency and services:

- **Routine physicals** – annually age 12 and over
- **Mammograms** – 1 every year age 35 and over
- **Smoking cessation counseling** – 8 visits per 12 months

- **Well-child care** – unlimited up to age 12
- **Colonoscopy** – 1 every 10 years age 50 and over
- **Healthy diet/obesity counseling** – unlimited to age 22; age 22 and over – 26 visits per 12 months

- **Well woman exam & pap smear** – annually age 18 and over
- **Prostate cancer screening** – 1 per year age 50 and over
- **Breastfeeding support** – 6 lactation counseling visits per 12 months

Note: Covered services under this benefit must be billed by the provider as “preventive care.” Non-network preventive care is not paid at 100%. If you receive preventive services from a non-network provider, you will be responsible for any applicable deductible and coinsurance under the ActiveCare 1-HD and ActiveCare 2. There is no coverage for non-network services under the ActiveCare Select plan or ActiveCare Select Whole Health.

For a complete listing of preventive care services, please view the Benefits Booklet at www.trselectivecareetna.com for the latest list of covered services.

2017 – 2018 TRS-ActiveCare Plan Highlights

Prescription Coverage	ActiveCare 1-HD	ActiveCare Select or ActiveCare Select Whole Health (Baptist Health System and HealthTexas Medical Group; Baylor Scott & White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance)	ActiveCare 2
Drug Deductible (per person, per plan year)	Must meet plan-year deductible before plan pays.**	\$0 generic; \$200 brand	\$0 generic; \$200 brand
Short-Term Supply at a Retail Location (up to a 31-day supply) Tier 1 – Generic Tier 2 – Preferred Brand Tier 3 – Non-Preferred Brand	20% coinsurance after deductible, except for certain generic preventive drugs that are covered at 100%.**	\$20 for a 1- to 31-day supply \$40 for a 1- to 31-day supply*** 50% coinsurance for a 1- to 31-day supply***	\$20 for a 1- to 31-day supply \$40 for a 1- to 31-day supply*** \$65 for a 1- to 31-day supply***
Extended-Day Supply at Mail Order or Retail-Plus Pharmacy Location (60- to 90-day supply)**** Tier 1 – Generic Tier 2 – Preferred Brand Tier 3 – Non-Preferred Brand	20% coinsurance after deductible	\$45 for a 60- to 90-day supply \$105 for a 60- to 90-day supply*** 50% coinsurance for a 60- to 90-day supply***	\$45 for a 60- to 90-day supply \$105 for a 60- to 90-day supply*** \$180 for a 60- to 90-day supply***
Specialty Medications	20% coinsurance after deductible	20% coinsurance per fill	\$200 per fill (up to 31-day supply) \$450 per fill (32- to 90-day supply)
Short-Term Supply of a Maintenance Medication at Retail Location (up to a 31-day supply) The second time a participant fills a short-term supply of a maintenance medication at a retail pharmacy, they will pay a convenience fee. They will be charged the coinsurance and copays in the row below the second time they fill a short-term supply of a maintenance medication. Participants can avoid paying the convenience fee by filling a larger day supply of a maintenance medication through mail order or at a Retail-Plus location.			
Tier 1 – Generic Tier 2 – Preferred Brand Tier 3 – Non-Preferred Brand	20% coinsurance after deductible	\$35 for a 1- to 31-day supply \$60 for a 1- to 31-day supply 50% coinsurance for a 1- to 31-day supply	\$35 for a 1- to 31-day supply \$60 for a 1- to 31-day supply \$90 for a 1- to 31-day supply

What is a maintenance medication?

Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

When does the convenience fee apply?

For example, if you are covered under TRS-ActiveCare Select, the first time you fill a 31-day supply of a generic maintenance drug at a retail pharmacy you will pay \$20, then you will pay \$35 each month that you fill a 31-day supply of that generic maintenance drug at a retail pharmacy. A 90-day supply of that same generic maintenance medication would cost \$45, and you would save \$225 over the year by filling a 90-day supply.

Premium Information for ALEX

You will need to enter the applicable amount – YOUR ANNUAL COST – from the table below into ALEX when prompted. To determine this cost, ask your Benefits Administrator for your monthly cost (this is the amount you will owe each month after your employer contributes to your coverage). Then multiply your monthly cost by 12 to get YOUR ANNUAL COST.

