A healthy outside starts from the inside.
EVERYTHING YOU NEED TO KNOW ABOUT YOUR 2022 BENEFITS

ADA DISCLAIMER: If you cannot read this guide due to a disability, please email benefitsoffice@houstonisd.org and let us know how we can accommodate you. All the information in this guide is also available on our website: www.hisdbenefits.org.

DISCLAIMER: This guide provides an overview of your benefit options. The complete provisions of the plans, including legislated benefits, exclusions, and limitations, are set forth in the plan documents or insurance contracts. The insurance contracts are available for your review in the Benefits Department. If the information in this guide is not consistent with the plan documents or insurance contracts or state and federal regulations, the plan documents, insurance contracts, and state and federal regulations will prevail. This guide is not intended as a contract of employment or a guarantee of current or future employment or benefits. This enrollment guide constitutes a Summary of Material Modifications (SMM) to the HISD Summary Plan Descriptions (SPD). It is meant to supplement and/or replace certain information in the SPDS, so retain it for future reference along with your SPDS. Please share these materials with your covered family members.

RESPONSABILIDADES: esta guía proporciona una descripción general de sus opciones de beneficios. Las disposiciones completas de los planes, sus beneficios, exclusiones y limitaciones legislados, se establecen en los documentos del plan o en los contratos de seguro. Los contratos de seguro están disponibles para su revisión en el Departamento de Beneficios. Si la información en esta guía no es consistente con los documentos del plan o contratos de seguro o regulaciones estatales y federales, prevalecerán los documentos del plan, los contratos de seguro y las regulaciones estatales y federales. Esta guía no pretende ser un contrato de empleo o una garantía de empleo o Beneficios actual o futuro. Esta guía de inscripción constituye un Resumen de Modificaciones Materiales (SMM) a la Descripción resumida del plan (SPD) de HISD. El propósito de esta guía es complementar y / o reemplazar cierta información en el SPD, así que guárdelo para referencia futura junto con su SPD. Síntase con la libertad de compartir estos materiales con los miembros de su familia que están cubiertos bajo un plan.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What’s new and notable in 2022</td>
<td>04</td>
</tr>
<tr>
<td>Dependent verification services</td>
<td>07</td>
</tr>
<tr>
<td>Preventive health care</td>
<td>15</td>
</tr>
<tr>
<td>Choose your plan</td>
<td>18</td>
</tr>
<tr>
<td>Medical plan options</td>
<td>23</td>
</tr>
<tr>
<td>Prescription benefits</td>
<td>30</td>
</tr>
<tr>
<td>Compare coverage options</td>
<td>34</td>
</tr>
<tr>
<td>Voluntary options</td>
<td></td>
</tr>
<tr>
<td>FSA</td>
<td>38</td>
</tr>
<tr>
<td>Dental</td>
<td>40</td>
</tr>
<tr>
<td>EyeMed</td>
<td>47</td>
</tr>
<tr>
<td>Life and AD&amp;D</td>
<td>52</td>
</tr>
<tr>
<td>Legal</td>
<td>56</td>
</tr>
<tr>
<td>AFLAC</td>
<td>63</td>
</tr>
<tr>
<td>Enroll For Coverage</td>
<td>72</td>
</tr>
<tr>
<td>Wellness Resources</td>
<td>74</td>
</tr>
<tr>
<td>Aetna Programs</td>
<td>79</td>
</tr>
<tr>
<td>Employee Assistance Plan (EAP)</td>
<td>90</td>
</tr>
<tr>
<td>Retirement</td>
<td>92</td>
</tr>
<tr>
<td>Coverage Costs</td>
<td>95</td>
</tr>
<tr>
<td>Provider Contacts</td>
<td>100</td>
</tr>
</tbody>
</table>
WELCOME TO ANNUAL ENROLLMENT! WE ARE PLEASED TO HAVE YOU WITH US.

It’s time to take a look at your benefits and the changes and elections you may want to make for 2022.

Whether you are new to HISD or returning to the district, we have resources, information, and useful tools to guide you through your benefits information. Even if you are not enrolling in some of the benefit options, as an employee of the district you have access to benefits such as the Employee Assistance Program and resources that may be useful.

LET’S START BY LOOKING AT WHAT’S NEW AND NOTABLE FOR 2022.

Aetna is our medical provider for 2022, along with a host of other benefits providers. Please look through the Benefits website for detailed information about plan options, tools you can use, and other benefits materials. We look forward to hearing from you during annual enrollment 2022, which takes place November 1 –19, 2021.

ONSITE REPRESENTATIVES

You may reach the Aetna Onsite Representative, Jeanne’ Johnson, at 281-627-7489 or by email at JohnsonJ11@aetna.com. For your convenience, you may schedule a virtual appointment with the Aetna Onsite Representative.

You may reach the Cigna Dental Onsite Representative, Edward Garza, at 713-556-8207 or by email at Edward.Garza2@houstonisd.org. For your convenience, you may schedule a virtual appointment with the Cigna Dental Onsite Representative.
THE MEDICAL PLAN

Beginning in 2020, we added Accountable Care Organizations to our plan options, and we added copays to the Kelsey ACO plan options. Many employees have elected one of the ACO plans to manage their overall health plan costs while providing excellent healthcare options. The rate increases are shown in the chart below. These are per paycheck deductions over 24 pay periods.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Kelsey Basic ACO</th>
<th>Memorial Hermann Basic ACO</th>
<th>TX Medical Neighborhood Basic</th>
<th>Kelsey Plus ACO</th>
<th>Memorial Hermann Plus ACO</th>
<th>TX Medical Neighborhood Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ee only</td>
<td>19.25</td>
<td>21.18</td>
<td>33.59</td>
<td>38.79</td>
<td>42.67</td>
<td>67.63</td>
</tr>
<tr>
<td>Ee + Spouse</td>
<td>100.19</td>
<td>110.21</td>
<td>174.68</td>
<td>135.25</td>
<td>148.78</td>
<td>225.32</td>
</tr>
<tr>
<td>Ee + Child(ren)</td>
<td>96.37</td>
<td>106.01</td>
<td>168.05</td>
<td>130.10</td>
<td>143.11</td>
<td>217.47</td>
</tr>
<tr>
<td>Ee + Family</td>
<td>173.26</td>
<td>190.60</td>
<td>302.12</td>
<td>233.90</td>
<td>257.30</td>
<td>365.43</td>
</tr>
</tbody>
</table>

LIFE INSURANCE

Rates for Employee Supplemental Life Insurance have decreased overall about 20%. Please review your finances and see if you need to add or increase your employee supplemental life insurance coverage. At annual enrollment time, you are able to increase your life insurance, if you are already enrolled, by one times your annual salary without Evidence of Insurability up to five times your annual salary or $600,000, whichever requirement is met first.

PREPAID LEGAL

For $3.00 more per paycheck, regardless of the tier you are in (Employee only, Employee + Family), you can select the Plus Plan and it will include your parents. You can review more information under Prepaid Legal in this guide.
Next let’s review some things to remember as you enroll or change your benefits.

Beneficiaries
Please be sure to review your beneficiaries. If you need to make an immediate beneficiary change, you may do so by calling the Benefits Service Center at 1-877-780-4473 or you can go online to your benefits enrollment site. Under Manage Information, you can edit or add your updated beneficiary information for basic life and supplemental life. If you want to add beneficiaries to your Aflac plans, please go to www.hisdbenefits.org >Resources>Forms and look for the Aflac Beneficiary Form. Complete the form and send it to Aflac (address is on the form). Any changes in your beneficiary information will be effective at the Benefits Service Center on the day you make the change. Also, you may want to update your TRS Beneficiaries, which must be done through TRS. Additional information and forms can be found on the TRS website at www.trs.texas.gov or by calling 1-800-223-8778.

Eligible Dependents under HISD plans. Every year it is important to review your eligible dependents, as they are the only dependents who can be covered under your plans. It is your responsibility to change coverage levels if you have over-age dependents (life, accident, hospital indemnity, critical illness, cancer, etc.).

If you have a dependent who no longer qualifies as an eligible dependent, you must notify the Benefits Service Center at 1-877-780-4473 immediately or within 30 days of the loss of eligibility. If you fail to do so, we will remove the dependent when we discover the ineligible dependent while auditing our plans, and there will be no refund of premiums paid. If you cover your grandchild under the HISD benefits, you must have either a legal custody document or legal guardianship document that allows you to cover them.

Dependent Verification Services (DVS) required for added dependents and life events
If you add a dependent to your medical, dental, or vision plan, you will be asked to verify that dependent. You will receive letters from the DVS department of the Benefits Service Center and you will receive reminders through your HISD email asking you to verify your dependents. If you are adding dependents as a life event, you will also be asked to verify the life event. The information you receive from the DVS will tell you exactly which documents you need to provide.
Dependent verification services

Dependent Verification Services – Adding Dependents

Frequently Asked Questions - these questions and answers should provide employees with the information they need to complete the process of adding any eligible dependents.

Q: Why is dependent verification being done?
A: At HISD, we are committed to providing affordable healthcare benefits for all employees and their eligible dependents. One way to ensure we effectively spend our benefits dollars and provide an equal level of benefit to all employees is to verify we are only paying the expenses of eligible dependents as specified in our healthcare plans.

Q: Who will be conducting the verification?
A: HISD has partnered with Automatic Data Processing, Inc. (ADP) to conduct Dependent Eligibility Verification.

Q: Who will be included in the verification?
A: All active employees who wish to enroll in a medical, dental and/or vision plan will be required to provide supporting documents to substantiate dependent eligibility.

Q: How do I know if my dependents are eligible?
A: The definition of eligible dependents is:
  • Your legal spouse
  • Your dependent children; eligible dependent children under 26 years of age include:
    • Your biological children
    • Your stepchildren
    • Your legally adopted children
    • Your foster children, including any children placed with you for adoption
    • Any children for whom you are responsible under a court order
    • Your child who qualifies as your dependent under the terms of a qualified medical child support order (QMSCO)

You must verify your dependents. Dependent verification is a way of showing proof that any dependent you would like to enroll for benefits coverage meets our plan guidelines for eligibility. It’s a very simple, very important process. You only need to do it once. You will be required to show documentation that your dependents meet the HISD plan guidelines. Employees and their dependents may lose or have their benefits eligibility suspended if they are found to have dependents on the plan who are not eligible.

For a child, one of these documents verifies eligibility:
  • Adoption certificate
  • Birth certificate with parent’s name listed
  • Documentation of legal guardianship
  • Qualified medical child support order
  • Adoption placement agreement
  • Documentation of legal custody
  • Hospital birth record (within 90 days of birth)
For a spouse, one of these documents verifies eligibility:

- Declaration of informal marriage
- Marriage licenses or certificate. If your dependent is a stepchild, you must also provide a copy of a marriage certificate to substantiate the child’s relationship to the employee or spouse.

If you have any questions, please call the HISD Benefits Service Center at 877-780-HISD (4473)

Q: What types of documentation do I need to provide to satisfy the verification requirements?
A: There are multiple forms of documentation that will be accepted for your dependents.

**LIST OF ACCEPTABLE DOCUMENTS**

Please Submit One Item

- From Spouse: Declaration of Informal Marriage Marriage License/Certificate
- Child:* Adoption Certificate, Adoption Placement Agreement, Birth Certificate with Parent’s Name, Listed Documentation of Legal Custody, Documentation of Legal Guardianship, Hospital Birth Record (within 90 Days of Birth), Qualified Medical Child Support Order

*Please note: If the dependent is a stepchild, you must also provide a copy of a marriage certificate or current tax return to substantiate the child’s relationship to the Employee or Spouse.

Important Tips When Submitting Documents

- Do not send original documents because they will not be returned.
- Birth certificates must list the parent(s) name.
- Marriage Licenses or Certificates must be the final document that includes the date of the marriage.

Q: What do I need to do at this time?
A: You should refer to the letter you receive from ADP and collect the documents that you are required to provide for the verification to be approved. They should be submitted as soon as you have the available documents but no later than the deadline provided in your letter and emails. All you need to do is complete these three simple steps:

1. Review the Cover Sheet and confirm that each dependent is eligible for coverage.
2. Obtain the required documentation for each dependent listed on the Cover Sheet.
3. Upload, fax or mail the completed Cover Sheet, along with the required documentation, by the deadline in your letter. **SECURE UPLOAD:** adpdvs.com **REGISTRATION CODE:** n3wTqDDQ (sample)

Note: To upload scanned images of your documentation, please log onto adpdvs.com. If this is your first time using the site, you will need a registration code like the one listed above, along with additional requirements that will be listed on the website. Click on the First Time Registration link and follow the instructions on your screen. The website allows you to view the required documents, view a copy of this letter, submit documents and check the status of your audit.
SECURE FAX: ADP Dependent Verification Services 866-400-1686 MAIL: ADP Dependent Verification Services ADP-DVS PO Box 2338 Alpharetta, GA 30023-2338.

Note: Do not mail original documents; they will not be returned. ADP is committed to protecting employee privacy and can assure you that all documentation will be treated confidentially. You will receive a confirmation letter from ADP Dependent Verification Services after your documentation has been processed. If you have questions or need additional information regarding the necessary documentation, call HISD Benefits Service Center at ADP: 877-780-HISD (4473). Representatives are available 7:00 a.m. - 7:00 p.m. CT Monday-Friday (except holidays) to assist you.

In some situations, you may need to contact a state or local agency. You can access cdc.gov/nchs/w2w.htm for information on where to obtain the necessary documents.

Q: Can I bring my documents to HR instead of sending them to ADP?
A: No. The HISD Benefits department will not accept your documents; you must provide your documents to ADP. ADP will send you a letter and email directly that will provide the submission instructions.

Q: How will I know if my dependents pass the verification?
A: Once your documentation has been processed, you will receive a letter and email informing you that your dependents have been approved. However, if the documentation provided was insufficient, you will be notified by letter and email what information is still required.

Q: Will my private information be protected?
A: Yes. The information that is needed for the dependent verification is your name, address and dependent information. You can remove or black out any information that pertains to your Social Security Number, account information, account numbers and financial information.

Q: How can I provide my documentation?
A: The letter and email sent from ADP outline three options for providing your documentation. You can scan it and upload it to a secure website, fax your documentation, or mail it to the Dependent Verification Services mailbox.

Q: What will happen if I don’t respond to the verification letter?
A: Any dependent not verified by document submission by the verification deadline date will be removed from HISD medical, dental and vision benefits. Any necessary rate change due to the removal of the dependents will be reflected on your paycheck following the verification deadline.

Q: Who should I contact for more information?
A: The HISD Benefits Service Center will be available to you during the verification process to answer any questions that you have. You can contact the Service Center by calling 877-780-HISD (4473) and representatives are available 7:00 a.m. to 7:00 p.m. CT, Monday-Friday (except holidays) to assist you.
Dependent Verification Services

**Q:** What should be provided to validate a Life Event?

**A:** You would need to provide any documentation that would support the life event you are declaring. (ex. Marriage, you would provide a Marriage certificate that shows the date of Marriage. Dependent Age out at 26, you would provide the notice received from the insurance company where you were previously insured that shows you are losing coverage and shows the date coverage will be lost.

**Q:** What happens if I don’t receive that documentation?

**A:** You have 30 days to provide the documentation to support your life event. If you are experiencing delays in receiving that information, please call the Benefits Service Center immediately and let them know you need more time. They are able to give you a small amount of additional time to receive and submit your documents.

**Q:** What are some examples of life events?

**A:** Marriage, Birth of a Child, Adoption, Adding a Grandchild, Divorce, and Death. If you have any questions about your specific life event, you can contact the Benefits Service Center at 1-877-780-4473 to ensure that you know how to declare your life event, as well as when to declare the life event so you can make the changes that are consistent with that life event.

**Q:** What is a combo audit?

**A:** This is an audit that includes adding a dependent and a life event. In this case you would need to provide documentation on your dependent such as a birth certificate or birth facts within 90 days of birth from the hospital. For a grandchild, you would need to provide proof of guardianship or a custody agreement from the courts that shows that you have legal custody of your grandchild.

**Q:** Who should I contact for more information?

**A:** Contact the Benefits Service Center at 1-877-780-4473.
Dear Dina:

Houston Independent School District (HISD) makes every effort to provide our employees with a competitive and comprehensive benefit program. As part of the program only eligible employees and dependents are allowed to be covered in each appropriate plan. Therefore your participation in the dependent verification process is very important and will help ensure that only eligible dependents are enrolled.

If you do not complete the process and provide acceptable proof of dependent and event eligibility, your dependent coverage may be terminated or rescinded.

All you need to do is complete these three simple steps:

1. Review the enclosed Cover Sheet and confirm that each dependent is eligible for coverage and the event is valid.
2. Obtain the required documentation for each dependent and the event listed on the Cover Sheet. For information regarding where to obtain the necessary documentation, log onto [http://www.cdc.gov/nchs/w2w.htm](http://www.cdc.gov/nchs/w2w.htm) or [https://www.usa.gov/replace-vital-documents](https://www.usa.gov/replace-vital-documents).
3. Upload, fax or mail the completed Cover Sheet, along with the required documentation, by 05/22/2021.

SECURE UPLOAD: [https://mybenefits.adp.com](https://mybenefits.adp.com) or the MyHISD portal

Note: To upload scanned images of your documentation, please log onto the MyHISD portal and click on the Benefits heart icon; click on Enrollment; Click on Enroll Now, then option 4 to access the ADP Enrollment website. From there you can select the Benefits Section, then click on View Status in the View Verification Status tile. Please follow the instructions on your screen to complete the dependent or event verification requirements.

The website allows you to view the required documents, view a copy of this letter, submit documents and check your verification status.

SECURE FAX: Dependent Verification Services 866-400-1686

MAIL: Dependent Verification Services ADP-DVS PO Box 2338 Alpharetta, GA 30023-2338

Note: Do not mail original documents; they will not be returned.

We are committed to protecting employee privacy and can assure you that all documentation will be treated confidentially. You will receive a confirmation letter after your documentation has been processed.

If you have questions or need additional information regarding the necessary documentation, call:

**HISD Benefits Service Center**

1-877-780-4473

Representatives are available 7 AM - 7 PM CT Monday - Friday, 7 AM - 4 PM CT Saturday (except holidays).

Sincerely,

HISD Benefits Service Center

Enclosure(s)

See reverse side of this sheet
# DEPENDENT VERIFICATION SERVICES

## Required Documentation

**Important!** If you are sending a copy of your tax return, block out Social Security numbers and any financial information. Only the first page of the tax return is required.

### Child

Please submit one item from List A. If the dependent is a stepchild, you must also provide a copy of a marriage certificate to substantiate the child’s relationship to the Employee or Spouse.

**List A**

- Adoption Certificate
- Adoption Placement Agreement
- Birth Certificate with Parent’s Name Listed
- Documentation of Legal Custody
- Documentation of Legal Guardianship
- Hospital Birth Record (within 90 Days of Birth)
- Qualified Medical Child Support Order

### Spouse

Please submit one item from List A. All Documentation must show the date the Marriage was performed.

**List A**

- Declaration of Informal Marriage
- Marriage Certificate

### You/Spouse Loses Other Employer Sponsored Coverage

Please submit one item from List A.

**List A**

- COBRA Notification w/Coverage End Date
- Letter from Insurance Verifying Loss of Coverage
- Letter from Previous Employer w/Coverage End Date
Houston Independent School District

Cover Sheet

(This sheet must be returned with the required documentation included)

From: DINA L VERIFICATION
2211 DEPENDENT DR
BENEFIT, UT 84071

To verify the eligibility of each of your dependents and your event, complete the following three simple steps by 05/22/2021.

Step 1: Review the dependent/event information below and confirm that each dependent is eligible for coverage and the event is valid. If your dependent is not eligible for coverage, please check “Not Eligible.”

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Dependent Type</th>
<th>Not Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Thomas Verification</td>
<td>Spouse</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Wallie Verification</td>
<td>Child</td>
<td></td>
</tr>
</tbody>
</table>

Event

You/Spouse Loses Other Employer Sponsored Coverage

Step 2: Obtain the Required Documentation for each dependent and the event listed.

Refer to the previous page for a list of documents that must be submitted for dependent and event verification. Also, print Houston Independent School District on each of the proof items you are sending.

If you have questions concerning your audit, please call 1-877-780-4473.

Step 3: Upload, fax or mail this completed Cover Sheet, along with the required documentation, by 05/22/2021.

Note: This completed Cover Sheet is required for your documentation to be processed.

**SECURE UPLOAD:** [https://mybenefits.adp.com](https://mybenefits.adp.com) or the MyHISD portal

Note: To upload scanned images of your documentation, please log onto the MyHISD portal and click on the Benefits heart icon; click on Enrollment; Click on Enroll Now, then option 4 to access the ADP Enrollment website. From there you can select the Benefits Section, then click on View Status in the View Verification Status tile. Please follow the instructions on your screen to complete the dependent or event verification requirements.

The website allows you to view the required documents, view a copy of this letter, submit documents and check your verification status.

**SECURE FAX:** Dependent Verification Services
866-400-1686

**MAIL:**
Dependent Verification Services
ADP-DVS
PO Box 2338
Alpharetta, GA 30023-2338

Note: Do not mail original documents; they will not be returned.

Your Signature

Date

---

VERIFICATION DEADLINE
05/22/2021
FAX THIS PAGE ON TOP
Dear Dina:

This notice is to inform you that, as part of the enrollment process for benefits coverage, you are required to furnish proof of dependent/event eligibility. Please see the attached document for instructions on verifying eligibility. A copy was also mailed to your home address on file.

Once you submit acceptable documentation, you will receive a confirmation letter notifying you of your approval status. **If you do not receive a confirmation notice, please call the HISD Benefits Service Center at 1-877-780-4473.** Representatives are available 7 AM - 7 PM CT Monday - Friday, 7 AM - 4 PM CT Saturday (except holidays).

Please do not submit any materials for auditing purposes to this e-mail box as they will not be processed.

Sincerely,

HISD Benefits Service Center

This message and any attachments are intended only for the use of the addressee and may contain information that is privileged and confidential. If the reader of the message is not the intended recipient or an authorized representative of the intended recipient, you are hereby notified that any dissemination of this communication is strictly prohibited. If you have received this communication in error, delete the message and any attachments from your system.
YOU’RE COVERED

Preventive care services* are covered at no extra cost through your health benefits and insurance plan when you see a physician or provider in your plan's network.

We’ve got you covered with no cost share**

Coverage includes routine screenings and checkups, as well as some counseling to prevent illness, disease and other health problems.

Many of these services are covered as part of physical exams. You won’t have to pay out of pocket for these preventive visits when they are provided in network. They include:

- Regular checkups for adults
- Routine gynecological exams for women
- Wellness exams for children

These services are generally not preventive if you get them as part of your visit to diagnose, monitor or treat an illness or injury. In these cases, copays, coinsurance and deductibles may apply.

Aetna follows preventive recommendations as determined by the U.S. Preventive Services Task Force, Centers for Disease Control and Prevention and other advisory committees. Screenings, services and other covered preventive services can vary by age, gender and other factors. Be sure to talk with your doctor about which services are right for you.

*Employers with grandfathered plans may choose not to cover some of these preventive services or to include cost share (deductible, copay or coinsurance) for preventive care services. Certain religious employers and organizations may choose not to cover contraceptive services as part of the group health coverage.

**Preventive care at no cost share covered in accordance with the Affordable Care Act.

Covered preventive services for adults commonly include:

- Abdominal aortic aneurysm (one-time screening for men of specified ages who have ever smoked)
- Alcohol misuse
- Cholesterol (for adults of certain ages or at higher risk)
- Colorectal cancer*
- Depression
- Diabetes
- Hepatitis B surface antigen
- High blood pressure
- Human immunodeficiency virus (HIV)
- Lung cancer* (for adults with a history of smoking)
- Obesity
- Prostate cancer*
- Syphilis (for all adults at higher risk)
- Tobacco use
- Tuberculosis (TB) testing
**Medicine and supplements**

Doses, recommended ages and recommended populations vary.

- Aspirin for women at risk of preeclampsia and adults ages 50 – 69 with certain heart risk factors*
- Bowel preparation medication (for preventive colorectal cancer screening)
- Low-dose statins: dependent on cardiovascular disease (CVD) and risk factors
- Tobacco-cessation medicine approved by the U.S. Food and Drug Administration (FDA), including over-the-counter medicine when prescribed by a health care provider and filled at a participating pharmacy

**Counseling for:**

- Alcohol misuse
- Domestic violence
- Nutrition (for adults with cardiovascular and diet-related chronic disease)
- Obesity
- Sexually transmitted infection (STI) prevention (for adults at higher risk)
- Tobacco use (including programs to help you stop using tobacco)

**Immunizations**

Doses, recommended ages and recommended populations vary.

- Hepatitis A and B
- Herpes zoster
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps, rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Tetanus, diphtheria, pertussis (Tdap)
- Varicella (chickenpox)

### Covered preventive services for women commonly include:

**Screenings and counseling for:**

- Breast cancer chemoprevention if you’re at a higher risk
- Breast cancer (BRCA) gene counseling and genetic testing if you’re at high risk with no personal history of breast and/or ovarian cancer
- Breast cancer mammography*
- Cervical cancer*
- Chlamydia infection*
- Gonorrhea
- Interpersonal or domestic violence
- Osteoporosis* (depending on risk factors)

**Medicine and supplements:**

- Folic acid supplements (for women of childbearing ages)
- Risk-reducing medicine, such as tamoxifen and raloxifene, for women with an increased risk for breast cancer*

**Counseling and services**:

- Prescribed FDA-approved over-the-counter or generic female contraceptives*** when filled at a network pharmacy
- Two visits a year for patient education and counseling on contraceptives
- Voluntary sterilization services

**Covered preventive services for pregnant women:**

- Anemia screenings
- Bacteriuria, urinary tract or other infection screenings
- Breastfeeding interventions to support and promote breastfeeding after delivery, including up to six visits with a lactation consultant*
- Diabetes screenings
- Expanded counseling on tobacco use
- Hepatitis B counseling (at the first prenatal visit)
- Maternal depression screening
- Rh incompatibility screening, with follow-up testing for women at higher risk
- Routine prenatal visits (you pay your normal cost share for delivery, postpartum care, ultrasounds, or other maternity procedures, specialist visits and certain lab tests)
Covered preventive supplies for pregnant women:

- Breast pump supplies if you get pregnant again before you are eligible for a new pump
- Certain standard electric breastfeeding pumps (nonhospital grade) anytime during pregnancy or while you are breastfeeding, once every three years
- Manual breast pump anytime during pregnancy or after delivery for the duration of breastfeeding

*Subject to age restrictions.

**Certain eligible religious employers and organizations may choose not to cover contraceptive services as part of the group health coverage.

***Brand-name contraceptive drugs, methods or devices are only covered with no member cost sharing under certain limited circumstances, including when required by your doctor due to medical necessity.

†Limits may vary depending upon state requirements and applicability.

Covered preventive services for children commonly include:

Screening and assessments* for:

- Adolescent depression screening
- Alcohol and drug use
- Anemia
- Attention deficit disorder (ADD)
- Autism
- Behavioral and psychological issues
- Congenital hypothyroidism
- Development
- Hearing
- Height, weight and body mass index
- Hematocrit or hemoglobin
- Hemoglobinopathies or sickle cell
- Inactivated poliovirus
- Hepatitis A

- Hepatitis B
- HIV
- Lead (for children at risk for exposure)
- Lipid disorders (dyslipidemia screening for children at higher risk)
- Medical history
- Newborn blood screenings
- Obesity
- Oral health (risk assessment)
- STIs
- TB testing
- Vision

Medicine and supplements:

- Gonorrhea preventive medicine for the eyes of all newborns
- Oral fluoride for children* (prescription supplements for children without fluoride in their water source)
- Topical application of fluoride varnish by primary care providers

Counseling for:

- Obesity
- STI prevention (for adolescents at higher risk)

Immunizations

From birth to age 18 — doses, recommended ages and recommended populations vary.

- Haemophilus influenzae type B
- Hepatitis A and B
- HPV
- Inactivated poliovirus
- Influenza
- Meningococcal (meningitis)

- MMR
- Pneumococcal (pneumonia)
- Rotavirus
- Tdap/diphtheria, tetanus, pertussis (DTaP)
- Varicella (chickenpox)
CHOOSE YOUR PLAN

KNOW YOUR OPTIONS
HISD provides a wide array of valuable benefits, from medical coverage to life insurance, and from dental plans to wellness programs. HISD also provides an excellent selection of voluntary benefits such as Accident, Cancer and Specified Diseases, Critical Illness, and Hospital Indemnity, as well as Disability and additional life insurance and legal plans. Many of these plans provide additional benefits, including cash payouts that are paid in addition to other benefits such as your medical plan benefits. Please review these carefully.

TAKE YOUR TIME. STUDY YOUR OPTIONS.
Everyone has different needs, health challenges, budgets, and goals. By choosing your options carefully, you and your family can get the coverage that fits your needs—and the support to use your benefits to your advantage.

ARE YOU READY TO GET HEALTHY OR MAINTAIN YOUR HEALTH?
Here are the steps you can take toward a healthy you (dependents covered under the medical plan can also take these steps).

REGISTER ON AETNA.COM
This will allow you to access all your benefits for medical, HRA, FSA, and claims. Most importantly, you can access your ID cards immediately.

SELECT A PRIMARY CARE PHYSICIAN (PCP)
If you don’t have a regular doctor with whom you have established a relationship, now is the time to find one using aetna.com. Selecting a Primary Care Physician will help you build a relationship with your own selected medical professional who will gather and keep up with your medical history, as well as help coordinate your care. A PCP can be a doctor who practices general medicine, family medicine, internal medicine or a pediatrician for your children.

KNOW YOUR BENEFITS
Read your Explanation of Benefits (EOB) each time you visit a healthcare professional and they file a claim. Be sure you understand the terms and how claims are paid. This will help to ensure your personal benefits are administered correctly.

COMPLETE YOUR HEALTH RISK ASSESSMENT ON AETNA.COM
Just think of it as a confidential mini survey of your health history and habits with instant results and advice that you can take with you forever.

You can:
• Learn about your health risks and how to lower them
• Gain real-life tips for better well-being
• Share results with your doctor
IMPORTANT REMINDERS

ANNUAL ENROLLMENT IS NOVEMBER 1–19, 2021

Take advantage of the tools on HISDbenefits.org to get started.

OTHER ITEMS TO NOTE

WORKING COUPLES
If you and your spouse both work for HISD, each of you may have coverage, but only one of you can cover your eligible dependents. In addition, only one employee can enroll in life insurance for their spouse.

ELIGIBLE DEPENDENTS COVERAGE
Every year it is important to review your eligible dependents, as they are the only dependents who can be covered under your plans. It is your responsibility to change coverage levels if you have over-age dependents (life, accident, hospital indemnity, critical illness, cancer, etc.).

If you have a dependent who no longer qualifies as an eligible dependent, you must notify the Benefits Service Center at 1-877-780-4473 immediately. If you fail to do so, we will make an adjustment to remove the dependent when we discover the ineligible dependent while auditing our plans, and there will be no refund of premiums paid.

EMPLOYER-PROVIDED LIFE AND AD&D INSURANCE
HISD provides $10,000 each of Life and AD&D insurance coverage at no cost to all employees who are eligible for health benefits. You also may purchase supplemental life with a matching AD&D benefit for you, your spouse, and your dependent children.
A STEP-BY-STEP GUIDE TO CHOOSING THE BENEFITS THAT WORK FOR YOU

CHOOSE THE PLAN THAT’S THE RIGHT FIT
HISD offers several options for your medical plan. Be clear on what’s important to you. Verify which network your doctors are in with Aetna. And this year, pay particular attention to your plan options to ensure you find the right fit for the things that are most important to you. Once your plan starts you will not be able to make changes without a life event.

COMPARE YOUR COVERAGE OPTIONS
You can expect to pay more in premiums when you choose a medical plan with greater flexibility in the doctors you use—or one that requires you to pay less when you use your health care. It’s a trade off that may not always be worth it. Think about how you use care, and gauge your comfort level to find the right balance.

CONSIDER YOUR VOLUNTARY OPTIONS
Add on the extras that make sense for you and your family.

NOW YOU’RE READY TO ENROLL
Log onto myHISD to get started.

Everyone has different needs, health challenges, budgets, and goals. By carefully considering your medical plan options, you can choose the plan that works best for you and your family. With options being offered for 2022, it’s especially important to:

• Know how the plans work. This section has descriptions of your 2022 medical plan options. Be sure to read about each plan before you enroll for benefits during Annual Enrollment. Check Medical Plan 101 below for definitions of common terms.

Check plan networks for the doctors you use.

• Think about how you and your family use health care. Do you use mostly preventive services during the year? Are you anticipating a hospital stay? Do you live with a chronic medical condition? The more health care you use, the more coverage you may need.
• Consider your budget. Check the plan charts in this section to see what you will pay in premiums for each option. Compare premiums to see how much you pay for care versus how much the plan pays. The more you pay of your own healthcare costs, the less you will pay in premiums and vice versa.

### MEDICAL PLAN 101

While your 2022 plan options offer different coverage levels and premium rates, they have features in common.

HISD no longer contributes to the Healthcare Reimbursement Account (HRA). The HRA is an HISD-funded account for those who were previously enrolled in one of the legacy Consumer or Select plan options that may be used to pay for covered services under the medical and pharmacy plan, up to plan limits. Members may continue to use any funds left over from previous years to pay for eligible expenses, as long as they are currently enrolled in an HISD medical plan. HRA balances are forfeited when an employee is no longer enrolled in an HISD medical plan or is no longer employed with HISD.

For members who had existing HRAs, your amounts will rollover until exhausted, and these funds have been added to your debit card. The HRA account will pay first when you have eligible expenses, and then your flexible spending account healthcare funds will be used.

The Consolidated Appropriations Act was passed January 14, 2021, and provides for several changes to our health and welfare plans.

• Expanded grace periods. You have until 12/31/2022 to use and file claims for your 2021 benefits.
• You are permitted to file claims from remaining funds for 2021 even if you or your benefits are terminated.
• For dependent care flexible spending accounts, if you had a child who turned 14 during 2021, you can still file claims for this dependent during the pandemic.

Should you have questions, please contact PayFlex at 1-888-678-8242.
If you choose a plan with a low deductible, the plan will start to pay sooner, but you will pay more in premiums. A plan with a higher deductible will cost less in premiums, but you will pay more of your own expenses before the plan starts to pay.

- Once you meet the deductible, the plan pays a percentage of covered services. You pay a percentage as well. This is called your coinsurance. For example, if the plan covers a service at 80%, your coinsurance is 20% once you’ve met the deductible. Plans that pay a higher percentage of your covered expenses cost more in premiums than those that pay a lower percentage.

- If there is money in your HRA, you may swipe your payflex debit card to pay for eligible expenses. If not, and you elect a Health Care Flexible Spending Account (FSA) during Annual Enrollment, you can use your FSA to pay toward your out-of-pocket expenses.

All medical plan options pay benefits ONLY when you receive care from network providers.

If you seek care outside the network, you will pay the full cost of care out of your own pocket.

- For some types of medical or prescription drug expenses, you may pay a flat fee or copay. If you elect a Health Care Flexible Spending Account during Annual Enrollment, you can use your healthcare FSA to pay copays.

- Once the total amount you pay in deductible and coinsurance reaches the out-of-pocket maximum, the plan pays covered expenses at 100% for the rest of the year.

Each time your network doctor or other care provider files a claim with Aetna, an Explanation of Benefits (EOB) statement is generated. It shows the service provided, how the claim was processed, any amounts paid, and how much you may owe. It also shows your progress toward meeting the plan’s deductible and out-of-pocket maximum.

You’ll be able to view EOB statements on your member website at Aetna.com.

The charts in this guide show each plan’s deductible, coinsurance, copay, and out-of-pocket maximum amounts.
YOUR 2022 MEDICAL PLAN OPTIONS

You will have a choice of Accountable Care Organization (ACO) plans for 2022. When you enroll in an ACO plan, you’ll have access to primary care doctors, specialists, hospitals, and other providers in one of two ACO networks: the Memorial Hermann Accountable Care Network and the Kelsey-Seybold Accountable Care Network. There is a third broad-access network plan called the Texas Medical Neighborhood Network.

If you enroll in an ACO plan, you will have a care team of doctors, nurses, and other providers who belong to the ACO network. They are dedicated to your good health and work to:

• Help you get and stay healthy
• Achieve better outcomes when you need care
• Share information and coordinate services
• Spot potential problems
• Encourage you to play an active role in your health and health care

Are your doctors in the network? You can find out by...

• Go to Aetna.com
• Click on Member Support
• Click on Account management
• Then select Find a doctor
• Click on Plan from an employer, then continue as Guest
• Under continue as a guest, enter your zip code or city (you can also select number of miles to look within)
• Click Search (this takes you to the networks)
• There are three networks:
  • Texas Medical Neighborhood
  • KelseyCare ACO
  • Memorial Hermann ACO
• To search the Texas Medical Neighborhood, go to the category State-Based Plans
  • Select TX Medical Neighborhood – Houston Aetna Select
• To search the Kelsey-Seybold ACO
  • Select (under State-Based Plans) TX KelseyCare – HMO
• To search the Memorial Hermann ACO
  • Go to Aetna Whole Health Plans (this is the very first group)
  • Select TX Aetna Whole Health – Memorial Hermann Accountable Care Network – Elect Choice/Aetna Select
MEMORIAL HERMANN ACO PLANS

There are two Memorial Hermann plan options.

✅ THE BASIC PLAN

- Offers lower premiums than Plus options but has higher deductible and coinsurance amounts. This means you will pay more when you need health care. If you don’t visit the doctor often and use the plan mostly for preventive care, the Basic option may be right for you.

주의: The Memorial Hermann ACO plan pays benefits ONLY when you receive care from the Memorial Hermann ACO network providers. If you seek care outside the network, you will pay the full cost of care out of your own pocket.

Both plan options include prescription drug benefits administered by Express Scripts. You meet a separate prescription drug deductible each year and then pay the appropriate copay for your prescriptions.

The Memorial Hermann ACO network is a healthcare system with:

- More than 900 primary care doctors
- More than 5,000 specialists
- 12 acute care hospitals
- 62 walk-in clinics
- 86 urgent care centers

The Memorial Hermann ACO network plans are designed to improve the quality of your care, provide a better experience for you and your family, and save you money. You will have access to an integrated network of primary care doctors, specialists, and hospitals focused on you. Led by a primary care doctor you choose (recommended but not required), your care team will work with you to:

- Help keep you healthy or improve your health, not just treat you when you’re sick or injured
- Better coordinate your care and keep tabs on your prescriptions, lab results, health history, and more
- Spot problems and build personalized care plans to treat you
- Encourage you to play an active and informed role in your health and healthcare decisions
### Memorial Hermann Basic ACO

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Rate Employee only</th>
<th>Rate Employee + spouse</th>
<th>Rate Employee + child(ren)</th>
<th>Rate Employee + family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$21.18</td>
<td>$110.21</td>
<td>$106.01</td>
<td>$190.60</td>
</tr>
<tr>
<td></td>
<td>$42.67</td>
<td>$148.78</td>
<td>$143.11</td>
<td>$257.30</td>
</tr>
</tbody>
</table>

### Memorial Hermann Plus ACO

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Rate Employee only</th>
<th>Rate Employee + spouse</th>
<th>Rate Employee + child(ren)</th>
<th>Rate Employee + family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$21.18</td>
<td>$110.21</td>
<td>$106.01</td>
<td>$190.60</td>
</tr>
<tr>
<td></td>
<td>$42.67</td>
<td>$148.78</td>
<td>$143.11</td>
<td>$257.30</td>
</tr>
</tbody>
</table>

### Plan Limits

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible</td>
<td>$2,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>Family</td>
<td>$1,750</td>
<td>$3,500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual out-of-pocket max (includes all medical and pharmacy deductibles, copays, and coinsurance)</td>
<td>$6,900</td>
<td>$13,800</td>
</tr>
<tr>
<td></td>
<td>$5,150</td>
<td>$10,300</td>
</tr>
</tbody>
</table>

### Cost for Covered Services After Your Deductible Has Been Met

1. Preventive care exams
   - Employee: Free
   - Family: Free

2. Office visits
   - Primary care (PCP): 25% Employee, 20% Family
   - Specialists: 25% Employee, 20% Family
   - HISD clinics: Free Employee, Free Family

3. Inpatient—hospital
   - 25% Employee, 20% Family

4. Outpatient—hospital
   - 25% Employee, 20% Family

5. Outpatient—freestanding and surgical center
   - 25% Employee, 20% Family

6. Emergency care
   - 25% + $300 copay (Copay waived if admitted) Employee
   - 20% + $300 copay (Copay waived if admitted) Family

7. Virtual Health/Telemedicine
   - CareAccess Live: Free Employee, Free Family

8. Urgent care facility
   - 25% Employee, 20% Family

9. Lab, X-ray, diagnostic mammogram
   - 25% Employee, 20% Family

10. Diagnostic scans (MRI, MRA, CAT, PET)
    - 25% Employee, 20% Family

11. Maternity—delivery
    - 25% Employee, 20% Family

12. Mental health and substance abuse—inpatient
    - 25% Employee, 20% Family

13. Mental health and substance abuse—outpatient
    - 25% Employee, 20% Family

1. Kelsey ACO PCP and specialist copays do not count toward the annual deductible but do apply toward the annual out-of-pocket maximum.
2. Free if you are enrolled in an HISD medical plan.
3. Pre-certification may be required.
4. OB GYN Specialists are tiered.
5. Copay applies after pharmacy deductible has been met.
6. Preventive services are not subject to the deductible.
7. The copays in the Kelsey plans are not subject to the deductible.

If footnote is not shown on this chart it does not apply to this plan option.
There are three Kelsey-Seybold plan options.

**THE BASIC PLAN**
offers lower premiums than Plus options but has higher deductible and coinsurance amounts. This means you will pay more when you need health care. If you don’t visit the doctor often and use the plan mostly for preventive care, the Basic option may be right for you.

**THE PLUS PLAN**
has higher premiums than the Basic plan, and the deductible and coinsurance amounts are lower. This means more of your expenses will be covered when you need care. If you think you will visit the doctor often and need more care, the Plus option may be right for you.

**THE SELECT PLAN**
has the lowest deductible and out-of-pocket maximum, but this option is only available to employees who make $29,120 or less in annual base salary.

**Important:** the Kelsey-Seybold ACO plan pays benefits ONLY when you receive care from Kelsey Seybold ACO network providers. If you seek care outside the network, you will pay the full cost of care out of your own pocket.

All plan options include prescription drug benefits administered by Express Scripts. You must meet a separate prescription drug deductible each year and then pay the appropriate copay for your prescriptions.

**THE KELSEY–SEYBOLD ACO NETWORK**
The Kelsey–Seybold ACO network is a provider group that includes:
• More than 500 doctors representing 55 medical specialties at 27 Houston-area Kelsey–Seybold Clinic locations with two more locations opening by the end of 2021
• More than 150 primary care doctors and 180 specialists
• 2 accredited ambulatory surgery centers
• 2 cancer center locations
• 1 sleep center

If you need hospital care, your Kelsey–Seybold doctor will determine the most appropriate hospital for your care.

Kelsey has onsite pharmacies located at 17 of their clinics. Kelsey is also approved by Express Scripts as a Smart 90 pharmacy, so you can even get your 90-day maintenance medications filled at a Kelsey–Seybold pharmacy.
<table>
<thead>
<tr>
<th>RATES</th>
<th>Kelsey Basic ACO</th>
<th>Kelsey Plus ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on 24 pay periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$19.25</td>
<td>$38.79</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$100.19</td>
<td>$135.25</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$96.37</td>
<td>$130.10</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$173.26</td>
<td>$233.90</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAN LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Annual out-of-pocket max (includes all medical and pharmacy deductibles, copays, and coinsurance)</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COST FOR COVERED SERVICES AFTER YOUR DEDUCTIBLE HAS BEEN MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care exams²</td>
</tr>
<tr>
<td>Office visits</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

1. Kelsey ACO PCP and specialist copays do not count toward the annual deductible but do apply toward the annual out-of-pocket maximum
2. Free if you are enrolled in an HISD medical plan
3. Pre-certification may be required
4. OBGYN Specialists are tiered.
5. Copay applies after pharmacy deductible has been met
6. Preventive services are not subject to the deductible
7. The copays in the Kelsey plans are not subject to the deductible

If footnote is not shown on this chart it does not apply to this plan option.
There are two Texas Medical Neighborhood plan options.