TRS-ActiveCare Monthly Premium	ActiveCare 1-HD	ActiveCare Select/ActiveCare Select Whole Health	ActiveCare 2	Your Monthly Cost (amount you pay after employer contribution)	Your Annual Cost (use this amount for ALEX)
Individual	\$351	\$514	\$714		
+Spouse	\$991	\$1,264	\$1,694		
+Children	\$671	\$834	\$1,062		
+Family	\$1,316	\$1,589	\$2,004		

A specialist is any physician other than family practitioner, internist, OB/GYN or pediatrician.

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

**For ActiveCare 1-HD, certain generic preventive drugs are covered at 100%. Participants do not have to meet the deductible (\$2,500 - individual, \$5,000 - family) and they pay nothing out of pocket for these drugs. The list of drugs is on the TRS-ActiveCare website.

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

****Participants can fill 32-day to 90-day supply through mail order.

Scott & White Health Plan

Summary of Benefits for TRS-ActiveCare

Fully Covered Health Care Services	Copay
Preventive Services	No Charge
Standard Lab and X-ray	No Charge
Disease Management and Complex Case Management	No Charge
Well Child Care Annual Exams	No Charge
Immunizations (age appropriate)	No Charge

Plan Provisions	Copay
Annual Deductible	\$1,000 Individual/ \$3,000 Family
Annual out-of-pocket maximum (including medical and prescription co-pays and co-insurance)	\$6,550 Individual/ \$13,100 Family (includes combined Medical and RX copays, deductibles and coinsurance)
Lifetime Paid Benefit Maximum	None

Outpatient Services	Copay
Primary Care ¹	\$20 Copay (First Primary Care Visit for Illness \$0 Copay ²)
Specialty Care	\$50 copay
Other Outpatient Services	20% after deductible ³
Diagnostic/Radiology Procedures	20% after deductible
Eye Exam (one annually)	No Charge
Allergy Serum & Injections	20% after deductible
Outpatient Surgery	\$150 copay and 20% of charges after deductible

Maternity Care	Copay
Pre-Natal Care	No Charge
Inpatient Delivery	\$150 per day ⁴ and 20% of charges after deductible

Inpatient Services	Copay
Overnight hospital stay; includes all medical services including semi-private room or intensive care	\$150 per day ⁴ and 20% of charges after deductible

Diagnostic & Therapeutic Services	Copay
Physical and Speech Therapy	\$50 copay
Manipulative Therapy ⁵	20% without office visit \$40 plus 20% with office visit

Equipment and Supplies	Copay
Preferred Diabetic Supplies and Equipment	\$ 3 copay; no deductible
Non-Preferred Diabetic Supplies and Equipment	30% after deductible
Durable Medical Equipment/ Prosthetics	20% after deductible

Home Health Services	Copay
Home Health Care Visit	\$50 copay

Worldwide Emergency Care	Copay
Nurse Advice Line	1-877-505-7947
Online Services	No Charge — go to trs.swhp.org
After Hours Primary Care Clinics	\$20 copay
Ambulance and Helicopter	\$40 copay and 20% of charges after deductible
Emergency Room ⁶	\$150 copay and 20% of charges after deductible
Urgent Care Facility	\$55 copay

Prescription Drugs	
Annual Benefit Maximum	Unlimited
Rx Deductible	\$150
Does not apply to preferred generic drugs	

Ask a SWHP Pharmacy representative how to save money on your prescriptions.	Retail Quantity (Up to a 30-day supply)	Maintenance Quantity BSWH Pharmacies Only (Up to a 90-day supply)
Preferred Generic ⁷	\$6 copay	\$10 copay
Preferred Brand	30% after Rx deductible	30% after Rx deductible
Non-preferred	50% after Rx deductible	50% after Rx deductible
Non-formulary	Greater of \$50 or 50% after Rx deductible	Not available
Mail Order	1-800-707-3477	
Online Refills	trs.swhp.org	

20% after Rx deductible

¹Including all services billed with office visit

²Does not apply to wellness or preventive visits

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

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

⁵5 visits max per month, 35 max visit per year

⁶Copay waived if admitted within 24 hours

⁷If a brand name drug is dispensed when a generic is available, 50% copay applies



Scott & White
HEALTH PLAN

trs.swhp.org