**THE BASIC PLAN**
offers lower premiums each month but has higher deductible and co-insurance amounts. This means you will pay more when you need health care. If you don’t visit the doctor often and use the plan mostly for preventive care, the Basic option may be right for you.

**THE PLUS PLAN**
has higher premiums than the Basic plan, but the deductible and co-insurance amounts are lower. This means more of your expenses will be covered when you need care. If you think you will visit the doctor often and need more care, the Plus option may be right for you.

When you enroll in the plan, you are required to select a Primary Care Physician from the Texas Medical Neighborhood Network. If you do not select a Primary Care Physician, one will be assigned to you based on your zip code. Your primary care doctor will provide routine and preventive care, and help you find the right network specialists when you need one. However, specialist referrals are not necessary if you want to see a specialist.

**Important:** The Texas Medical Neighborhood Network plan pays benefits ONLY when you receive care from network providers. If you seek care outside the network, you will pay the full cost of care out of your own pocket. Both plans include prescription drug benefits administered by Express Scripts. You must meet a separate prescription drug deductible each year and then pay the appropriate copay for your prescriptions.

**THE TEXAS MEDICAL NEIGHBORHOOD NETWORK**
For the Texas Medical Neighborhood plan participants, there are 20 specialties that are tiered. Tier 1 is Maximum Savings and Tier 2 is Standard Savings. When you see a physician in one of these specialties, you will save more if you select one where Maximum Savings are indicated. This is just a guide to help you save on your health care. As long as your physicians are in your network, benefits will pay in accordance with your plan. Maximum Savings will save you from paying more out of pocket than needed. The 20 specialties are:

- Allergy/Immunology
- Cardiology
- Cardiothoracic Surgery
- Dermatology
- Endocrinology
- Gastroenterology
- Infectious Disease
- Nephrology
- Neurology
- Neurosurgery
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedics
- Otolaryngology
- Plastic Surgery
- Pulmonary/Critical Care
- Rheumatology
- Surgery
- Urology
- Vascular Surgery
# TX Medical Neighborhood Basic vs TX Medical Neighborhood Plus

## RATES

Based on 24 pay periods

<table>
<thead>
<tr>
<th></th>
<th>TX Medical Neighborhood Basic</th>
<th>TX Medical Neighborhood Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$33.59</td>
<td>$67.63</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$174.68</td>
<td>$225.32</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$168.05</td>
<td>$217.47</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$302.12</td>
<td>$365.43</td>
</tr>
</tbody>
</table>

## PLAN LIMITS

|                          | | |
|--------------------------|--------------------------|
| Annual deductible        | Individual               | $2,500 |
|                          | Family                   | $5,000 |
| Annual out-of-pocket max | Individual               | $6,900 |
| (includes all medical    | Family                   | $13,800 |
| and pharmacy deductibles,|                          |       |
| copays, and coinsurance) |                          |       |

## COST FOR COVERED SERVICES AFTER YOUR DEDUCTIBLE HAS BEEN MET

<table>
<thead>
<tr>
<th>Service</th>
<th>TX Medical Neighborhood Basic</th>
<th>TX Medical Neighborhood Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care exams</td>
<td>Free</td>
<td>Free</td>
</tr>
<tr>
<td>Office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care (PCP)</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Specialists</td>
<td>25%/45%</td>
<td>20%/40%</td>
</tr>
<tr>
<td>HISD clinics</td>
<td>Free</td>
<td>Free</td>
</tr>
<tr>
<td>Inpatient—hospital</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient—hospital</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient—freestanding and</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>surgical center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency care</td>
<td>25% + $300 copay</td>
<td>20% + $300 copay</td>
</tr>
<tr>
<td>(Copay waived if admitted)</td>
<td>(Copay waived if admitted)</td>
<td></td>
</tr>
<tr>
<td>Virtual Health/Telemedicine</td>
<td>Free</td>
<td>Free</td>
</tr>
<tr>
<td>CareAccess Live</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Urgent care facility</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Lab, X-ray, diagnostic</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>mammogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic scans (MRI, MRA, CAT</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>PET)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity—delivery</td>
<td>25%/45%</td>
<td>20%/40%</td>
</tr>
<tr>
<td>Mental health and substance</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>abuse—inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health and substance</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>abuse—outpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Kelsey ACO PCP and specialist copays do not count toward the annual deductible but do apply toward the annual out-of-pocket maximum
2. Free if you are enrolled in an HISD medical plan
3. Pre-certification may be required
4. OBGYN Specialists are tiered.
5. Copay applies after pharmacy deductible has been met
6. Preventive services are not subject to the deductible
7. The copays in the Kelsey plans are not subject to the deductible

If footnote is not shown on this chart it does not apply to this plan option.
YOUR PRESCRIPTION BENEFITS

All medical plan options include prescription drug benefits through Express Scripts available at any participating pharmacy and through mail order.

Here’s how the plan works:

• You pay a separate prescription drug deductible each year before the plan starts to pay its share of your prescription drug costs.
• Once you have met your deductible, you pay a copay for your prescriptions.
• The money you pay out of pocket for drugs, either in copays or in meeting your deductible, is applied toward meeting your medical plan’s annual out-of-pocket maximum, except for the specialty drug copays through the SaveonSP Manufacturer Copay Assistance Program.
• When your medical annual out-of-pocket maximum is met, your prescription drugs will be covered at no cost to you for the remainder of the calendar year.

NO-COST PRESCRIPTIONS FOR HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, AND DIABETES

Generic drugs for high blood pressure, high cholesterol, and diabetes (including injectable insulin) remain available at no cost to you, as long as you are enrolled in an HISD medical plan and purchase 90-day supplies through Express Scripts or at an Express Scripts retail Smart90 pharmacy partner.

HISD plans also cover women’s generic contraceptives (as well as those that have no generic available) at 100%.

FILLING PRESCRIPTIONS AT RETAIL PHARMACIES

With Express Scripts, HISD’s pharmacy benefits management company, you have a choice of participating pharmacies. If you need a short-term prescription like an antibiotic or pain medication, take the prescription and your Express Scripts member ID card to any of the participating pharmacies listed below.

For long-term and maintenance medications, the Smart90 Program allows you to receive a 90-day supply of your medication in two ways—either through the Express Scripts’ Mail Service Pharmacy (online, by phone or through mail) or at a Smart90 retail pharmacy near you. No matter which option you choose, your copay remains the same. You must obtain a 90-day prescription from your physician, and you can pick up your 90-day maintenance prescription locally at Costco, HEB, Kelsey-Seybold Kroger, Randall’s, and Walmart or through mail order. Refer to www.Express-Scripts.com or call Express Scripts at 1-855-712-0331 for the most current network information.
For new long-term drug prescriptions, you can get two 30-day supplies of your medication at any network retail pharmacy for the retail copay, but after that you will need to use the Smart 90 Program described above or you will have to pay the mail copay to receive a 30-day supply at any network retail pharmacy. Ordering a 90-day supply through Express Scripts Mail Service Pharmacy or a Smart90 retail pharmacy (retail location or mail order) will result in substantial savings to you for long-term and maintenance medications.

FILLING PRESCRIPTIONS WITH THE MAIL ORDER SERVICE

The Express Scripts mail order service is a cost-effective and convenient choice for filling long-term prescriptions, including those for maintenance medications provided at no charge. To use the mail order service:

• Go to HISDBenefits.org and click on the prescription drug icon to access the mail order form.
• Complete the mail order form and mail to the address indicated.
• Once you’ve placed your order, you can sign up for the Express Scripts automatic refill program. Express Scripts will even request a new prescription from your doctor when your refills are up or your prescription has expired.

IF YOU NEED SPECIALTY DRUGS

When you have chronic or complex medical conditions such as multiple sclerosis or rheumatoid arthritis, your doctor may prescribe specialty drugs. These drugs typically require special handling, administration or monitoring. You can order specialty drugs through Accredo, the Express Scripts specialty mail order pharmacy.

You also may be able to take advantage of the Express Scripts SaveonSP (Specialty Pharmacy) Manufacturer Copay Assistance Program. This program is designed to help you save money on certain specialty medications. If you participate, certain specialty medications will be free of charge ($0). Your prescriptions will still be filled through Accredo, your existing specialty mail pharmacy.

Express Scripts will contact you if you are eligible to participate in the SaveonSP program. Enrollment in the program is voluntary. If you choose not to participate, you will be responsible for the applicable prescription copay. Keep in mind that the copay will not count toward your deductible or out-of-pocket maximums.

For more information about the SaveonSP Manufacturer Copay Assistance Program, please contact SaveonSP at 1-800-683-1074 Monday-Thursday 8:00 a.m.-8:00 p.m., and Friday 8:00 a.m.-6:00 p.m. Eastern Time.
YOUR PRESCRIPTION BENEFITS

THE EXPRESS SCRIPTS DISCOUNT RX PROGRAM

If you waive HISD-sponsored medical coverage, you may enroll in the Express Scripts Discount Rx program. Eligible employees can enroll by:

• Signing up via the HISD portal
• Calling the HISD Benefits Service Center from 7:00 a.m.- 7 p.m., Monday-Friday, at 1-877-780-HISD (4473).

You can enroll at initial eligibility, annual enrollment or during a qualifying life event change.

The program entitles you to a cash discount through Express Scripts participating pharmacies and mail service. The Discount Rx card is not insurance, and you do not have a copay amount. You are responsible for paying 100% of the discounted Express Scripts price and any dispensing fee. Express Scripts will provide you an ID card when you choose to enroll.

THINGS TO CONSIDER ABOUT YOUR PHARMACY PLAN

Express Scripts prior authorization drives plan savings by monitoring the dispensing of high-cost medications and those with the potential for misuse. Our program ensures drug coverage consistent with the client’s intent for the prescription benefit, while maintaining member and physician satisfaction. Twenty-four hours a day, personnel specially trained on our PA program’s diseases, drugs, and coverage criteria provide review services, giving physicians and pharmacists quick, easy access to information and ensuring effective treatment by monitoring patient response to therapy.

The Step Therapy program applies edits to drugs in specific therapeutic classes at the point of sale. Coverage for back-up therapies (second/third step) is determined at the patient level based on the presence or absence of front-line drugs or other automated factors in the patient’s claims history. Our systems’ capability supports automatic concurrent review of patients’ claims profile for use of front-line alternatives. Only claims for patients whose histories do not show use of first-step products are rejected for payment at the point of sale.

The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied for each copayment is consistent with clinical dosing guidelines. The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care. Express Scripts clinicians maintain a list of quantity limited drugs, which is based upon manufacturer-recommended guidelines and medical literature. Online edits help make sure optimal quantities of medication are dispensed per copayment and per days’ supply.
Print and Virtual Member ID Cards

You can print your member ID card from express-scripts.com or view your virtual member ID card on your smartphone using the Express Scripts mobile app.

Print a member ID card

Log in to express-scripts.com. If you are a first-time visitor, take a moment to register using your member ID number or social security number (SSN).

1. From the home page, select Print & Request Forms & Cards from the menu under Health & Benefits Information.
2. Scroll to ‘Print a member ID card’ and click ‘print a member ID card’.
3. An image of your member ID card will appear. Click ‘print card’ and follow your printer’s prompts, if needed.

View a virtual member ID card

Log in to the Express Scripts mobile app*. If you have never registered via the app or express-scripts.com, take a moment to register using your member ID number or social security number (SSN). Touch ID login available on some iOS devices.

1. Tap the menu in the upper left-hand corner.
2. Tap Prescription ID card and
3. Your virtual card will appear.

* The app is compatible with most iPhone®, iPad®, Android®, Windows Phone®, AmazonTM and BlackBerry® mobile devices. Search for “Express Scripts” in your app store and download the app for free.
## 2022 MEDICAL PLAN COMPARISON

### RATES

<table>
<thead>
<tr>
<th></th>
<th>Kelsey Basic ACO</th>
<th>Memorial Hermann Basic ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Based on 24 pay periods</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$19.25</td>
<td>$21.18</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$100.19</td>
<td>$110.21</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$96.37</td>
<td>$106.01</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$173.26</td>
<td>$190.60</td>
</tr>
</tbody>
</table>

### PLAN LIMITS

<table>
<thead>
<tr>
<th></th>
<th>Kelsey Basic ACO</th>
<th>Memorial Hermann Basic ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,500</td>
<td>$2,500</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>Annual out-of-pocket max</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes all medical and pharmacy deductibles, copays, and coinsurance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$6,900</td>
<td>$6,900</td>
</tr>
<tr>
<td>Family</td>
<td>$13,800</td>
<td>$13,800</td>
</tr>
</tbody>
</table>

### COST FOR COVERED SERVICES AFTER YOUR DEDUCTIBLE HAS BEEN MET

<table>
<thead>
<tr>
<th></th>
<th>Kelsey Basic ACO</th>
<th>Memorial Hermann Basic ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care exams$^6$</td>
<td>Free</td>
<td>Free</td>
</tr>
<tr>
<td>Office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care (PCP)</td>
<td>$30 copay $^1$</td>
<td>25%</td>
</tr>
<tr>
<td>Specialists</td>
<td>$65 copay $^1$</td>
<td>25%</td>
</tr>
<tr>
<td>HISD clinics$^2$</td>
<td>Free</td>
<td>Free</td>
</tr>
<tr>
<td>Inpatient—hospital$^3$</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Outpatient—hospital$^3$</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Outpatient—freestanding and surgical center$^4$</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Emergency care</td>
<td>25% + $300 copay (Copay waived if admitted)</td>
<td>25% + $300 copay (Copay waived if admitted)</td>
</tr>
<tr>
<td>Virtual Health/Telemedicine</td>
<td>Kelsey Telemedicine CareAccess Live</td>
<td>$20 PCP/$55 Specialist$^1$</td>
</tr>
<tr>
<td>Urgent care facility</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Lab, X-ray, diagnostic mammogram</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Diagnostic scans (MRI, MRA, CAT, PET)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Maternity—delivery</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Mental health and substance abuse—outpatient</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Mental health and substance abuse—inpatient</td>
<td>$65 Copay$^1$</td>
<td>25%</td>
</tr>
</tbody>
</table>

1. Kelsey ACO PCP and specialist copays do not count toward the annual deductible but do apply toward the annual out-of-pocket maximum
2. Free if you are enrolled in an HISD medical plan
3. Pre-certification may be required
4. Pre-certification may be required
5. Copay applies after pharmacy deductible has been met
6. Preventive services are not subject to the deductible

---

**COMPARE YOUR COVERAGE OPTIONS**
<table>
<thead>
<tr>
<th>Plan</th>
<th>TX Medical Neighborhood Basic</th>
<th>Kelsey Plus ACO</th>
<th>Memorial Hermann Plus ACO</th>
<th>TX Medical Neighborhood Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate 1</td>
<td>$33.59</td>
<td>$38.79</td>
<td>$42.67</td>
<td>$67.63</td>
</tr>
<tr>
<td>Rate 2</td>
<td>$174.68</td>
<td>$135.25</td>
<td>$148.78</td>
<td>$225.32</td>
</tr>
<tr>
<td>Rate 3</td>
<td>$168.05</td>
<td>$130.10</td>
<td>$143.11</td>
<td>$217.47</td>
</tr>
<tr>
<td>Rate 4</td>
<td>$302.12</td>
<td>$233.90</td>
<td>$257.30</td>
<td>$365.43</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
<th>TX Medical Neighborhood Basic</th>
<th>Kelsey Plus ACO</th>
<th>Memorial Hermann Plus ACO</th>
<th>TX Medical Neighborhood Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible 1</td>
<td>$2,500</td>
<td>$1,750</td>
<td>$1,750</td>
<td>$1,750</td>
</tr>
<tr>
<td>Deductible 2</td>
<td>$5,000</td>
<td>$3,500</td>
<td>$3,500</td>
<td>$3,500</td>
</tr>
<tr>
<td>Deductible 3</td>
<td>$6,900</td>
<td>$5,150</td>
<td>$5,150</td>
<td>$5,150</td>
</tr>
<tr>
<td>Deductible 4</td>
<td>$13,800</td>
<td>$10,300</td>
<td>$10,300</td>
<td>$10,300</td>
</tr>
</tbody>
</table>

### PLAN LIMITS
- Annual deductible:
  - Individual: $2,500
  - Family: $5,000
- Annual out-of-pocket max:
  - Individual: $6,900
  - Family: $13,800

### COST FOR COVERED SERVICES AFTER YOUR DEDUCTIBLE HAS BEEN MET
- Preventive care exams: Free
- Primary care (PCP): $30 copay
  - 25%
  - 20%
- Specialists: $65 copay
  - 25%
  - 20%
- HISD clinics: Free
- Inpatient—hospital: 25%
- Outpatient—hospital: 25%
- Outpatient—freestanding and surgical center: 25%
- Emergency care: 25% + $300 copay
  - Copay waived if admitted
- Virtual Health/Telemedicine:
  - Kelsey Telemedicine CareAccess Live: $20 PCP/$55 Specialist
  - OBGYN Specialists are tiered.
  - Copay applies after pharmacy deductible has been met
  - Preventive services are not subject to the deductible
  - The copays in the Kelsey plans are not subject to the deductible

1. Kelsey ACO PCP and specialist copays do not count toward the annual deductible but do apply toward the annual out-of-pocket maximum
2. Free if you are enrolled in a HISD medical plan
3. Pre-certification may be required
4. OBGYN Specialists are tiered.
5. Copay applies after pharmacy deductible has been met
6. Preventive services are not subject to the deductible
7. The copays in the Kelsey plans are not subject to the deductible
# COMPARE YOUR COVERAGE OPTIONS

## 2022 PRESCRIPTION DRUG COMPARISON

<table>
<thead>
<tr>
<th>Prescription Type</th>
<th>Kelsey Basic ACO</th>
<th>Memorial Hermann Basic ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual pharmacy deductible</td>
<td>$50 per person</td>
<td>$50 per person</td>
</tr>
<tr>
<td>Prescription drugs (30-day retail)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Preferred brand</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Non-preferred brand generic</td>
<td>$70</td>
<td>$70</td>
</tr>
<tr>
<td>Prescription drugs (90-day mail or retail)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Preferred brand</td>
<td>$125</td>
<td>$125</td>
</tr>
<tr>
<td>Non-preferred brand generic</td>
<td>$175</td>
<td>$175</td>
</tr>
<tr>
<td>Specialty (30-day supply)</td>
<td>$150</td>
<td>$150</td>
</tr>
</tbody>
</table>

5. Copay applies after pharmacy deductible has been met

---

## BE CAREFUL

If you or your physician request a brand-name drug when a generic drug is available, you pay the brand copay PLUS the difference in cost between the two drugs, along with any remaining prescription deductible.
<table>
<thead>
<tr>
<th>Plan</th>
<th>TX Medical Neighborhood Basic</th>
<th>Kelsey Plus ACO</th>
<th>Memorial Hermann Plus ACO</th>
<th>TX Medical Neighborhood Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(30-day retail)</td>
<td>$50 per person</td>
<td>$50 per person</td>
<td>$50 per person</td>
<td>$50 per person</td>
</tr>
<tr>
<td>Generic</td>
<td>$20</td>
<td>$15</td>
<td>$15</td>
<td>$15</td>
</tr>
<tr>
<td>Preferred brand</td>
<td>$50</td>
<td>$40</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Non-preferred brand</td>
<td>$70</td>
<td>$60</td>
<td>$60</td>
<td>$60</td>
</tr>
<tr>
<td>(90-day mail or retail)</td>
<td>$50 per person</td>
<td>$50 per person</td>
<td>$50 per person</td>
<td>$50 per person</td>
</tr>
<tr>
<td>Generic</td>
<td>$50</td>
<td>$37.50</td>
<td>$37.50</td>
<td>$37.50</td>
</tr>
<tr>
<td>Preferred brand</td>
<td>$125</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Non-preferred brand</td>
<td>$175</td>
<td>$150</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>Specialty (30-day supply)</td>
<td>$150</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
</tbody>
</table>

5. Copay applies after pharmacy deductible has been met

Kelsey Basic ACO
Memorial Hermann Basic ACO
TX Medical Neighborhood Basic

Health is a state of complete mental, social and physical well-being, not merely the absence of disease or infirmity.

– World Health Organization, 1948
CONSIDER YOUR VOLUNTARY OPTIONS

FLEXIBLE SPENDING ACCOUNTS (FSA)
Flexible spending accounts allow you to set aside money to pay for eligible health and dependent day-care expenses.

Your contributions are taken out of your paycheck before taxes, which means your money goes further because it’s tax-free. That’s why an FSA can be a smart choice for anyone who has regular predictable health or dependent day-care costs.

You decide the amount ahead of time based on your expected out-of-pocket expenses for the entire calendar year. For more information, visit the IRS website at IRS.Gov/Publications for a full list of eligible expenses.

PAYFLEX DEBIT CARD
If you already have your PayFlex debit card and decide to enroll in the Healthcare Flexible Spending Account (FSA) for 2022, you will be able to use the same card, which is already active and ready to go. Please retain this debit card for use as you continue to enroll each year in the healthcare flexible spending account. Take note of the expiration date – you will be issued a new debit card based on this date.

PLEASE NOTE
You have to enroll in your FSA each year. There’s no automatic enrollment. If you join HISD after January 1, 2022, your deductions are allocated over the remaining pay periods for the calendar year to reach your annual goal amount.

BE CAREFUL
Estimate the amount you expect to spend carefully. You lose any funds you don’t use.
HEALTH CARE FSA

• You can set aside up to $2,750.00 pre-tax to pay for eligible healthcare expenses that are not reimbursable from any other source.

• You can use your FSA for all eligible healthcare costs for you and your dependents, including vision and dental, even if your dependents are not covered under an HISD medical plan.

• 2021 FSA contribution limits will be posted after the IRS releases the information in late November 2021.

• The full amount you set aside is available to you on January 1, 2022, even though it is deducted from your paycheck over 24 pay periods.

• You have a 2½-month grace period to incur additional claims and until May 15 to file for reimbursement generally, but under current regulations you have until 12/31/2022 to spend and file claims.

DEPENDENT DAYCARE FSA

• You and your spouse can set up a combined total of up to $5,000 pre-tax to pay for daycare and eldercare expenses for a qualified person so you can work or look for work.

• Unlike the health care FSA, you can only be reimbursed funds that have already been withheld from your paycheck.

• Eligible expenses include daycare, nursery school, after-school care, summer day camp and elder day care.

You can’t use this account to pay for dependent medical expenses.

PLEASE NOTE

You will receive a healthcare debit card from Payflex (an Aetna partner) with your available funds.

IMPORTANT

If you have money in a previous year’s Health Reimbursement Account, you must use this money first to pay for eligible medical expenses before using your FSA.
CONSIDER YOUR VOLUNTARY OPTIONS

CIGNA DENTAL HMO – CIGNA’S ACCESS PLUS NETWORK

- Coverage includes dental implants and teeth whitening.
- You must choose a network general dentist (NGD) and use only providers in this Cigna DHMO network. The cutoff for choosing or changing your NGD is the 15th of each month in order to be effective the first of the following month.
- You must be referred for specialty services through your NGD before specialty services can be rendered. For more information visit HISDBenefits.org.
- You pay the set copays when you receive covered services, but you don’t pay deductibles or have to file claim forms.
- Services outside the network are covered only in emergencies and require prior approval from Cigna Dental.

You must use the DHMO fee schedule to determine covered expenses and copays.

- Orthodontia is included.
- No annual limits.

CIGNA DENTAL PPO

- Coverage includes dental implants and adult orthodontia.
- Cigna’s Oral Health Integration Program provides extra cleanings and services for chronic medical conditions.
- You pay a deductible before the plan begins to pay its share of covered expenses.
- You may use any provider you choose, but keep in mind you generally save money by using an in-network provider. If you use an out-of-network provider, you are responsible for costs that may exceed the usual, customary, and reasonable guidelines; in this case, you must file a claim form.
- There is an annual maximum benefit of $1,350 to $1,650 per person in the PPO or $2,000 for the buyup option.
- This plan includes a Wellness Plus feature. You and your covered dependents can increase your annual maximum by $100 in the following year (up to a total maximum of $1,650) by taking advantage of the plan’s preventive care.
- The PPO buyup plan does not have a deductible for preventive.
Cigna Dental HMO - CIGNA’S ACCESS PLUS NETWORK

• Coverage includes dental implants and teeth whitening.
• You must choose a network general dentist (NGD) and use only providers in this Cigna DHMO network. The cutoff for choosing or changing your NGD is the 15th of each month in order to be effective the first of the following month.
• You must be referred for specialty services through your NGD before specialty services can be rendered. For more information visit HISDBenefits.org.
• You pay the set copays when you receive covered services, but you don’t pay deductibles or have to file claim forms.
• Services outside the network are covered only in emergencies and require prior approval from Cigna Dental.
• Orthodontia is included.
• No annual limits.

Cigna Dental PPO

• Coverage includes dental implants and adult orthodontia.
• Cigna’s Oral Health Integration Program provides extra cleanings and services for chronic medical conditions.
• You pay a deductible before the plan begins to pay its share of covered expenses.
• You may use any provider you choose, but keep in mind you generally save money by using an in-network provider. If you use an out-of-network provider, you are responsible for costs that may exceed the usual, customary, and reasonable guidelines; in this case, you must file a claim form.
• There is an annual maximum benefit of $1,350 to $1,650 per person in the PPO or $2,000 for the buyup option.
• This plan includes a Wellness Plus feature. You and your covered dependents can increase your annual maximum by $100 in the following year (up to a total maximum of $1,650) by taking advantage of the plan’s preventive care.
• The PPO buyup plan does not have a deductible for preventive.
Cigna Dental Oral Health Integration Program®

Improved health starts with the mouth

Are you making the most of your dental benefits?

Together, all the way.

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, or their affiliates.
What is the Cigna Dental Oral Health Integration Program?
It’s a program that reimburses out-of-pocket costs for preventive dental treatments to combat dental issues such as gum disease and tooth decay. The program is for people with certain medical conditions with a higher risk of oral health issues. There’s no additional cost for the Oral Health Integration Program - if you qualify, you get reimbursed.*

Friendly customer support
Get guidance on everything from overcoming dental-related anxiety to understanding the impact of tobacco.

Who qualifies?
If you have a Cigna dental plan, you’re eligible for the program. You do NOT have to be enrolled in a Cigna medical plan to be eligible for this program. You must be treated by a doctor for any of the following conditions:

- Heart disease
- Stroke
- Diabetes
- Maternity
- Chronic kidney disease
- Organ transplants
- Radiation for head or neck cancers
- Rheumatoid arthritis
- Sjogren’s syndrome
- Lupus
- Parkinson’s disease
- Amyotrophic lateral sclerosis (ALS)
- Huntington’s disease
- Opioid misuse and addiction

How to enroll?
To get reimbursed, you first have to enroll in the Cigna Dental Oral Health Integration Program by either:

- Going to myCigna.com, selecting Coverage > Dental and filling out the registration form online
- Calling the number on the back of your Cigna ID card and asking for a mailed registration form

What is the reimbursement process?
1. Go to your dentist and pay the copay or coinsurance for the covered treatment.
2. If your dentist is in the Cigna network, they’ll send us a claim for reimbursement. If your dentist isn’t in the Cigna network, you might need to submit the claim.**
3. We’ll review the claim and mail reimbursements for eligible dental services in about 30 days.

### What dental services are covered under the Cigna Dental Oral Health Integration Program?:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Heart disease</th>
<th>Stroke</th>
<th>Diabetes</th>
<th>Maternity</th>
<th>Chronic kidney disease</th>
<th>Organ transplants</th>
<th>Radiation for head or neck cancers</th>
<th>Rheumatoid arthritis</th>
<th>Sjogren’s syndrome</th>
<th>Lupus</th>
<th>Parkinson’s disease</th>
<th>ALS</th>
<th>Huntington’s disease</th>
<th>Opioid misuse and addiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gum treatment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Gum evaluation</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral evaluation</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deep cleaning and plaque removal</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency pain relief treatment</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride and fluoride varnish</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Fluoride and fluoride varnish</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Sealants</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Sealant repair</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Interim caries arresting medicament application</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Caries preventive medicament application</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

1. Eligibility, reimbursement and coverage for eligible services are subject to plan year maximums. 2. Two additional treatments per year than the plan covers. 3. One additional evaluation. 4. One additional cleaning. 5. Unlimited visits. 6. Open to all ages, but plan limits apply.
The Cigna Dental Oral Health Integration Program may not be available under your specific plan. Reimbursement under OHIP is subject to plan terms and conditions, including applicable annual benefit maximums and other exclusions and limitations. For costs and details of coverage, contact your Cigna representative or see your plan documents.


Questions?
Reach out to us 24/7 at 800.Cigna24 (800.244.6224).

* You do not have to meet your DPPO or indemnity deductible to receive reimbursement for these services. However, reimbursement will apply to and is subject to your annual benefits maximum for traditional indemnity and DPPO plans as well as plan rules for visits to network dentists and out-of-network dentists.

**The reimbursement for out-of-network services will also be subject to plan limitations for out-of-network care costs.

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. Your plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.

<table>
<thead>
<tr>
<th>Cigna Dental Choice Plan</th>
<th>In-Network:</th>
<th>Out-of-Network:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cigna DPPO Network</td>
<td>Based on Contracted Fees</td>
<td>Maximum Reimbursable Charge</td>
</tr>
</tbody>
</table>

### Calendar Year Benefits Maximum
- Applies to: Class I, II, III & IX expenses
- In-Network: $2,000
- Out-of-Network: $2,000

### Calendar Year Deductible
- Individual: $50
- Family: $150

### Benefit Highlights

<table>
<thead>
<tr>
<th>Class I: Diagnostic &amp; Preventive</th>
<th>Plan Pays</th>
<th>You Pay</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Evaluations</td>
<td>100%</td>
<td>No Deductible</td>
<td>100%</td>
<td>No Deductible</td>
</tr>
<tr>
<td>Prophylaxis: routine cleansings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays: routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays: non-routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride Application</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants: per tooth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space Maintainers: non-orthodontic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care to Relieve Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Class II: Basic Restorative</th>
<th>Plan Pays</th>
<th>You Pay</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restorative: fillings</td>
<td>80%</td>
<td>After Deductible</td>
<td>80%</td>
<td>After Deductible</td>
</tr>
<tr>
<td>Endodontics: minor and major</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontics: minor and major</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery: minor and major</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia: general and IV sedation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs: Bridges, Crowns and Inlays</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs: Dentures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denture Relines, Rebases and Adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Class III: Major Restorative</th>
<th>Plan Pays</th>
<th>You Pay</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inlays and Onlays</td>
<td>50%</td>
<td>After Deductible</td>
<td>50%</td>
<td>After Deductible</td>
</tr>
<tr>
<td>Prosthesis Over Implant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns: prefabricated stainless steel / resin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns: permanent cast and porcelain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bridges and Dentures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Class IV: Orthodontia</th>
<th>Plan Pays</th>
<th>You Pay</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage for Employee and All Dependents</td>
<td>50%</td>
<td>No Deductible</td>
<td>50%</td>
<td>No Deductible</td>
</tr>
<tr>
<td>Lifetime Benefits Maximum: $2,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Class IX: Implants</th>
<th>Plan Pays</th>
<th>You Pay</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>After Deductible</td>
<td>50%</td>
<td>After Deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Benefit Plan Provisions:

- **In-Network Reimbursement**: For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.

- **Non-Network Reimbursement**: For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.

- **Cross Accumulation**: All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
CIGNA DISCOUNT DENTAL

- Website: www.CignaPlusSavings.com
- Customer service: 1-877-521-0244
- You pay set fees for selected services and receive a discount for other services.
- You agree to use Cigna network providers for your care.
- You don’t pay deductibles, file claim forms or have restrictions for pre-existing conditions or number of visits.
- This is not insurance.

VISION

- You may choose between Basic and Plus options.
- Both options have a retail frame allowance of $150.
- With both, you receive a 40 percent discount off a second pair of glasses at most participating in-network providers.
- Both give you access to online ordering tools, including Glasses.com and ContactsDirect.com.
- Both options offer in- and out-of-network benefits.
- There’s a copay, but both options offer added coverage for progressive lenses and lens options, including UV coating, tint, basic polycarbonate, and standard anti-reflective lenses.
- Both cover an annual in-network eye exam for a $10 copay.
- Both cover eyeglass lenses or contacts every 12 months after a set materials copay of $20 for Basic and $10 for Plus.
- Vision Basic covers new frames every 24 months; Vision Plus covers new frames every 12 months.

“ONLY THE DEVELOPMENT OF COMPASSION AND UNDERSTANDING FOR OTHERS CAN BRING US THE TRANQUILITY AND HAPPINESS WE ALL SEEK
– Dalai Lama XIV”
Vision Basic covers new frames every 24 months; Vision Plus covers new frames every 12 months.

Basic and $10 for Plus.

Both cover eyeglass lenses or contacts every 12 months after a set materials copay of $20 for:

- In-network eye exam for a $10 copay.
- In- and out-of-network benefits.
- 40 percent discount off a second pair of glasses at most participating in-network providers.
- Retail frame allowance of $150.

This is not insurance.

You pay set fees for selected services and receive a discount for other services. You don’t pay deductibles, file claim forms or have restrictions for pre-existing conditions.

You agree to use Cigna network providers for your care.

Customer service: 1-877-521-0244

### Additional Discounts:

- 80% off the Retail Price for Lenticular lens options
- 85% off the Retail Price for Trifocal lens options
- 85% off the Retail Price for Single Vision lens options
- 85% off the Retail Price for Polarized lens options
- 85% off the Retail Price for Premium Anti-Reflective Coating

Additional Pairs Benefit:

Members also receive a 40% discount on complete pair eyeglass purchases and a 15% discount on conventional contact lenses once the funded benefit has been used.

Tier 1:

- Standard Contact Lens Fit and Follow-Up: $0 Copay
- Basic Polycarbonate Lens: $120
- Standard Anti-Reflective Coating: $55
- Standard Poly carbonate - Kids under 19: $90
- Standard Poly carbonate - Adults: $88
- Lenticular: $80
- Trifocal: $75
- Single Vision: $70
- UV Treatment: $15
- Tint (Solid and Gradient): $15
- Standard Plastic Scratch Coating: $8
- Premium Anti-Reflective Coating:
  - See attached Fixed Premium Progressive price list

Tier 2:

- Standard Contact Lens Fit and Follow-Up: $5 Copay
- Basic Polycarbonate Lens: $125
- Standard Anti-Reflective Coating: $60
- Standard Poly carbonate - Kids under 19: $95
- Standard Poly carbonate - Adults: $93
- Lenticular: $85
- Trifocal: $80
- Single Vision: $75
- UV Treatment: $15
- Tint (Solid and Gradient): $15
- Standard Plastic Scratch Coating: $8
- Premium Anti-Reflective Coating:
  - See attached Fixed Premium Progressive price list

Tier 3:

- Standard Contact Lens Fit and Follow-Up: $10 Copay
- Basic Polycarbonate Lens: $130
- Standard Anti-Reflective Coating: $65
- Standard Poly carbonate - Kids under 19: $100
- Standard Poly carbonate - Adults: $98
- Lenticular: $90
- Trifocal: $85
- Single Vision: $80
- UV Treatment: $15
- Tint (Solid and Gradient): $15
- Standard Plastic Scratch Coating: $8
- Premium Anti-Reflective Coating:
  - See attached Fixed Premium Progressive price list

Tier 4:

- Standard Contact Lens Fit and Follow-Up: $15 Copay
- Basic Polycarbonate Lens: $135
- Standard Anti-Reflective Coating: $70
- Standard Poly carbonate - Kids under 19: $105
- Standard Poly carbonate - Adults: $103
- Lenticular: $95
- Trifocal: $90
- Single Vision: $85
- UV Treatment: $15
- Tint (Solid and Gradient): $15
- Standard Plastic Scratch Coating: $8
- Premium Anti-Reflective Coating:
  - See attached Fixed Premium Progressive price list

Laser Vision Correction:

- Standard Progressive:
  - $85 Copay
- Standard Anti-Reflective Coating:
  - $45

Premium Progressives as follows:

- Tier 1: $105 Copay
- Tier 2: $115 Copay
- Tier 3: $130 Copay
- Tier 4: $85 Copay, 80% of charge less $120 allowance

### Anti-Reflective Coating Price List*:

- Standard Anti-Reflective Coating:
  - $45

Premium Anti-Reflective Coatings as follows:

- Tier 1: $57
- Tier 2: $68
- Tier 3: 80% of charge

### Other Add-ons Price List:

- Photochromic (Plastic):
  - $75
- Polarized:
  - 80% of charge

---

EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.

---

877-780-HISD (4473).
### EYE MED PLUS OPTION

<table>
<thead>
<tr>
<th>Vision Care Services</th>
<th>Member Cost In-Network</th>
<th>Out-of-Network Reimbursement*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam with Dilatation as Necessary</strong></td>
<td>$10 Copay</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Retinal Imaging Benefit</strong></td>
<td>Up to $39</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Exam Options:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Contact Lens Fit and Follow-Up:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Contact Lens Fit and Follow-Up:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Frames:</strong></td>
<td>$0 Copay; $150 Allowance, 20% off balance over $150</td>
<td>$45</td>
</tr>
</tbody>
</table>

Any available frame at provider location

<table>
<thead>
<tr>
<th>Standard Plastic Lenses</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Vision</td>
<td>$10 Copay</td>
<td>$40</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$10 Copay</td>
<td>$60</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$10 Copay</td>
<td>$80</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$10 Copay</td>
<td>$120</td>
</tr>
<tr>
<td>Standard Progressive Lens</td>
<td>$75 Copay</td>
<td>$120</td>
</tr>
<tr>
<td>Premium Progressive Lens</td>
<td>See attached Fixed Premium Progressive price list</td>
<td>$160</td>
</tr>
</tbody>
</table>

**Lens Options:**
- **UV Treatment:** $15
- **Tint (Solid and Gradient):** $15
- **Standard Plastic Scratch Coating:** $15
- **Standard Polycarbonate - Adults:** $40
- **Standard Polycarbonate - Kids under 19:** $40
- **Standard Anti-Reflective Coating:** $45
- **Polarized:** 20% off Retail Price
- **Photostatic / Transitions Plastic:** $75
- **Premium Anti-Reflective:** See attached Fixed Premium Anti-Reflective Coating list
- **Other Add-Ons:** 20% off Retail Price

**CONTACT LENSES:**
- **Contact lens allowance includes materials only**
- **Conventional:** $0 Copay; $125 allowance, 15% off balance over $125
- **Disposable:** $0 Copay; $125 allowance, plus balance over $125

**Laser Vision Correction**
- **Lask or PRK from U.S. Laser Network:** 15% off Retail Price or 5% off promotional price

**Amplifon Hearing Health Care**
- **Hearing Health Care from Amplifon Hearing Health Care Network:** N/A

**Additional Pairs Benefit:**
- Members also receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Member Cost In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>$5.71</td>
</tr>
<tr>
<td>Lenses or Contact Lenses</td>
<td>$11.33</td>
</tr>
<tr>
<td>Frame</td>
<td>$18.24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monthly Rate</th>
<th>Member Cost In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber</td>
<td>$5.71</td>
</tr>
<tr>
<td>Subscriber + Spouse</td>
<td>$11.33</td>
</tr>
<tr>
<td>Subscriber + Children</td>
<td>$11.89</td>
</tr>
<tr>
<td>Subscriber + Family</td>
<td>$18.24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Progressive Price List*</th>
<th>Member Cost In-Network (Includes Lens Copay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Progressive</strong></td>
<td>$75 Copay</td>
</tr>
</tbody>
</table>

**Premium Progressives as Follows:**
- **Tier 1:** $95 Copay
- **Tier 2:** $105 Copay
- **Tier 3:** $120 Copay
- **Tier 4:** $75 Copay, 80% of charge less $120 allowance

**Anti-Reflective Coating Price List* | Member Cost In-Network |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Anti-Reflective Coating</strong></td>
<td>$45</td>
</tr>
</tbody>
</table>

**Premium Anti-Reflective Coatings as Follows:**
- **Tier 1:** $57
- **Tier 2:** $68
- **Tier 3:** 80% of charge

<table>
<thead>
<tr>
<th>Other Add-ons Price List</th>
<th>Member Cost In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Photochromic (Plastic)</strong></td>
<td>$75</td>
</tr>
<tr>
<td><strong>Polarized</strong></td>
<td>80% of charge</td>
</tr>
</tbody>
</table>

EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.
FOUR WAYS AN ANNUAL VISIT CAN IMPROVE YOUR LIFE

Here are words worth reading twice: An eye exam can make legends. Just ask Billie Jean King. As a youth, the future World No. 1 professional tennis player couldn’t figure out why her game wasn’t improving. Then when she had trouble reading in the classroom, she put 20 and 20 together. She went to the eye doctor, got a pair of glasses and never looked back, even when told there had never been a champion who wore glasses.

“Within a week, I was like twice as good,” King told Pearle Vision in a video for its vision health campaign. “My dreams started to be a possibility.”

An eye exam can open up possibilities for a fuller life for everyone, not just tennis champs — and it’s easier today than ever to get one. Thanks to new technologies and the expanded availability of eye doctors, you can locate an eye doctor with flexible hours and schedule an exam online or on your mobile device in minutes.

FROM MUSCLES TO HEART: FOUR REASONS TO GET AN EYE EXAM

1. The eyes are your body’s iron men: Your eyes have the busiest muscles in the body. They move three times a second, more than 100,000 times every day.¹ Like athletes, your eyes should get regular checkups to address wear and tear.

2. Fuzziness is on the horizon, no matter what. If you’re approaching 40, there’s a good chance you’ll be seeing a little fuzzy in a few years. Presbyopia is an age-related condition that everyone experiences at some point.² Untreated, it can cause headaches and eye fatigue. But if you experience signs well before 40, it could indicate anemia, diabetes, cardiovascular disease or multiple sclerosis.³

3. It could prevent you from being blind-sided. Did you know age-related macular degeneration, the gradual loss of central vision, is the leading cause of blindness among people 50 and older? It’s often caused by protein and fat deposits beneath the retina, which accumulate slowly so it could be hard to notice. An eye exam can help detect it so you can get treated.⁴

4. An exam could detect problems below the neck. A lot could be revealed about your health beyond the eyes — including the presence of blood clots. Blocked blood vessels in the eye also could signal high cholesterol, heart disease, diabetes, or other blood disorders.⁵
FROM CHILD TO CHAMPION
Like young Billie Jean King, kids have much to gain from an annual eye exam as well.

HERE ARE FOUR REASONS WHY CHILDREN SHOULD SEE THE EYE DOCTOR EVERY YEAR:

1. Blurry could be normal to them. How do you know if your child has a vision problem? Kids aren’t likely to say they don’t see clearly because they probably don’t know it. But one out of four kids has an undiagnosed vision issue, which can lead to learning challenges.6

2. 123s and AB-Sees. Billie Jean King was old enough to understand she had trouble reading and seeing the ball, but what if she was 5 or 6? 80% of what a child learns in school is presented visually, so if their vision is compromised, their education is, too.7

3. Screenings don’t cover everything. You might think a recent school screening would have detected any potential vision problems in your child, but school screenings aren’t enough. Many vision screenings test only for distance, for example.8

4. To make healthy adults. Roughly 35% of American preschoolers are farsighted, nearsighted or have astigmatism.9 And don’t be fooled by the condition amblyopia, often called lazy eye. The eye may look normal, but the condition could cause irreversible vision loss if untreated.10

In short, follow the ball. As Billie Jean King discovered, good vision is empowering. Find an eye doctor near you and schedule an eye exam.

This sponsored content was produced in conjunction with our partners at Pearle Vision.

3. Ibid. Accessed Dec. 13, 2018
MAKE A DATE FOR YOUR EYES

YOUR ANNUAL EXAM

Getting your eyes checked can help you be the vision of health.
You may think you need an eye exam only when it's time to update your eyewear prescription. But the truth is, eye exams are about a lot more than seeing whether you need a new pair of glasses or contacts. Comprehensive eye exams play an important role in your overall wellness, and you should get one every year for optimal vision health. Besides measuring your vision, regular eye exams can help identify early signs of certain chronic health conditions, including high blood pressure, diabetes, heart disease, and high cholesterol.¹

During an eye exam, your doctor will check all aspects of your vision, including your eye's structure and how well the eyes work together. Based on the exam results, your doctor will recommend a solution that is right for your eye health and vision care needs. Annual eye exams enable your doctor to monitor the health of your eyes and track changes that can occur from year to year.² For example, subtle changes in the retina can be a warning sign of high blood pressure.³

So even if you don't need vision correction, it's important to take charge of your eye care. When you get your eyes checked every year, your eyes—and possibly your whole body—stay well.

---

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

HISD provides $10,000 each of life and AD&D coverage at no cost to all employees who are eligible for benefits. You may purchase supplemental life and a matching AD&D benefit for yourself. If you do, you may also add supplemental coverage for your spouse and/or dependent child(ren).

During annual enrollment, employees are eligible for an enhancement to their life insurance program. They are able to enroll or increase their life insurance benefit one times their annual salary with no evidence of insurability up to five times their annual salary or $600,000, whichever comes first. A micro-site will be available to answer questions and guide you through the process. You must already be enrolled in at least one times your annual salary to take advantage of this increase.

SUPPLEMENTAL LIFE AND MATCHING AD&D FOR YOURSELF

Coverage is available for up to eight times your annual base salary, up to a maximum of $1,000,000. Guaranteed issue (no EOI required) up to five times your annual salary or $600,000, whichever is less.*

*Try Benefits Scout, which offers suggestions on how much life insurance you made need. Visit HISDbenefits.org to access.

SUPPLEMENTAL LIFE AND MATCHING AD&D FOR YOUR SPOUSE

- Coverage is available at one to three times your salary, equal to your total supplemental life coverage amount or $250,000, whichever is less. Guaranteed issue (no EOI required) or $100,000, or your total supplemental life coverage amount, whichever is less.

- If your spouse also works for HISD, only one of you can be covered by supplemental or spouse life and AD&D.
Child life and matching AD&D with options available at $5,000, $10,000, $15,000 or $20,000
A child may not be covered by more than one employee. You must designate or update your beneficiary online, and the actively at-work provision applies to all.

For elections under the guaranteed issue*, no EOI is required:

- If you or your spouse or your child enroll as a new employee or within 31 days of becoming eligible.
- When you or your spouse increase existing coverage by one multiple of your salary (i.e., 1x to 2x or 2x to 3x) during annual enrollment.
- When you or your spouse elect or increase coverage by one multiple of your salary within 31 days of a qualified status change (i.e., 1x to 2x or 2x to 3x).

**PLAN MAXIMUMS**

<table>
<thead>
<tr>
<th>Employee</th>
<th>1x, 2x, 3x, 4x, 5x, 6x, 7x, 8x annual base salary up to $1 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>1x, 2x, 3x your annual base salary up to amount of employee supplemental life or $250,000, whichever is less</td>
</tr>
</tbody>
</table>
| Child(ren) | $5,000, $10,000, $15,000 or $20,000  
According to the policy, all children are eligible from live birth to the attainment of age 26. |
CONSIDER YOUR VOLUNTARY OPTIONS

**DISABILITY**

This plan pays up to a maximum monthly benefit of $8,000 after a set elimination period if you are disabled and unable to work due to an injury, illness or pregnancy.

- You have a choice of elimination periods (30, 60, 90 or 180 days) before benefits begin, and you select the percentage of annual base salary (40%, 50% or 66.67%) that you want to replace each month.
- No evidence of insurability is required to enroll or increase coverage.
- 3/12 pre-existing condition and actively at-work provisions apply.
- This benefit is offset by any other sources of pay.

**CANCER AND SPECIFIED DISEASES**

This plan includes a wellness benefit per calendar year for screening tests and provides a cash benefit for covered procedures and other care related to the diagnosis and treatment of cancer and other specified diseases. This plan pays you in addition to any other coverage you may have.

- You don’t need to show evidence of good health to enroll in either option.
- 12-month pre-existing conditions exclusion and actively at-work provisions apply.
- The cancer and specified diseases plan offers low or high coverage options.

**IMPORTANT VOLUNTARY PLAN EXCLUSIONS**

**3/12 pre-existing condition**

Disability coverage only

New or increased disability coverage is subject to a 3/12 pre-existing condition exclusion. This means that if you have a condition that was treated or medically advised in the three months before your coverage effective date, you are not covered for that condition for the first 12 months.

**12-month pre-existing condition**

Cancer and specified diseases coverage only

The plan doesn’t cover pre-existing conditions. A pre-existing condition is any sickness or loss for which medical advice or treatment was received or recommended within 12 months prior to the effective date of coverage.

**Actively at work**

(Life and AD&D, disability, cancer and specified diseases, critical illness, hospital indemnity, and accident coverage)

If you are not actively at work when coverage is scheduled to become effective, your coverage does not take effect until you complete your first day at work.
CRITICAL ILLNESS

This plan pays you a wellness screening benefit, along with a lump-sum cash benefit when you’re first diagnosed with a covered critical illness. This plan pays you in addition to any other coverage you may have.

- If you choose spouse coverage, the spouse benefit is 50 percent of your employee benefit. If you choose employee + child or employee + family coverage, your dependent children are automatically covered at no additional charge. The dependent children’s benefit is 50 percent of your employee benefit.
- You have a choice of low or high options.
- There’s no pre-existing conditions exclusion.
- There’s no reduction in benefits due to age.
- No more frozen rates. Rates increase as an employee enters the next age band.
- You don’t need to provide evidence of good health to enroll in either option.
- Actively at-work provisions apply.
- Additional covered illnesses payable at 25 percent of the selected benefit amount include: Addison’s disease, Lou Gehrig’s disease, cerebral palsy, cystic fibrosis, diphtheria, encephalitis, Huntington’s chorea, Legionnaires’ disease, malaria, bacterial meningitis, multiple sclerosis, muscular dystrophy, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, rabies, scleroderma, sickle cell anemia, systemic lupus, tetanus, and tuberculosis.

HOSPITAL INDEMNITY

This plan provides a cash payment to help you pay your portion of hospital expenses, including deductibles and coinsurance amounts. This plan pays you in addition to any other coverage you may have.

- Benefits are paid for hospital admission and hospital stays, including ICU, of up to 365 days.
- When you experience a hospital confinement, you submit a claim form, along with the receipts for services received, to receive your lump-sum payment as described in the policy.
- All employees pay the same rate regardless of age.
- You don’t need to provide evidence of good health to enroll in either option.
- There’s no pre-existing conditions exclusion, including for pregnancy.
- Actively at-work provisions apply.
CONSIDER YOUR VOLUNTARY OPTION

ACCIDENT PLAN

This plan covers emergency treatment, hospital admissions, confinements, and diagnostic exams, as well as other expenses related to you or an insured family member injured in a covered accident. This plan pays you in addition to any other coverage you may have.

- If you have a covered accident, you receive cash benefits for expenses that may not be fully covered by your medical plan.
- You don’t need to provide evidence of good health to enroll.
- There’s no pre-existing conditions exclusion.
- Actively at-work provisions apply.
- Rates and plan stays the same.

PERSONAL LEGAL PLAN

This plan provides personal legal guidance on a variety of issues and services such as will preparation, traffic ticket defense, and consumer matters. Issues related to your employment are excluded.

Plan Features and Rates*

Our Legal Plan Plus Parents plan helps your employees and their parents navigate life’s twists and turns.

All services listed are available to employees, spouses and eligible dependents through the legal plan. Services in bold are available to parents through Plus Parents.

<table>
<thead>
<tr>
<th>Money Matters</th>
<th>Home &amp; Real Estate</th>
<th>Estate Planning</th>
<th>Family &amp; Personal</th>
<th>Civil Lawsuits</th>
<th>Elder-Care Issues</th>
<th>Traffic &amp; Criminal Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credit Collection</td>
<td>Deeds</td>
<td>Codicils</td>
<td>Adoption</td>
<td>Administration</td>
<td>Consultation &amp; Document Review</td>
<td>Defense of Traffic Tickets²</td>
</tr>
<tr>
<td>Defense</td>
<td>Eviction Defense</td>
<td>Complex Wills</td>
<td>Affidavits</td>
<td>Civil Litigation Hearing</td>
<td>Driving Privileges Restoration</td>
<td></td>
</tr>
<tr>
<td>Foreclosure</td>
<td>Identity Theft</td>
<td>Healthcare Proxy</td>
<td>Conservatorship</td>
<td>Disputes Over Consumer Goods &amp; Services</td>
<td>Driving Under the Influence Defense</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defense</td>
<td></td>
<td>Demand Letters</td>
<td>Incompetency Defense</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Divorce (22 hours)</td>
<td></td>
<td>Medicaid</td>
<td>Felony Defense</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Garnishment Defense</td>
<td></td>
<td>Medicare</td>
<td>Habeas Corpus</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Guardianship</td>
<td></td>
<td>Notes</td>
<td>License Suspension Due to DUI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Nursing Home Agreements</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Misdemeanor Defense</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Repossession</td>
</tr>
</tbody>
</table>

*Exclusions apply. Please see page 18 for more details.
1. MetLife administers PlanSmart’s Retirewise program, but has arranged for specially-trained third party financial professionals to offer financial education and, upon request, provide personal guidance to employees and former employees of companies providing PlanSmart’s Retirewise through MetLife.
2. This benefit provides the Participant with access to LifeStages Identity Management Services provided by CyberScout LLC. CyberScout is not a corporate affiliate of MetLife Legal Plans.
3. Does not cover DUI.
4. Rate is standard and subject to change.

### Benefit Definitions & Reimbursements

We enhanced your legal plan offering even further and have added the new coverages listed below to the Houston ISD plan design. The full list of benefit definitions and reimbursements can be found on the pages that follow.

<table>
<thead>
<tr>
<th>New Coverages</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guardianship or Conservatorship</td>
<td>Fully Covered</td>
<td>$650</td>
</tr>
<tr>
<td>- Uncontested</td>
<td>Fully Covered</td>
<td>$650</td>
</tr>
<tr>
<td>- Contested</td>
<td>Fully Covered</td>
<td>$1,500</td>
</tr>
<tr>
<td>- Plus Trial Supplement for Out-of-Network Service*</td>
<td>Fully Covered</td>
<td>$100,000</td>
</tr>
<tr>
<td>Premarital Agreement</td>
<td>Fully Covered</td>
<td>$1,000</td>
</tr>
<tr>
<td>Tax Audit Representation</td>
<td>Fully Covered</td>
<td>$1,200</td>
</tr>
<tr>
<td>- Preparation and Settlement</td>
<td>Fully Covered</td>
<td>$250</td>
</tr>
<tr>
<td>- Documentation and Hearing</td>
<td>Fully Covered</td>
<td>$500</td>
</tr>
</tbody>
</table>

---

1. Rate guarantees: Five years.
2. Usage reports: Usage reports, and analysis and evaluation of the reports.
3. Portability: Offers additional ease of use and flexibility for employees.
### Advice and Consultation

**Office Consultation:** This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The plan attorney will explain the participant's rights, point out his or her options and recommend a course of action. The plan attorney will identify any further coverage available under the plan, and will undertake representation if the participant so requests. If representation is covered by the plan, the participant will not be charged for the plan attorney's services. If representation is recommended, but is not covered by the plan, the plan attorney will provide a written fee statement in advance. The participant may choose whether to retain the plan attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a participant may use this service, although it is not intended to provide the participant with continuing access to a plan attorney in order to undertake his or her own representation.

**Telephone Advice** (see Office Consultation definition)

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Covered</td>
<td>$70</td>
<td></td>
</tr>
</tbody>
</table>

### Consumer Protection Matters

**Consumer Protection Matters:** This service covers the participant as plaintiff for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.

- **Correspondence and Negotiation**
  - Fully Covered $500
- **Filing of Suit, Filing in Settlement or Judgment**
  - Fully Covered $2,000
- **Plus Trial Supplement for Out-of-Network Service**
  - $100,000

### Benefit Definitions & Reimbursements (Continued)

**Consumer Protection Matters (continued)**

- **Personal Property Protection:** This service covers counseling the participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits, and demand letters.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Covered</td>
<td>$126</td>
<td></td>
</tr>
</tbody>
</table>

- **Small Claims Assistance:** This service covers counseling the participant on prosecuting a small claims action, helping the participant prepare documents; advising the participant on evidence, documentation and witnesses; and preparing the participant for trial. The service does not include the plan attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Covered</td>
<td>$200</td>
<td></td>
</tr>
</tbody>
</table>

**Defense of Civil Lawsuits**

- **Administrative Hearing Representation:** This service covers participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. Includes the hearing before an administrative board or agency over an adverse government action. It does not apply where services are available or are being provided by virtue of a homeowner or vehicle insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Covered</td>
<td>$500</td>
<td></td>
</tr>
<tr>
<td>Contested Hearings Ending in Settlement or Judgment</td>
<td>Fully Covered</td>
<td>$1,800</td>
</tr>
<tr>
<td>Plus Trial Supplement for Out-of-Network Service</td>
<td>Fully Covered</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

- **Civil Litigation Defense:** This service covers the participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counter, third party or cross claims.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Covered</td>
<td>$650</td>
<td></td>
</tr>
<tr>
<td>Filing Answer, Litigation Ending in Settlement or Judgment</td>
<td>Fully Covered</td>
<td>$2,000</td>
</tr>
<tr>
<td>Plus Trial Supplement for Out-of-Network Service</td>
<td>Fully Covered</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

**Incompetency Defense:** This service covers the participant in the defense of any incompetence action, including court hearings when there is a proceeding to find the participant incompetent.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Covered</td>
<td>$500</td>
<td></td>
</tr>
<tr>
<td>Trial</td>
<td>Fully Covered</td>
<td>$1,800</td>
</tr>
<tr>
<td>Plus Trial Supplement for Out-of-Network Service</td>
<td>Fully Covered</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

**Document Preparation and Review**

- **Affidavit:** This service covers preparation of any affidavit in which the participant is the person making the statement.
  - Fully Covered $75
- **Deed:** This service covers the preparation of any deed for which the participant is the grantor or grantee.
  - Fully Covered $100
- **Demand Letter:** This service covers the preparation of letters that demand money, property or some other property interest of the participant, except an interest that is an excluded service. It also covers mailing them to the addressee, and forwarding and explaining any response to the participant.
  - Fully Covered $75
- **Document Review:** This service covers the review of any personal legal document of the participant, such as letters, leases or purchase agreements.
  - Fully Covered $100
**Benefit Definitions & Reimbursements (Continued)**

<table>
<thead>
<tr>
<th>Estate Planning Documents</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Wills: This service covers the preparation of a living will for the participant.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual</td>
<td>Fully Covered</td>
<td>$75</td>
</tr>
<tr>
<td>• Member and Spouse</td>
<td>Fully Covered</td>
<td>$85</td>
</tr>
<tr>
<td>Powers of Attorney: This service covers the preparation of any power of attorney when the participant is granting the power.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual</td>
<td>Fully Covered</td>
<td>$95</td>
</tr>
<tr>
<td>• Member and Spouse</td>
<td>Fully Covered</td>
<td>$450</td>
</tr>
<tr>
<td>Trusts: This service covers the preparation of revocable and irrevocable living trusts for the participant. It does not include tax planning or services associated with funding the trust after it is created.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual</td>
<td>Fully Covered</td>
<td>$325</td>
</tr>
<tr>
<td>• Member and Spouse</td>
<td>Fully Covered</td>
<td>$450</td>
</tr>
<tr>
<td>Wills and Codicils (Including Simple Support Trust for Minor Children): This service covers the preparation of a simple or complex will for the participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual</td>
<td>Fully Covered</td>
<td>$150</td>
</tr>
<tr>
<td>• Member and Spouse</td>
<td>Fully Covered</td>
<td>$200</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Law</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption and Legitimization: This service covers all legal services and court work in a state or federal court for an adoption for the plan member and spouse. Legitimization of a child for the plan member and spouse, including reformation of a birth certificate, is also covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Uncontested</td>
<td>Fully Covered</td>
<td>$650</td>
</tr>
<tr>
<td>• Contested</td>
<td>Fully Covered</td>
<td>$1,500</td>
</tr>
<tr>
<td>• Plus Trial Supplement for Out-of-Network Service*</td>
<td></td>
<td>$100,000</td>
</tr>
<tr>
<td>Divorce, Dissolution, and Annulment (Contested &amp; Uncontested) - Twenty Hour Maximum: This service is available to the Plan Member only, not to a spouse or dependents, for the first twenty hours of service. This service includes preparing and filing all necessary pleadings, motions and affidavits, drafting settlement agreements, and representation at the hearing or trial, whether the Plan Member is a plaintiff or a defendant. This service does not include disputes that arise after a divorce is issued. It is the Plan Member's responsibility to pay fees beyond the first twenty hours.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Uncontested</td>
<td>Fully Covered</td>
<td>$1,800</td>
</tr>
<tr>
<td>• Contested</td>
<td>Fully Covered</td>
<td>$1,800</td>
</tr>
<tr>
<td>• Plus Trial Supplement for Out-of-Network Service*</td>
<td></td>
<td>$100,000</td>
</tr>
<tr>
<td>Guardianship or Conservatorship: This service covers establishing a guardianship or conservatorship over a person and his or her estate when the plan member or spouse is being appointed as guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, any annual accountings after the initial accounting, or terminating the guardianship or conservatorship once it has been established.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Uncontested</td>
<td>Fully Covered</td>
<td>$650</td>
</tr>
<tr>
<td>• Contested</td>
<td>Fully Covered</td>
<td>$1,500</td>
</tr>
<tr>
<td>• Plus Trial Supplement for Out-of-Network Service*</td>
<td></td>
<td>$100,000</td>
</tr>
</tbody>
</table>
### Benefit Definitions & Reimbursements

(Continued)

<table>
<thead>
<tr>
<th>Family Law (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name Change:</strong> This service covers the participant for all necessary pleadings and court hearings for a legal name change.</td>
</tr>
<tr>
<td><strong>Prenuptial Agreement:</strong> This service covers representation of the participant and includes the negotiation, preparation, review, and execution of a prenuptial agreement between the participant and his or her fiancé/partner prior to their marriage or legal union (where allowed by law). It does not include subsequent litigation arising out of a prenuptial agreement. The fiancé/partner must either have separate counsel or waive his/her right to representation.</td>
</tr>
<tr>
<td><strong>Protection from Domestic Violence:</strong> This service covers the participant only, not the spouse or dependents, as the victim of domestic violence. It provides the participant with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action or representation for the offender.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Debt Collection Defense:</strong> This benefit provides participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter, cross or third party claims, bankruptcy, any action arising out of family law matters including support and post-decree issues or any matter where the creditor is affiliated with the sponsor or employer.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Debt Collection Defense (Consumer Debts)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negotiation and Settlement</strong></td>
</tr>
<tr>
<td><strong>Negotiation and Settlement after Complaint and Answer Filed</strong></td>
</tr>
<tr>
<td><strong>Trial</strong></td>
</tr>
<tr>
<td><strong>Plus Trial Supplement for Out-of-Network Service</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Debt Collection Defense (Foreclosures)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negotiation</strong></td>
</tr>
<tr>
<td><strong>Complaint and Answer Filed, Settlement Negotiations</strong></td>
</tr>
<tr>
<td><strong>Trial</strong></td>
</tr>
<tr>
<td><strong>Plus Trial Supplement for Out-of-Network Service</strong></td>
</tr>
</tbody>
</table>

| Identity Theft Defense: This service provides the Participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the Participant with online help and information about identity theft and prevention. It does not include counter, cross or third party claims, bankruptcy, any action arising out of family law matters, including support and post-decree matters or any matter where the creditor is affiliated with the sponsor or employer. |
| **Identity Theft Defense** | Fully Covered | $250 |

| LifeStages Identity Management Services: This benefit provides the Participant with access to LifeStages Identity Management Services provided by CyberScout. It includes both Proactive Services when the Participant believes their personal data has been compromised as well as Resolution Services to assist the Participant in recovering from account takeover or identify theft with unlimited assistance to fix issues, handle notifications, and provide victims with credit and fraud monitoring, Theft Support, Fraud Support, Recovery, and Replacement services are covered by this benefit. |
| **LifeStages Identity Management Services** | Fully Covered |

| Personal Bankruptcy or Wage Earner Plan: This service covers the Participant and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or wage earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the sponsor or employer, even if the Participant or spouse chooses to reaffirm that specific debt. |
| **Personal Bankruptcy or Wage Earner Plan** |
| - **Chapter 7 Individual or Member/Spouse** | Fully Covered | $850 |
| - **Chapter 13 Individual or Member/Spouse** | Fully Covered | $1,400 |
Benefit Definitions & Reimbursements (Continued)

<table>
<thead>
<tr>
<th>Financial Matters (continued)</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tax Audit Representation:</strong> This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority may have concerning the Participant’s tax return, negotiating with the agency, advising the participant on necessary documentation, and attending an IRS or a state or local taxing authority audit. This service does not include prosecuting a claim for the return of overpaid taxes, costs of hiring an accountant, or the preparation of any tax returns.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Negotiation and Settlement</td>
<td>Fully Covered</td>
<td>$500</td>
</tr>
<tr>
<td>· Audit Hearing</td>
<td>Fully Covered</td>
<td>$1,200</td>
</tr>
<tr>
<td><strong>Immigration</strong></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Immigration Assistance: This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the participant prepare for hearings.</td>
<td>Fully Covered</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Juvenile Matters</strong></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Juvenile Court Defense: This service covers the defense of a Participant and a Participant’s dependent child in any juvenile court matter, provided there is no conflict of interest between the Participant and the dependent child. In that event, this service provides an attorney for the plan member only, including services for parental responsibility.</td>
<td>Fully Covered</td>
<td></td>
</tr>
<tr>
<td>· Negotiation and Settlement</td>
<td>Fully Covered</td>
<td>$500</td>
</tr>
<tr>
<td>· Trial</td>
<td>Fully Covered</td>
<td>$1,200</td>
</tr>
<tr>
<td>· Plus Trial Supplement for Out-of-Network Service*</td>
<td></td>
<td>$100,000</td>
</tr>
<tr>
<td><strong>Personal Injury</strong></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Personal Injury (25% Network Maximum): Subject to applicable law and court rules, plan attorneys will handle personal injury matters (where the participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the participant’s responsibility to pay this fee and all costs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Probate</strong></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Probate (10% Network Reduced Fee): Subject to applicable law and court rules, plan attorneys will handle probate matters at a fee of 10% less than the plan attorney’s normal fee. It is the participant’s responsibility to pay this reduced fee and all costs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Real Estate Matters</strong></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Eviction and Tenant Problems: This service covers the Participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.</td>
<td>Fully Covered</td>
<td>$280</td>
</tr>
<tr>
<td>· Correspondence and Negotiations</td>
<td>Fully Covered</td>
<td>$840</td>
</tr>
<tr>
<td>· Eviction Trial Defense</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Plus Trial Supplement for Out-of-Network Service*</td>
<td></td>
<td>$100,000</td>
</tr>
<tr>
<td><strong>Security Deposit Assistance:</strong> This service covers counselling the Participant in recovering a security deposit from the Participant’s residential landlord; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the Participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the Participant for the small claims trial. The service does not include the plan attorney’s attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Demand Letter/Negotiations</td>
<td>Fully Covered</td>
<td>$250</td>
</tr>
<tr>
<td>· Counseling on Preparing Small Claims Complaint and Trial Preparation</td>
<td>Fully Covered</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Zoning Applications:</strong> This service provides the Participant with the services of a lawyer to help get a zoning change or variance for the Participant’s residence. Services include reviewing the law, reviewing the survey, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Preparation of Documentation</td>
<td>Fully Covered</td>
<td>$250</td>
</tr>
<tr>
<td>· Documentation/Attending Hearing</td>
<td>Fully Covered</td>
<td>$500</td>
</tr>
</tbody>
</table>
### Benefit Definitions & Reimbursements (Continued)

#### Traffic & Criminal Matters

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Driving Under the Influence Defense</strong>: This service covers representation of the Participant in defense of any driving under the influence of driving while intoxicated charge, including court hearings, negotiation with the prosecutor and trial. It does not cover vehicular homicide. This service does not include any post-sentencing proceeding, probation violation hearing or appeals by either party.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Negotiation and Settlement | Fully Covered | $500 |
- File Request for Hearing with Attendance at Hearing | Fully Covered | $1,000 |
- Plus Trial Supplement for Out-of-Network Service* | | $100,000 |

**Felony Defense**: This service covers representation for Participants in defense of any criminal felony charge. Representation includes court hearings, negotiation with the prosecutor and trial. This service does not cover any post-sentencing proceeding, probation violation hearing or appeals by either party.

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
</table>
- Negotiation and Settlement | Fully Covered | $650 |
- File Request for Hearing with Attendance at Hearing | Fully Covered | $1,750 |
- Plus Trial Supplement for Out-of-Network Service* | | $100,000 |

**Habeas Corpus**: This service covers the Participant for the preparation of all paperwork needed, and attendance at the hearing to pursue a habeas corpus proceeding to obtain the release of a Participant who is being unlawfully imprisoned.

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
</table>
- Negotiation and Settlement | Fully Covered | $420 |
- File Request for Hearing with Attendance at Hearing | Fully Covered | $1,250 |
- Plus Trial Supplement for Out-of-Network Service* | | $100,000 |

* Trial Supplement — In addition to fees indicated, we will pay the attorney's fees for representation in trial beyond the third day of trial up to a maximum of $600 per day up to $100,000 total trial supplement maximum.

**Exclusions**: No service, including advice and consultations, will be provided for 1) employment-related matters, including company or statutory benefits: 2) matters involving the employer, MetLife® and affiliates, and plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) family and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) costs and fines; 8) tortious or unethical matters; 9) matters for which an attorney-client relationship exists prior to the participant becoming eligible for plan benefits. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters listed above.

---

Today's benefits environment is filled with significant challenges due to rising health care costs. These challenges, coupled with meeting the benefits needs of an increasingly diverse, multi-generational workforce are driving employers to re-evaluate their benefits strategy and investment.

Voluntary benefits can effectively help address today's challenges because they provide a cost effective solution that can help optimize an overall benefits program. Additionally, they provide employees the access and choice they need to fill financial gaps and meet individual protection needs.

With MetLife's broad product suite, flexible coverage options and proven expertise, you have the advantage you need to build benefits solutions in a simple, cost-effective and hassle-free way.

**Get expert guidance for confident decisions**

Contact your MetLife representative today.
Q: I was diagnosed with COVID-19. Will Aflac pay benefits for the period of time I am unable to work? Will I have to pay premiums during that time?
A: You will need to look to your Disability coverage for help during this time period. Aflac’s plans offered at HISD do not specifically address time off from work.

Q: I am in the hospital with COVID-19. Will Aflac cover that?
A: Aflac will pay benefits under those circumstances if you have Aflac’s hospital plan.

Q: I have tested positive for COVID-19. My local hospital is at full capacity. They have created an alternative care site, and that is where I’m receiving my treatment. Will Aflac cover that?
A: Alternative care sites are occurring in many states, and we treat them like standard hospitals if they provide hospital-level care and care in a hospital was not available.

Q: I need to be tested for COVID-19. Will Aflac cover that?
A: Your test would be covered under the wellness benefits provided by the Accident, Hospital, Cancer, and Critical Illness plans.

Q: What if I am unable to see a doctor in person, so I use telemedicine? Will Aflac still cover me?
A: Aflac considers a telemedicine visit the same as an in-person visit to the doctor.

Q: I haven’t tested positive for COVID-19. However, I possibly have been exposed to the virus. My doctor thinks it is best that I remain in self-isolation or the government has put me under quarantine. Will Aflac pay benefits while I’m staying home?
A: Not under these specific plans.
AFLAC GROUP INSURANCE PLANS

CANCER AND SPECIFIED DISEASES • HOSPITAL INDEMNITY • CRITICAL ILLNESS • ACCIDENT

Even a small trip to the hospital can have a major impact on your finances. Here's a way to help make your visit a little more affordable.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Plan Option 1</th>
<th>Plan Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOSPITAL CONFINEMENT</strong> (first continuous 30 days)</td>
<td>$200</td>
<td>$300</td>
</tr>
<tr>
<td>We will pay the amount shown for Hospital Confinement for the first continuous 30 days of hospital confinement due to Internal Cancer. Benefit: Per Day / No Lifetime Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HOSPITAL CONFINEMENT</strong> (31st day and thereafter)</td>
<td>$400</td>
<td>$600</td>
</tr>
<tr>
<td>We will pay the amount shown after the 31st day for hospital confinement due to Internal Cancer. Benefit: Per Day / No Lifetime Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SURGICAL BENEFIT</strong></td>
<td>$95 – $3,000</td>
<td>$100 – $5,000</td>
</tr>
<tr>
<td>We will pay the amount shown in the Surgical Schedule section of the plan for surgery performed on an insured for a diagnosed cancer. Benefits are payable for in or out of hospital surgery in accordance with the Surgical Schedule. Benefit: Per Procedure / No Lifetime Limit on Number of Operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SECOND SURGICAL OPINION</strong></td>
<td>$200</td>
<td>$250</td>
</tr>
<tr>
<td>We will pay up to the amount shown for a second surgical opinion by a licensed physician, not a relative, concerning cancer surgery for each positively diagnosed cancer. This benefit is payable once for each malignant condition. Not payable for reconstructive surgery or skin cancer. Benefit: Per Malignant Condition / No Lifetime Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FIRST OCCURRENCE BENEFIT</strong></td>
<td>$1,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>We will pay this benefit the first time the insured is diagnosed as having internal (not skin) cancer. This benefit is payable only once for each insured and will be paid in addition to any other benefit in the plan. Internal cancer includes melanomas classified as Clark’s Level III and higher. In addition to the pathological or clinical diagnosis required by the plan, we may require additional information from the attending physician and hospital.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CANCER SCREENING/WELLNESS BENEFIT</strong></td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>For each insured, we will pay the actual incurred charges up to the amount shown for: · Bone Marrow Testing · Biopsy · Breast Ultrasound · CA 125 (blood test for ovarian cancer) · CA 15-3 (blood test for breast cancer) · CEA (blood test for colon cancer) · Chest X-Ray · Colonoscopy · Flexible Sigmoi doscopy · Hemocult Stool Analysis · Mammography · Pap Smear · PSA (blood test for prostate cancer) · Serum Protein Electrophoresis (blood test for myeloma) · Thermography No Lifetime Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RADIATION AND CHEMOTHERAPY</strong></td>
<td>$200</td>
<td>$300</td>
</tr>
<tr>
<td>We will pay up to the amount shown for each day the insured receives radioactive or chemical treatments prescribed by a doctor for the destruction of abnormal tissue during the treatment of Cancer. For oral chemotherapy not requiring the administration by medical personnel, we will pay the amount shown for each prescription not to exceed $800 a month for Option I and $1,200 a month for Options II and III. Benefit: Per Day / No Lifetime Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EXPERIMENTAL TREATMENT</strong></td>
<td>$200</td>
<td>$300</td>
</tr>
<tr>
<td>We will pay the charges incurred, up to the amount shown, per day for an insured who receives experimental cancer treatment for the purpose of modification or destruction of abnormal tissue. The treatments must be consistent with one or more National Cancer Institute sponsored protocols. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, and therapeutic devices or other procedures related to these therapy treatments. Benefit: Per Day / No Lifetime Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SKIN CANCER SURGERY</strong></td>
<td>$100</td>
<td>$600</td>
</tr>
<tr>
<td>We will pay the amount shown in the Surgical Schedule section of the Plan for surgery performed on an insured for a diagnosed cancer. Benefits are payable for in or out of hospital surgery in accordance with the Surgical Schedule. Benefit: Per Malignant Condition / No Lifetime Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IN-HOSPITAL BLOOD AND PLASMA</strong></td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>We will pay the amount shown for each day an insured receives blood or plasma during a covered hospital confinement. Benefit: Per Day / No Lifetime Limit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### OUTPATIENT BLOOD AND PLASMA

We will pay up to the amount shown for each day an insured receives blood or plasma as an outpatient in a doctor’s office, clinic, hospital, or ambulatory surgical center due to cancer.

<table>
<thead>
<tr>
<th>Benefit: Per Day / No Lifetime Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200</td>
</tr>
<tr>
<td>$250</td>
</tr>
</tbody>
</table>

### PROSTHESIS/ARTIFICIAL LIMB

We will pay the amount shown for each prosthetic device or artificial limb surgically implanted which is prescribed as a result of surgery for cancer treatment. Lifetime limit is benefit shown for each option per insured.

We will pay up to $200 for the charges incurred for prosthetic devices prescribed as a direct result of cancer treatment that does not require surgical implantation. Lifetime limit $200 per insured.

<table>
<thead>
<tr>
<th>Benefit: Per Device</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incurred charges up to: $2,500</td>
</tr>
<tr>
<td>Incurred charges up to: $3,000</td>
</tr>
</tbody>
</table>

### TRANSPORTATION BENEFIT

We will pay the amount shown for the insured’s transportation to and from a hospital located outside a 100 mile radius of their legal residence.

The insured must require special treatment for internal cancer which has been prescribed by the local attending physician and which cannot be obtained locally.

This benefit will be paid only for the insured person for whom this special treatment is prescribed, unless the treatment is for a dependent child, then the child’s parent or legal guardian who travels with the dependent child will also receive this benefit (only one person will be paid to travel with such dependent child).

No Lifetime Limit

| Automobile: $0.40 per mile up to $1,200 |
|                                          |
| Airfare or other commercial travel: up to $1,200 |
|                                          |

### FAMILY MEMBER LODGING BENEFIT

We will pay the amount shown per day for each night’s lodging in a motel/hotel room for the insured or any one family member when an insured person is confined to a hospital for internal cancer treatment. The hospital and motel/hotel room must be more than 100 miles from the insured’s residence. The special cancer treatment must be prescribed by a local physician.

<table>
<thead>
<tr>
<th>Benefit: Per Day / Lifetime limit 60 days per covered person</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50</td>
</tr>
<tr>
<td>$60</td>
</tr>
</tbody>
</table>

### NATIONAL CANCER CONSULTATION

We will pay up to the amount shown when consultation at an NCI-sponsored cancer center as a result of receiving a prior diagnosis of internal cancer. The purpose of the evaluation/consultation must be to determine the appropriate course of cancer treatment. We will pay $250 for the transportation and lodging of the covered person receiving the evaluation/consultation. The NCI-sponsored cancer center must be more than 100 miles from the covered person’s residence for the transportation and lodging portion of this benefit to be payable. This benefit is payable once per insured. No Lifetime Limit

<table>
<thead>
<tr>
<th>BOTH PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>$500</td>
</tr>
</tbody>
</table>

### ANESTHESIA

We will pay 25% of the amount shown in the Surgical Schedule opposite the appropriate surgical procedure if the insured receives anesthesia administered by an anesthesiologist or anesthetist during a surgical procedure which is performed for the treatment of cancer. This benefit is not payable for reconstructive surgery.

<table>
<thead>
<tr>
<th>Benefit: Per Procedure / No Lifetime Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>25% of surgery</td>
</tr>
</tbody>
</table>

### ANTI-NAUSEA MEDICATION

We will pay up to the amount shown for anti-nausea medication as a result of radiation/chemotherapy treatments and as prescribed by a Physician. We will pay this benefit for no more than the number of days the insured receives treatment for radiation/chemotherapy.

<table>
<thead>
<tr>
<th>Benefit: Per Month / No Lifetime Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
</tr>
</tbody>
</table>

### NURSING SERVICES

We will pay the amount shown per day for full-time nursing services (not performed by a relative) while hospitalized. Benefit: Per Day / No Lifetime Limit

<table>
<thead>
<tr>
<th>BOTH PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
</tr>
</tbody>
</table>

### HOME HEALTH CARE

We will pay charges incurred up to $50.00 per day for visits by a home health care agency. This benefit is limited to 30 visits per calendar year.

<table>
<thead>
<tr>
<th>Incurred charges up to $50 per day</th>
</tr>
</thead>
</table>

### AFLAC GROUP INSURANCE PLANS

### HOSPICE CARE

We will pay the amount shown for care provided by a hospice. The insured must be diagnosed with cancer and therapeutic intervention directed toward the cure of the disease is medically determined to be no longer appropriate, and if medical prognosis indicates a life expectancy of six months or less as a direct result of cancer.

<table>
<thead>
<tr>
<th>Benefit: Per Day / Lifetime limit of $12,000 per insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100 per day/first 60 days $50 per day thereafter</td>
</tr>
</tbody>
</table>

### EXTENDED CARE FACILITY

We will pay $100 per day when the insured person is confined to a section of the hospital used as an Extended Care Facility, a Skilled Nursing Facility, or any bed designated as a swing bed. Confinement must follow hospitalization and the insured must be receiving benefit under the Hospital Confinement Benefit. Limited to the same number of days the insured received Hospital Confinement Benefits.

<table>
<thead>
<tr>
<th>Benefit: Per Day / Lifetime limit of 365 days per insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
</tr>
</tbody>
</table>
AMBIENCE
We will pay the amount shown if an insured requires transportation to a hospital, within 100 miles of the insured person’s residence, for overnight confinement for cancer treatment. This benefit is limited to two (2) trips per confinement. This ambulance service must be performed by a licensed professional ambulance company.
Benefit: Per Trip / No Lifetime Limit

BONE MARROW TRANSPLANT
We will pay the charges incurred up to $10,000 for the harvesting and reinfusion of bone marrow if the insured requires a bone marrow transplantation during a covered hospital confinement.
We will pay the charges incurred up to $5,000 for the harvesting and reinfusion of bone marrow performed on an outpatient basis.
We will pay an indemnity of $1,000 to the bone marrow donor for his or her expenses incurred as a result of the transplantation procedure.
Benefit: Per Procedure / No Lifetime Limit

STEM CELL TRANSPLANTATION
We will pay the charges incurred up to $2,500 if an insured receives a peripheral stem cell transplantation for the treatment of cancer. This benefit is payable once per insured. This benefit is not payable in conjunction with the payment of the Bone Marrow Transplantation Benefit.
Lifetime Maximum of $2,500 per insured

WAIVER OF PREMIUM
If the insured, due to having internal cancer, is completely unable to do all of the usual and customary duties of your occupation for a period of 90 continuous days, we will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, we will require an employer’s statement (if applicable) and a physician’s statement of the insured’s inability to perform said duties or activities, and may each month thereafter require a physician’s statement that total inability continues.

SPECIFIED DISEASE BENEFIT
We will pay $200 per day for the first 30 days and $500 per day thereafter for hospital confinement when such confinement is due to the treatment of a specified disease if: 1. the insured receives treatment for a specified disease beginning while the Certificate is in force; and 2. it is not excluded by name or specific description.
Benefits will be paid from the first day of hospital confinement due to a specified disease. We will pay the daily amount regardless of whether the insured is charged by the hospital for such confinement. If more than one specified disease is diagnosed at the same time then we will only pay the amount shown for one disease but not both.
Covered Diseases Include: Addison’s disease, Amyotrophic Lateral Sclerosis (ALS), Cerebral palsy, Cerebrospinal Meningitis, Cystic fibrosis, Diphtheria, Encephalitis, Huntington’s chorea, Legionnaires’ disease, Malaria, Meningitis (bacterial), Multiple sclerosis, Muscular dystrophy, Myasthenia gravis, Necrotizing fasciitis, Osteomyelitis, Polio, Rubies, Scleroderma, Sickle cell anemia, Systemic lupus, Tumors, Tuberculosis.
The lifetime maximum benefit payable under this benefit is $100,000 per insured.

OPTIONAL INTENSIVE CARE BENEFIT / $600 A DAY IN HOSPITAL
Benefits will be paid if the insured is confined in a Hospital Intensive Care Unit (ICU). This benefit is limited to 30 days per period of confinement.

AFLAC GROUP HOSPITAL INDEMNITY

HOSPITAL ADMISSION BENEFIT (once per confinement)
This benefit is paid when you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident or because of a covered sickness. We will pay this benefit once for each covered accident or covered sickness. Confinement must be within 6 months of a covered accident.

HOSPITAL CONFINEMENT BENEFIT (up to 365 days per confinement)
The amount indicated is paid for overnight hospital confinement. This benefit begins with the first day of confinement and lasts up to 365 days. Confinement must be within 6 months of a covered accident.

HOSPITAL INTENSIVE CARE BENEFIT (365-day maximum for any one period of confinement)
The amount indicated is paid for overnight hospital intensive care unit confinement. The benefit begins the first day of confinement and lasts up to 365 days. “Total daily benefit if confined to an Intensive Care Unit.

WELLNESS BENEFIT
We will pay the amount shown when a covered person visits a doctor and the covered person is neither injured nor sick. This benefit is payable once per calendar year per covered person.
**GROUP PREMIUM**
Once enrolled in the program premiums will not increase because of age.

**WAIVER OF PREMIUM**
We will waive an insured’s premium after he or she is continuously confined to a hospital for 14 days. We will waive premium until he or she is discharged from the hospital or for 12 months, whichever comes first. This benefit applies only to the insured employee, not spouse or children.

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to the plan for complete details, definitions, limitations, and exclusions.

---

**AFLAC GROUP CRITICAL ILLNESS INSURANCE**

<table>
<thead>
<tr>
<th>Covered Illness</th>
<th>Benefit</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CANCER</strong> (Internal or Invasive)</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>HEART ATTACK</strong> (Myocardial Infarction)</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>STROKE</strong> (Ischemic or Hemorrhagic)</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>KIDNEY FAILURE</strong> (End-Stage Renal Failure)</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>BONE MARROW TRANSPLANT</strong> (Stem Cell Transplant)</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>SUDDEN CARDIAC ARREST</strong></td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>MAJOR ORGAN TRANSPLANT</strong> (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>NON-INVASIVE CANcer</strong></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td><strong>CORONARY ARTERY BYPASS SURGERY</strong></td>
<td>25%</td>
<td></td>
</tr>
</tbody>
</table>

**INITIAL DIAGNOSIS**
We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

**ADDITIONAL DIAGNOSIS**
We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

**REOCURRENCE**
We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

**CHILD COVERAGE AT NO ADDITIONAL COST**
Each dependent child is covered at 50 percent of the primary insured’s benefit amount at no additional charge. Children-only coverage is not available.

**SKIN CANCER BENEFIT**
We will pay $250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

**WAIVER OF PREMIUM**
If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.

**SUCCESSOR INSURED BENEFIT**
If spouse coverage is in force at the time of the primary insured’s death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

**HEALTH SCREENING BENEFIT**
You may receive a maximum of $100 High Option or $50 Low Option for health screening tests performed while an insured’s coverage is in force. We will pay this benefit once per calendar year.

This benefit is only payable 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 the covered employee, spouse and dependent children.
• Benefits available for spouse and/or dependent children.

<table>
<thead>
<tr>
<th>Optional Benefits Rider</th>
<th>Percentage of Face Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>BENIGN BRAIN TUMOR</td>
<td>100%</td>
</tr>
<tr>
<td>ADVANCED ALZHEIMER’S DISEASE</td>
<td>25%</td>
</tr>
<tr>
<td>ADVANCED PARKINSON’S DISEASE</td>
<td>25%</td>
</tr>
</tbody>
</table>

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis. We will pay the optional benefit if the insured is diagnosed with one of the conditions listed in the rider schedule if the date of diagnosis is while the rider is in force.

<table>
<thead>
<tr>
<th>Progressive Diseases Rider</th>
<th>25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPECIFIED DISEASES RIDER</td>
<td></td>
</tr>
<tr>
<td>HUMAN CORONAVIRUS SPECIFIED DISEASE BENEFIT</td>
<td></td>
</tr>
</tbody>
</table>
We will pay the benefit if an insured is diagnosed with Human Coronavirus and if the date of diagnosis is while the rider is in force.
In order to receive a benefit for Human Coronavirus, the insured must be confined to a Hospital or confined to a Hospital Intensive Care Unit for the minimum number of days shown. Only the highest eligible benefit amount shown will be payable under these benefits. In the event a lower benefit amount was previously paid under these benefits for any period of Hospital Confinement and that confinement is extended or the insured is moved to an Intensive Care Unit triggering a higher payment, the difference between the previous paid benefit amount and the new benefit amount will be provided.
Payment of all benefits contained in the rider is subject to the Critical Illness Benefit provisions. The benefits contained in the rider are considered to be Critical Illnesses.

| Hospitalization: 4 or more days | 25% |
| Hospitalization: 10 or more days | 25% |
| Hospitalization: ICU 40% |

<table>
<thead>
<tr>
<th>ADDITIONAL SPECIFIED DISEASES BENEFITS</th>
<th>25%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specified Diseases Rider</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOSPITAL ADMISSION</td>
</tr>
</tbody>
</table>
We will pay this benefit when you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident within six months of the date of the accident. We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit, or for emergency room treatment or outpatient treatment.

| $1,500 | $750 |

| HOSPITAL CONFINEMENT (per day) |
We will provide this benefit on the first day of hospital confinement for up to 365 days when you are confined to a hospital due to a covered accident. Hospital confinement must begin within 90 days from the date of the accident.

| $300 | $150 |

| HOSPITAL-intensive CARE (per day) |
We will pay this benefit for up to 30 days if you are injured in a covered accident and the injury causes you to be confined to a hospital intensive care unit. This benefit is payable in addition to the Hospital Confinement Benefit.

| $600 | $300 |
**Catastrophic Accident Elimination Period:**

- If a covered accident occurs, the certificate must remain in force for 90 days from the date of the accident.
- To be considered, the catastrophic loss must result in one of the following:
  - Death of the certificate holder
  - Disability of the certificate holder

**Covered Accident:**

- Occurs on or after the effective date, while the certificate is in force, and is not specifically excluded.

**Accidental Injury:**

- Caused solely by or as a result of a covered accident.

**Accidental Common Carrier Death Benefit:**

- Paid if the certificate holder is injured in a covered accident as a result of traveling as a fare-paying passenger on a common carrier and the injury causes death.
- If this benefit is paid and you later die as a result of the same covered accident, the Accidental Death Benefit will be paid instead.

**Accidental Death and Dismemberment:**

- Includes both inpatient and outpatient treatment for covered accidents.
- Benefits available for spouse and/or dependent children.
- Supplements and pays regardless of any other insurance programs.
- 24-Hour Coverage.

---

**Hospital Confinement (per day):**

- We will provide this benefit on the first day of hospital confinement for up to 365 days when you are confined to a hospital due to a covered accident. Hospital confinement must begin within 90 days from the date of the accident.

**Hospital Intensive Care (per day):**

- We will pay this benefit for up to 30 days if you are injured in a covered accident and the injury causes you to be confined to a hospital intensive care unit. This benefit is payable in addition to the Hospital Confinement Benefit.

**Medical Fees (for each accident):**

- If you are injured in a covered accident and receive treatment within one year after the accident, we will pay up to the maximum benefit amount for physician charges, emergency room services, supplies, and X-rays. Initial treatment must be received within 60 days after the accident.

**Paralysis (lasting 90 days or more and diagnosed by a physician within 90 days):**

- Quadriplegia: $10,000
- Paraplegia: $5,000

**Partial Amputation of finger(s) or toe(s) including at least one joint:**

- $100 for employee/spouse
- $250 for employee/spouse
- $62.50 for child

**Dismemberment:**

- If you are injured in a covered accident and lose a hand, foot or sight within 90 days after the accident, we will pay the appropriate Dismemberment Benefit shown.
- If this benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

**Partial Amputation of finger(s) or toe(s) including at least one joint:**

- $100 for employee/spouse
- $250 for employee/spouse
- $125 for child

---

**Benefits Overview:**

- Includes benefits for both inpatient and outpatient treatment of covered accidents.
- Benefits available for spouse and/or dependent children.
- Supplements and pays regardless of any other insurance programs.
- 24-Hour Coverage.

---

**Common Carrier:**

- Means an airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; or a railroad train which is licensed and operated for passenger service only; or a boat or ship which is licensed for passenger service and operated on a regular schedule between established ports.

**Accidental Death Benefit:**

- Paid if the certificate holder is injured in a covered accident as a result of traveling as a fare-paying passenger on a common carrier and the injury causes death.
- If this benefit is paid and you later die as a result of the same covered accident, the Accidental Death Benefit will be paid instead.

**Accidental-Death Benefit:**

- Paid if the certificate holder is injured in a covered accident and the injury causes death within 90 days after the accident.
- If you are injured in a covered accident and receive treatment within one year after the accident, we will pay up to the maximum benefit amount for physician charges, emergency room services, supplies, and X-rays. Initial treatment must be received within 60 days after the accident.

**Accidental-Death Benefit:**

- Paid if the certificate holder is injured in a covered accident and the injury causes death within 90 days after the accident.
- If you are injured in a covered accident and receive treatment within one year after the accident, we will pay up to the maximum benefit amount for physician charges, emergency room services, supplies, and X-rays. Initial treatment must be received within 60 days after the accident.

**Accidental Common Carrier Death**

- Paid if the certificate holder is injured in a covered accident as a result of traveling as a fare-paying passenger on a common carrier and the injury causes death.
- If this benefit is paid and you later die as a result of the same covered accident, the Accidental Death Benefit will be paid instead.

**Accidental-Death Benefit:**

- Paid if the certificate holder is injured in a covered accident and the injury causes death within 90 days after the accident.
- If you are injured in a covered accident and receive treatment within one year after the accident, we will pay up to the maximum benefit amount for physician charges, emergency room services, supplies, and X-rays. Initial treatment must be received within 60 days after the accident.

**Hospital Confinement (per day):**

- We will provide this benefit on the first day of hospital confinement for up to 365 days when you are confined to a hospital due to a covered accident. Hospital confinement must begin within 90 days from the date of the accident.

---

**Hospital Intensive Care (per day):**

- We will pay this benefit for up to 30 days if you are injured in a covered accident and the injury causes you to be confined to a hospital intensive care unit. This benefit is payable in addition to the Hospital Confinement Benefit.

**Medical Fees (for each accident):**

- If you are injured in a covered accident and receive treatment within one year after the accident, we will pay up to the maximum benefit amount for physician charges, emergency room services, supplies, and X-rays. Initial treatment must be received within 60 days after the accident.

**Paralysis (lasting 90 days or more and diagnosed by a physician within 90 days):**

- Quadriplegia: $10,000
- Paraplegia: $5,000

**Partial Amputation of finger(s) or toe(s) including at least one joint:**

- $100 for employee/spouse
- $250 for employee/spouse
- $62.50 for child

**Dismemberment:**

- If you are injured in a covered accident and lose a hand, foot or sight within 90 days after the accident, we will pay the appropriate Dismemberment Benefit shown.
- If this benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

**Partial Amputation of finger(s) or toe(s) including at least one joint:**

- $100 for employee/spouse
- $250 for employee/spouse
- $125 for child
sustains a Catastrophic Loss as the result of a covered accident; (2) is under the appropriate care of a physician during the Catastrophic Accident Elimination Period; and (3) Remains alive at the end of the Catastrophic Accident Elimination Period.

We will pay the applicable amount shown at the end of the Catastrophic Accident Elimination Period if any insured: (1) has suffered a Covered accident, which means an accident that occurs on or after the effective date, while the certificate is in force, and that is not specifically excluded.

Common carrier means an airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; or a railroad train which is licensed and operated for passenger service only; or a boat or ship which is licensed for passenger service and operated on a regular schedule between established ports.

If the Accidental Common Carrier Death Benefit is paid, we will not pay the Accidental-Death Benefit.

Accidental injury means bodily injury caused solely by or as the result of a covered accident.

Covered accident means an accident that occurs on or after the effective date, while the certificate is in force, and that is not specifically excluded.

<table>
<thead>
<tr>
<th>MAJOR INJURIES / FRACTURES / OPEN REDUCTION</th>
<th>HIGH</th>
<th>LOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip/Thigh</td>
<td>$6,750</td>
<td>$3,750</td>
</tr>
<tr>
<td>Vertebrae (except processes)</td>
<td>$6,075</td>
<td>$3,375</td>
</tr>
<tr>
<td>Pelvis</td>
<td>$5,400</td>
<td>$3,000</td>
</tr>
<tr>
<td>Skull (depressed)</td>
<td>$5,063</td>
<td>$2,813</td>
</tr>
<tr>
<td>Leg</td>
<td>$4,050</td>
<td>$2,250</td>
</tr>
<tr>
<td>Forearm / Hand / Wrist / Foot / Ankle / Knee cap</td>
<td>$3,375</td>
<td>$1,875</td>
</tr>
<tr>
<td>Shoulder blade / Collar bone / Lower Jaw (Mandible)</td>
<td>$2,700</td>
<td>$1,500</td>
</tr>
<tr>
<td>Skull (Simple) / Upper Arm / Upper Jaw</td>
<td>$2,363</td>
<td>$1,313</td>
</tr>
<tr>
<td>Facial bones (except teeth)</td>
<td>$2,050</td>
<td>$1,125</td>
</tr>
<tr>
<td>Vertebal Processes</td>
<td>$1,350</td>
<td>$750</td>
</tr>
<tr>
<td>Coccyx/Rib/Finger/Toe</td>
<td>$540</td>
<td>$300</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAJOR INJURIES / DISLOCATIONS / OPEN REDUCTION</th>
<th>HIGH</th>
<th>LOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip</td>
<td>$4,050</td>
<td>$2,025</td>
</tr>
<tr>
<td>Knee (not knee cap)</td>
<td>$2,925</td>
<td>$1,462.50</td>
</tr>
<tr>
<td>Shoulder</td>
<td>$2,250</td>
<td>$1,125</td>
</tr>
<tr>
<td>Foot/Ankle</td>
<td>$1,800</td>
<td>$900</td>
</tr>
<tr>
<td>Hand</td>
<td>$1,575</td>
<td>$747.50</td>
</tr>
<tr>
<td>Lower Jaw</td>
<td>$1,350</td>
<td>$675</td>
</tr>
<tr>
<td>Wrist</td>
<td>$1,125</td>
<td>$562.50</td>
</tr>
<tr>
<td>Elbow</td>
<td>$900</td>
<td>$450</td>
</tr>
<tr>
<td>Finger/Toe</td>
<td>$360</td>
<td>$180</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WELLNESS BENEFIT</th>
<th>HIGH</th>
<th>LOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ruptured Disc (treatment within 60 days; surgical repair within one year)</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Injury occurring during first certificate year</td>
<td>$400</td>
<td>$400</td>
</tr>
<tr>
<td>Injury occurring after first certificate year</td>
<td>$400</td>
<td>$400</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TENDONS/LIGAMENTS (within 60 days; surgical repair within 90 days)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If you tear, sever, or rupture a tendon or ligament in a covered accident, receive treatment from a doctor within 60 days, and have surgical repair within 90 days after the accident, we will pay the appropriate amount shown. The amount paid will be based on the number (single or multiple) of tendons or ligaments repaired.</td>
<td>$600 (Multiple)</td>
<td>$600 (Multiple)</td>
</tr>
<tr>
<td>If you fracture a bone or dislocate a joint in addition to tearing, severing, or rupturing a tendon or ligament, we will only pay one benefit. We will pay the largest of the fracture, dislocation, tendon, or ligament benefits.</td>
<td>$400 (Multiple)</td>
<td>$400 (Single)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TORN KNEE CARTILAGE (treatment within 60 days; surgical repair within one year)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury occurring during first certificate year</td>
<td>$100</td>
<td>$250</td>
</tr>
<tr>
<td>Injury occurring after first certificate year</td>
<td>$400</td>
<td>$400</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EYE INJURIES</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment and surgical repair within 90 days</td>
<td>$250</td>
<td>$125</td>
</tr>
<tr>
<td>Removal of foreign body, with or without anesthesia</td>
<td>$50</td>
<td>$25</td>
</tr>
<tr>
<td>CONCUSSION (a head injury resulting in electroencephalogram abnormality)</td>
<td>$400</td>
<td>$200</td>
</tr>
<tr>
<td>COMA (a state of profound unconsciousness lasting more than 30 days)</td>
<td>$10,000</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMERGENCY DENTAL (injury to sound natural teeth)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Repaired with crown</td>
<td>$150</td>
<td>$100</td>
</tr>
<tr>
<td>Resulting in extraction</td>
<td>$50</td>
<td>$25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BURNS (treatment within 72 hours and based on percent of body surface burned / First-degree burns are not covered.)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Second-Degree Burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10%</td>
<td>$180</td>
<td>$180</td>
</tr>
<tr>
<td>At least 10%, but less than 25%</td>
<td>$360</td>
<td>$360</td>
</tr>
<tr>
<td>At least 25%, but less than 35%</td>
<td>$900</td>
<td>$900</td>
</tr>
<tr>
<td>35% or more</td>
<td>$1,800</td>
<td>$1,800</td>
</tr>
</tbody>
</table>

- A fracture is a break in the bone which can be seen by X-ray. If you fracture a bone in a covered accident, and it is diagnosed and treated by a doctor, we will pay the appropriate amount shown.
- Dislocation means a completely separated joint. If you dislocate a joint in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the amount shown.
- We will pay no more than 150% of the benefit amount for the bone fracture or dislocated joint which has the higher dollar value. If you fracture a bone and dislocate a joint, we will pay for both, but no more than 150% of the benefit amount for the bone fractured or joint dislocated that has the higher dollar value.
- Open reduction is paid at 150% of closed reduction. Fracture and Dislocation benefits amounts for open reduction. See certificate schedule for closed reduction amounts.
- A chip fracture is a piece of bone which is completely broken off near a joint. Chip fractures are paid at 10% of the benefit shown.
- Partial dislocations are paid at 25% of the dislocation benefit.
**Lacerations** (treatment and repair within 72 hours)

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>2” to 5” long Laceration</td>
<td>$200</td>
<td>$100</td>
</tr>
<tr>
<td>Lacerations not requiring stitches</td>
<td>$25</td>
<td>$25</td>
</tr>
</tbody>
</table>

*Multiple Lacerations: We will pay for the largest single laceration requiring stitches.*

**Wellness Benefit** (per 12-month period)

While coverage is in force, we will pay this benefit for preventive testing once each 12-month period. Benefits include and are payable for annual physical exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, PSA tests, ultrasounds, and blood screenings.

**Ambulance**

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air Ambulance</td>
<td>$500</td>
<td>$250</td>
</tr>
<tr>
<td>First-Responder Service</td>
<td>$1,500</td>
<td>$750</td>
</tr>
</tbody>
</table>

**Blood/Plasma**

If you receive blood or plasma within 90 days following a covered accident, we will pay the amount shown.

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>$400</td>
<td>$200</td>
</tr>
</tbody>
</table>

**Appliances**

We will pay this benefit when you are advised by a physician to use a medical appliance due to injuries received in a covered accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces, and walkers.

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appliances</td>
<td>$100</td>
<td>$50</td>
</tr>
</tbody>
</table>

**Internal Injuries**

We will pay this benefit if you have internal injuries as the result of a covered accident which results in open abdominal or thoracic surgery.

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Injuries</td>
<td>$1,200</td>
<td>$750</td>
</tr>
</tbody>
</table>

**Accident Follow-Up Treatment** (maximum 6 visits)

We will pay this benefit for up to six treatments per covered accident, per insured for follow-up treatment. The insured must have received initial treatment within 72 hours of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Follow-Up Treatment</td>
<td>$50</td>
<td>$35</td>
</tr>
</tbody>
</table>

**Exploratory Surgery** (e.g., arthroscopy)

We will pay the amount shown in if a covered accident causes you to have exploratory surgery (without repair). The exploratory surgery must be required as the result of an injury.

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploratory Surgery</td>
<td>$400</td>
<td>$200</td>
</tr>
</tbody>
</table>

**Prosthesis**

If you require the use of a prosthetic device due to injuries received in a covered accident, we will pay this benefit. Hearing aids, wigs, or dental aids, including but not limited to false teeth, are not covered.

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthesis</td>
<td>$1,000</td>
<td>$500</td>
</tr>
</tbody>
</table>

**Physical Therapy** (maximum 6 visits)

We will pay this benefit for up to six treatments per covered accident, per insured for treatment from a physical therapist. The insured must have received initial treatment within 72 hours of the accident, and physical therapy must begin within 30 days of the covered accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td>$75</td>
<td>$50</td>
</tr>
</tbody>
</table>

**Transportation**

If hospital treatment or diagnostic study is recommended by your physician and is not available in your city of residence, we will pay the amount shown. Transportation must begin within 90 days from the date of the covered accident. The distance to the hospital must be greater than 50 miles from your residence.

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>$300 (train/plane)</td>
<td>$150 (train/plane)</td>
</tr>
<tr>
<td></td>
<td>$300 (bus)</td>
<td>$150 (bus)</td>
</tr>
</tbody>
</table>

**Family Lodging Benefit** (per night)

If you are required to travel more than 100 miles from your home for inpatient treatment of injuries received in a covered accident, we will pay this benefit for an immediate adult family member’s lodging. Benefits are payable up to 30 days per accident and only while you are confined to the hospital. The treatment must be prescribed by your local physician.

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Lodging Benefit</td>
<td>$100</td>
<td>$50</td>
</tr>
</tbody>
</table>

**Major Diagnostic Testing**

If a covered person requires one of the following exams for Injuries sustained in a covered accident and a charge is incurred, we will pay the amount shown for the following exams: CT (computerized tomography) scan; MRI (magnetic resonance imaging); or EEG (electroencephalogram).

These exams must be performed in a Hospital, a Physician’s office, or an Ambulatory Surgical Center. The Insured must incur a charge for the exam. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Diagnostic Testing</td>
<td>$400</td>
<td>$200</td>
</tr>
</tbody>
</table>

**Rehabilitation Unit**

We will pay this benefit when a covered person is confined in a Hospital and is transferred to a bed in a Rehabilitation Unit of a Hospital for a covered injury for each day you are charged for a room. This benefit is limited to 50 days for each insured per Period of Confinement and is limited to a calendar year maximum of 60 days. No lifetime maximum. Limitation - The Hospital Confinement benefit and the Rehabilitation Unit benefit will not be paid on the same day, only the highest eligible benefit will be paid.

<table>
<thead>
<tr>
<th>Description</th>
<th>Before 1/1/2005</th>
<th>After 12/31/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Unit</td>
<td>$150 per day</td>
<td>$75 per day</td>
</tr>
</tbody>
</table>
GO ONLINE AND MAKE IT OFFICIAL

ONLINE ENROLLMENT MADE EASY

Once you’ve studied your options and made your selections, it’s time to let us know about them.

HERE’S HOW YOU GET THERE.

1. Log into myHISD.
2. Click the Benefits heart icon. This takes you to HISDBenefits.org.
3. Click Enrollment at the top of the page.
4. Click Enroll Now on the left-hand side and then follow the instructions.

REMINDER

ANNUAL ENROLLMENT DATES
November 1-19, 2021

Don’t miss the deadline. Online enrollment ends at 11:00 p.m. CT and phone enrollment ends at 7:00 p.m. CT on November 19, 2021.
FOR NEW EMPLOYEES
If you’re a new employee, look for your benefits enrollment email from a benefit administrator on the Friday following the date that you are entered in the HISD HR system. You must enroll within 30 days of your hire date or you will need to wait until the next Annual Enrollment period or until you experience a qualifying life event. After you successfully enroll, you will receive a confirmation notice.

DEPENDENT VERIFICATION
It’s important you understand who can and can’t be considered a dependent on your plan. Documentation is required to support the eligibility status of each of your dependents. If you don’t provide it, your dependents will be removed from your coverage, regardless of their eligibility, and you won’t be able to add them back on until the next enrollment period or in the case of a life event. For more information about dependent eligibility, see HISDBenefits.org.
Your HISD medical plan includes benefits, programs, and services that can help you and your family live healthier lives and save money. Get to know what’s available and take advantage of them to reach your wellness goals.

### Preventive Care Covered at 100%

Routine preventive care is one of the keys to good health. Even if you are in the best shape of your life, a serious condition with no symptoms could put your health at risk. By getting preventive care, you and your doctor can catch problems early and prevent certain conditions altogether.

HISD follows the American Medical Association’s guidelines for preventive care. They define preventive care as services provided when you do not have any symptoms and have not been diagnosed with a health issue connected with a preventive service. Examples are mammograms, prostate exams, and colonoscopies. Preventive care that meets the AMA’s guidelines is covered at 100%.

If your doctor determines that you have a health issue, any additional screenings and tests after your diagnosis are not considered preventive. These services are covered at the appropriate coinsurance once you have met the deductible.

### Your Primary Care Doctor: Your Partner in Good Health

Preventive care is typically provided during a wellness exam with your primary care doctor (PCP). He or she can tell you which routine preventive tests and screenings are right for you based on your age, gender, personal and family health history, and current health status.

If you enroll in the Texas Medical Neighborhood Network ACO plan, you will be required to select a network PCP, but you may change it at any time. The Memorial Hermann ACO Network plan and the Kelsey-Seybold ACO Network plan do not have this requirement, but we encourage you to select a PCP.

**Why is this important? Your PCP is your first stop for care. He or she:**

- Gets to know your goals and health history
- Provides preventive and basic care
- Can help you find a specialist when needed
- Can help coordinate services with other providers
FREE MEDICAL CARE AT HISD EMPLOYEE HEALTH & WELLNESS CENTERS
OPERATED BY NEXT LEVEL MEDICAL

If you are enrolled in a HISD medical plan, you and your covered dependents ages 5 and up pay nothing for your medical care at the HISD Employee Health & Wellness Centers. If you are eligible for benefits but not enrolled in an HISD medical plan, you can still use the centers for $65 per visit plus any applicable lab fees.

With two onsite locations, the centers provide a great alternative to high-cost emergency centers or urgent care facilities for low-cost, non-emergency services, including:

• Preventive care and limited chronic conditions
• Limited immunizations (for example; FLU, Tetanus)
• Acute and urgent care for infections, minor burns, and more

Please note: The centers do NOT treat workers’ compensation injuries.

In addition to these onsite clinics, medical plan members and their covered dependents can visit one of the select Next Level centers under contract with HISD for a flat fee of $20. Kelsey Select ACO Plan members and covered dependents can access these centers at no cost.

SAVINGS ON LAB WORK WITH QUEST AND LABCORP

You can save big on lab services with Quest Diagnostics and LabCorp, Aetna’s preferred national labs. Here’s how:

• If your doctor is collecting your sample in the office, ask that it be sent to a Quest or LabCorp lab.
• If your doctor is sending you to a lab for the testing, ask for a lab requisition for Quest or LabCorp lab.
• Please remember, if you are in the Kelsey plans, you cannot use Quest Labs; you must use the lab facility in the Kelsey clinics (LabCorp)

It’s easy to find a lab near you. Just log in to Aetna.com and click “Find Care & Pricing” on the home page. Register first if you have not already. Or you can call Aetna Member Services at 1-877-224-6857. You can save on wait time and schedule an appointment ahead of time by visiting QuestDiagnostics.com or LabCorp.com.
HISD Employee HEALTH & WELLNESS CENTERS by next level

HISD Health and Wellness Centers are now operated by Next Level Urgent Care.
These convenient clinics make it easy for benefits-eligible employees and covered dependents to receive urgent care close to where they work. Walk-in patients are welcome, but we recommend booking an appointment on the Next Level app or by calling 281-869-3630.

CONVENIENT MEDICAL CARE FOR EMPLOYEES AND COVERED DEPENDENTS

- URGENT CARE
- SPORTS PHYSICALS
- HEADACHES
- RASHES
- SPRAINS & STRAINS
- LACERATIONS
- URINARY TRACT INFECTIONS
- LABS
- FLU SHOTS
- WELLNESS PHYSICALS
- PRIMARY CARE

PERSONAL, HIGH-QUALITY MEDICAL CARE

HISD Employee Health & Wellness Centers are here for most of your day-to-day health care and wellness exams. Even better, if you’re enrolled in an HISD medical plan, you can use these services at no cost to you. That also includes care for your covered dependents, age 5 and older.

If you’re eligible for HISD health care benefits but not enrolled in the HISD medical plan, you can still use the centers for just $65-$125 per visit, plus any additional lab fees.

NOTE: THE CENTERS DO NOT TREAT WORKERS’ COMPENSATION INJURIES.

TO MAKE AN APPOINTMENT ONLINE:

GET THE NEXT LEVEL APP
- CLICK THE MENU IN UPPER LEFT CORNER
- CLICK “SCHEDULE APPOINTMENT”
- SELECT HISD CLINIC AND FOLLOW INSTRUCTIONS

HATTIE MAE WHITE EDUCATIONAL SUPPORT CENTER
4400 West 18th Street, Houston, Texas 77092
281-869-3630
Monday: 7 a.m. to 4 p.m.
Tuesday–Thursday: 9 a.m. to 6 p.m.
Friday: 7 a.m. to 4 p.m.
Saturday: 8 a.m. to 12 p.m.

ATTucks MIDDLE SCHOOL
4330 Bellfort Street, Houston, Texas 77051
(located off Ferdinand — SW side of campus)
281-869-3630
Monday: 7 a.m. to 4 p.m.
Tuesday–Wednesday: 9 a.m. to 6 p.m.
Thursday: 9 a.m. to 1 p.m.
Friday: 7 a.m. to 4 p.m.

BOTH CENTERS CLOSE DAILY FROM 1 TO 2 P.M.

NEXTLEVELURGENTCARE.COM/HISD

76 HISDBENEFITS.ORG
URGENT CARE SERVICES
16 LOCATIONS TO SERVE YOU

OPEN UNTIL 9 P.M. | 7 DAYS A WEEK!

NO COST TO SELECT PLAN MEMBERS

$20 FOR MEMBERS ENROLLED IN AN HISD MEDICAL PLAN

COMMON CONDITIONS WE TREAT
EAR INFECTIONS • COLD/FLU
COUGH/SORE THROAT • MINOR BURNS
LACERATIONS • RASH/SKIN INFECTIONS
SPRAINS • BROKEN BONES
DEHYDRATION • STDs

3 WAYS TO GET IN LINE

CALL 281-783-8162
FOR A LIST OF LOCATIONS OR TO GET IN LINE ONLINE: NEXTLEVELURGENTCARE.COM
TEXT “NLUCAPP” TO 313131 TO DOWNLOAD THE APP

WE ALSO TAKE WALK-INS!

HISD

3WAYS TOGETINLINE

CALL 281-783-8162
FOR A LIST OF LOCATIONS OR TO GET IN LINE ONLINE: NEXTLEVELURGENTCARE.COM
TEXT “NLUCAPP” TO 313131 TO DOWNLOAD THE APP

WE ALSO TAKE WALK-INS!

HISD

3WAYS TOGETINLINE

CALL 281-783-8162
FOR A LIST OF LOCATIONS OR TO GET IN LINE ONLINE: NEXTLEVELURGENTCARE.COM
TEXT “NLUCAPP” TO 313131 TO DOWNLOAD THE APP

WE ALSO TAKE WALK-INS!

HISD
YOUR SECURE MEMBER WEBSITE AT AETNA.COM

Your secure member website is your one stop for benefits and health information, tools, and wellness resources. Log in to check on a claim payment, find network providers, get started with your member discounts, and much more. You can also take a Health Assessment to learn more about your current state of health, any risk factors, and steps you can take to avoid health problems and live well.

If you are already registered with the site, you can use your current login. If you are not registered with the site or you are new to Aetna, you can register and create your login once you’re an enrolled member. Just visit Aetna.com and click Individuals> Login> Don’t Have an Account? > Register.

You can also get the Aetna Health app to use the best features of the site wherever you go. Look for network providers, find an urgent care center, make a doctor’s appointment, get cost estimates, and more. You can download the app at the App Store or Google Play.

HEALTH AND WELLNESS PROGRAMS AND SERVICES

Your 2022 medical plan also includes these no-cost programs and services:

Try the Aetna Maternity Program for a healthier pregnancy and healthy baby. This program provides personal support from a trained OB/GYN nurse to help you make choices for a healthy pregnancy, lower your risk for early labor, cope with postpartum depression, and even stop smoking.
Baby love

Aetna Maternity Program
Everything for a healthy pregnancy

Exciting changes are coming your way. And with the Aetna Maternity Program, you can count on us to help you have a healthy pregnancy. The program is included in your Aetna® plan. So rest assured, you’re getting support and resources at no extra cost to you.

Getting started is easy
All you have to do is sign up at aetna.com and answer a few questions. This helps us get to know you a little better. To learn more and sign up, you can:

• Call us at 1-800-272-3531 (TTY: 711) weekdays from 8 a.m. to 7 p.m. ET.
• Log in to your member website at aetna.com and look under “Stay Healthy.”

You’ll learn about what to expect before and after delivery, early labor symptoms, newborn care and more.

We can also help you:
• Make choices for a healthy pregnancy
• Lower your risk for early labor
• Cope with postpartum depression
• Stop smoking

Enroll early and receive a reward when you sign up by the 16th week of pregnancy.
Extra help for at-risk pregnancies

Personalized nurse support
If you have a health condition or other risk that could affect your pregnancy, we can help. Our nurse case managers will work with you to manage or maybe even lower those risks.

Helping you deliver at the right time
In most cases, full-term babies have fewer health problems than preterm babies. So if you’re at risk for early labor, we’ll explain the signs and symptoms and help you lower those risks. We’ll also talk about treatment options.

Visit the Maternity Support Center
This no-cost resource is available through your member website and offers information about the maternity journey. Whether you are planning for baby, already pregnant or postdelivery, it is personalized for you. It’s where you can find:

- Prepregnancy checklists
- Coverage details, like ultrasound costs
- Breastfeeding and postpartum support
- Baby-care tips

Ready to get started?
Log in to your member website at aetna.com today.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).
This information is not intended to replace the advice of a doctor. Aetna is not responsible for the decisions you make based on this information. If you have specific health care needs or would like more complete health information, please see your doctor or other health care provider. For more information about Aetna® plans, refer to aetna.com.
Telemedicine – at your fingertips – no need to leave work or home. We have two telemedicine plans to meet the needs of all plan participants.

For Kelsey plan participants. Kelsey-Seybold has telemedicine visits available. You can visit their website at Kelsey-Seybold.com and sign in to your MyKelseyOnline portal. From there, you can schedule a video visit by clicking on the Schedule an Appointment tab at the top of the page. This will take you to a selection of visit types. Select E-Visit and enter your information. Not all visits can be addressed through a video appointment. There are copays required for Kelsey Telemedicine visits. Please see additional information in the Benefits Guide for 2022 or online through www.hisdbenefits.org.

For Memorial Hermann and Texas Medical Neighborhood participants. CareAccessLive is a virtual care platform that lets Aetna Memorial Hermann ACO and Texas Medical Neighborhood plan members securely text with a doctor any day, any time. This service is not available to Kelsey-Seybold ACO plan members or Kelsey Select ACO members, as Kelsey-Seybold has its own plan features (see below). The CareAccess Live app allows you to connect to easy, quality care from your phone or computer. The next time you have a non-emergency medical question, try using the CareAccess Live app to securely text with a doctor. There is a $0 member cost share, doctors are available 24/7, and you can talk for as long as you need to. Just download the app from the App Store or Google Play or visit www.careaccesslive.com to sign up and begin texting with a doctor in seconds.
Talk to a registered nurse anytime

With the 24-Hour Nurse Line, you can speak to a registered nurse about health issues — whenever you need to.*

Plus:
• It’s toll-free.
• You can call as many times as you need — at no extra cost.
• Your covered family members can use it, too.

*While only your doctor can diagnose, prescribe or give medical advice, the 24-Hour Nurse Line can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

More reasons to use the 24-Hour Nurse Line

You can:
• Get information on a wide range of health and wellness topics
• Make better health care decisions
• Find out more about a medical test or procedure
• Get help preparing for a visit to your doctor
• Receive emails with links to videos that relate to your question or topic

Your online source for health information

Prefer to go online for health information? Check out the 24-Hour Nurse Line page on your member website.

Here’s what you can do:
• Send us an email
• Use our symptom checker.
• Learn about treatment options and health risks.
• Research medications.

It explains things in terms that are easy to understand.

You could save time, money and a trip to the ER

The 24-Hour Nurse Line can provide helpful information and possibly prevent an unneeded trip to the emergency room (ER). That can be a money-saver.

Plus, you’ll be able to make smarter health decisions. You’ll have reliable information you can trust — and it’s only a phone call or click away.

Get the information you need

We asked our members what they liked about the 24-Hour Nurse Line.* Here’s what they said:

• 93 percent said it has improved their satisfaction with the plan.
• 95 percent said this program was an important part of their health plan benefits.

Two ways to get health information fast

1. Call a registered nurse anytime, toll-free.
2. Visit your member website at AetnaStudentHealth.com

Get health information — when and where you need it.

Call 1-800-556-1555 (TTY: 711).*

Or log in at AetnaStudentHealth.com

THIS IS NOT INSURANCE. THIS IS A PROGRAM AVAILABLE WITH THE MEDICAL PLAN.

*Ask the relay operator to dial 1-800-556-1555 and select the option to speak to a nurse.


Student health insurance plans are insured by Aetna Life Insurance Company (Aetna). In MD and NJ, student medical insurance is insured by Aetna Health and Life Insurance Company (AHLIC). Self-insured plans are funded by the applicable school and administered by Aetna Life Insurance Company. Aetna Student Health™ is the brand name for products and services provided by Aetna Life Insurance Company, Aetna Health and Life Insurance Company and their affiliates.

This material is for information only. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Health benefits and health insurance plans contain exclusions and limitations. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna Student Health plans, refer to AetnaStudentHealth.com.

Policy forms issued in Missouri include: AL SH HPoI-H 02.
The Informed Health® Line is a 24/7 service that puts you in touch with a nurse who can answer questions and provide information on a wide variety of health-related topics. Learn more about a medical diagnosis. Ask about the latest tests and treatments. Get help with a non-emergency problem until you can see a doctor.

Feel better

Aetna® Behavioral Health AbleTo support
Here for you when you need it

Manage life’s changes

Some life events can be overwhelming. Like having a baby. Or finding out you have diabetes or heart disease.

You may also feel emotions like:

- Worry
- Depression
- Confusion
- Anger

All of these feelings are normal. But they can make it harder for you to take control and make healthy changes. And it’s important to feel you can control the health condition or life change, instead of it controlling you.

In Idaho, health benefits and health insurance plans are offered and/or underwritten by Aetna Health of Utah Inc. and Aetna Life Insurance Company. For all other states, health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health of California Inc., Aetna Health Insurance Company of New York, Aetna HealthAssurance Pennsylvania Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Utah and Wyoming, by Aetna Health of Utah Inc. and/or Aetna Life Insurance Company. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.
AbleTo is a confidential program that lets you talk by phone with a therapist twice a week. The program is designed to provide help with issues such as grief and loss, depression and anxiety, caregiver stress, dealing with a new or continuing health condition, cancer recovery, and more.

Real help that fits your schedule
The AbleTo program can help you:
- Work through these normal emotions
- Understand and stick with your treatment plan
- Know the types of changes you need to make
- Feel like you are in control of your health and your life

AbleTo is part of your Aetna membership. But it’s not like traditional programs. It makes it easy to get the help you need.

Support when and where you need it
We’ve teamed up with AbleTo, a leading behavioral health care provider, to offer this convenient program. The goal is to make it easy for you to complete the program. And to help you see that you are in control and can make healthy changes.

Real help that works
Meet face-to-face with a therapist and behavior coach using online video. Or you can simply talk on the phone, if you prefer.

This removes the time and hassle of driving to appointments.

Plus, you choose the times that work best for you. During the day, in the evening or on weekends.

You’ll work with two AbleTo specialists for eight weeks
- Once a week with a therapist to address emotional challenges like depression, stress and anxiety that can come with a medical diagnosis
- Once a week with a behavior coach to identify health goals and develop an action plan

That's two sessions a week, including a final meeting with your therapist. And it’s all part of your Aetna membership.

Consider AbleTo support if you have experienced one of these health conditions or life changes:
- Infertility
- Digestive health issues
- Postpartum depression
- Breast or prostate cancer recovery
- Pain management
- Caregiving stress (child, elder or autism)
- Heart issues
- Breathing problems
- Grief and loss
- Diabetes
- Alcohol or substance use disorder
- Military transitions
- Depression, anxiety or panic
Convenient eight-week program
with counseling and coaching by video or phone.
Just call AbleTo at 1-844-330-3648.

It’s easy to get started

If your claims data shows you would benefit from this program, an Aetna or AbleTo representative will call you to explain how it works and how it can help you. In most cases, there is no cost to you.*

You'll be asked to confirm some information for privacy purposes.

95% of AbleTo graduates recommend the program to others.†

Choose AbleTo support and get real help that fits your schedule. Just call 1-844-330-3648 or contact your Aetna case manager.

Or you can let us know you're interested in participating by calling AbleTo at 1-844-330-3648, Monday-Friday from 9 AM-8 PM ET. You can ask questions, and an AbleTo staff member will ask you some screening questions.

You can also tell your Aetna case manager that you'd like to participate.
Member discounts save you and your family money on health-related products and services. As an Aetna member, you will be able to take advantage of special rates on vision and hearing care, fitness memberships and equipment, health coaching, natural products and services, oral health products, and more.

Fitness discounts
A little help reaching your best health

No stopping you
Every time you take the stairs, eat a healthy snack or kick a bad habit, your body gets stronger. Now here’s some motivation to keep up the good work: good savings.

With your Aetna plan, you get discounts on gym memberships, health coaching and much more through LifeMart®.

Built-in plan discounts with no referrals, claims or limits. Your family can use them, too.
Healthy lifestyle discounts

Save on gym memberships, health coaching, fitness gear and nutrition products that support a healthy lifestyle. You also save on:

- Wearables
- Yoga, meditation and wellness programs
- Group fitness on demand

Even more savings

If you’d like to work toward your fitness goals at home, you’ll love these savings.

One-on-one health coaching
Get support to lose weight, ease stress and more.

Online group fitness sessions
Try a class on your schedule, in private, with online, on-demand fitness sessions.

At-home weight-loss programs
Get weight-loss tips and menus and track progress from the privacy of your home.

How to get started
Log in to aetna.com and look for the “Stay Healthy” tab.

You’ll find discounts on fitness and much more.

Through our partnership with LifeMart, you can also save on thousands of products and services including health and wellness products, tickets, car rentals and coupons.

LifeMart is a registered trademark of LifeCare, Inc.

THIS IS NOT INSURANCE. THIS IS A DISCOUNT PROGRAM ONLY.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company, Aetna HealthAssurance Pennsylvania Inc. and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Utah and Wyoming, by Aetna Health of Utah Inc. and Aetna Life Insurance Company. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.

This material is for information only. Discount offers are available to people who have health benefits plans that are issued, administered or serviced by Aetna or our affiliates. Discount offers provide access to discounted services and are not part of an insured plan or policy. Discount offers are rate-access offers and may be in addition to any plan benefits. Check any insurance benefits you have before using these discount offers, as those benefits may result in lower costs to you than using these discounts. Discount offers are not guaranteed and may be discontinued at any time. Aetna makes no payment to the discount vendor. You are responsible for the full cost of the discounted services. Aetna does not endorse any vendor, product or service associated with these discount offers. Vendors are independent of Aetna, not agents or employees. Programs, products and services may not be available at all times. Certain offers may not be available in some states. Products may be subject to a warranty from the manufacturer. Aetna makes no representations or warranties, and disclaims all product warranties. Aetna has no liability for providing or guaranteeing service and assumes no liability for the quality of service rendered. Aetna may receive a percentage of the fee paid to a discount vendor. Information is believed to be accurate as of the production date; however, it is subject to change.
Your digital tools

The Aetna Health℠ app and Aetna® member website

Personalized tools make your plan easier to use.

Connect to care
Find in-network providers, facilities and procedures near you. And you’ll get personalized search results based on your health benefits and insurance plan. You can even get cost estimates for visits and procedures before you go.

Manage claims
You can pay claims and view up to two years of claims details for your whole family. Filter by member, provider, facility, service or date.

Get proactive with your health
You’ll get simple, personalized health actions recommended to you, based on your unique profile. This could include a reminder to get a shot when there’s a flu outbreak near you. Or a reminder that a preventive doctor’s visit can help you stay on top of your health and well-being.

Seamlessly connect with care and manage benefits — at home or on the go.

In Idaho, health benefits and health insurance plans are offered and/or underwritten by Aetna Health of Utah Inc. and Aetna Life Insurance Company. For all other states, health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health of California Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company, Aetna HealthAssurance Pennsylvania Inc. and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Utah and Wyoming, by Aetna Health of Utah Inc. and Aetna Life Insurance Company. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.
Take charge of your benefits

With the Aetna Health app and the Aetna member website, you can:

View your health plan summary and get detailed information about what’s covered

View claim details and pay claims for your whole family

Search for providers, procedures and medications

Get cost estimates before you get care

Track spending and progress toward meeting the deductibles for you and your family

Access your ID card whenever you need it

Get recommended health actions based on your profile

Once you’re a member, here’s how you can connect:

Your Aetna member website

Go to Aetna.com to create an account and log in to your member website.

The Aetna Health app

Get the Aetna Health app by texting “GETAPP” to 90156 for a link to download the app and create an account. Message and data rates may apply.*

*Terms and conditions: Bit.ly/2nJFYG. Privacy policy: Aetna.com/legal-notices/privacy.html. By texting 90156, you consent to receive a one-time marketing automated text message from Aetna with a link to download the Aetna Health app. Consent is not required to download the app. You can also download it from the App Store® or the Google Play™ store.

Apple® and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc. Android™ and Google Play are trademarks of Google LLC.

Program features and availability may vary by location and are subject to change. This material is for information only. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Health benefits and health insurance plans contain exclusions and limitations. Estimated costs not available in all markets. The tool provides an estimate of what would be owed for a particular service based on the plan at that very point in time. Actual costs may differ from an estimate if, for example, claims for other services are processed after the estimate is provided but before the claim for this service is submitted. Or if the doctor or facility performs a different service at the time of the visit. Health maintenance organization (HMO) members can only look up estimated costs for doctor and outpatient facility services. Information is believed to be accurate as of the production date; however, it is subject to change. Refer to Aetna.com for more information about Aetna® plans.
As a reminder, you have access to free benefits available through our Employee Assistance Program (EAP). Our EAP provider is ComPsych, and their GuidanceResources® program is a network of services that can help you improve your mental, physical and financial health, achieve more at work and home, and handle many personal or professional challenges you face. The program is an award-winning, comprehensive, interactive service that provides unique tools to assist you in every aspect of your life.

ComPsych’s GuidanceResources® are provided free of charge and offer someone to talk to when you need them, as well as resources to consult for a variety of expert content. These services are strictly confidential, and they are available to you and your household members 24 hours a day, seven days a week, either by phone or online.

**Take advantage of these valuable resources, which include:**

- Confidential emotional support with eight free counseling sessions per member, per issue, per year
- Financial resources
- Legal guidance
- Unlimited work-life solutions
- Online support

ComPsych’s GuidanceResources® EAP offers scheduled chat sessions and 24/7 counselor texting capabilities alongside existing video and telephonic modalities.

During the intake process, the GuidanceConsultant (GC) administers a comprehensive assessment and determines the level of risk or presenting issue. If the GC determines that digital counseling may be appropriate based on the presenting issue, the GC will gauge the member’s comfort level with that technology and provide a referral. The member will receive a chat counseling invite via email which will take them to the chat platform to schedule their appointment at a time/date of their preference.
GET IT TOGETHER

It can be hard to figure out how all the pieces of your life fit together. Your GuidanceResources program can help. The program is provided free of charge and offers someone to talk to and resources to consult whenever and wherever you need them. Call us anytime, 24 hours a day, seven days a week, for confidential help.

WE HAVE THE SOLUTIONS YOU NEED.

Call: 833.812.5181
TTY: 800.697.0353
Online: guidanceresources.com
App: GuidanceNow SM
Web ID: HISD

AVAILABLE 24/7
Eligible HISD employees are automatically enrolled

Mandatory Contribution: 8.65% from each paycheck
Before Tax: 8.0% is applied to your membership account (tax deferred; refundable upon resignation)
After Tax: 0.65% is applied to a general insurance fund (non-refundable)

Your Responsibilities as a TRS Member

1. Keep your mailing address current: Annual statement of account, newsletters, election ballots, information brochures, and other important communications are mailed.

2. Notify TRS of name changes: Written notification is required.

3. Keep your Beneficiary Designation current: Your beneficiary designation instructs TRS on how to distribute your benefits upon your death. Review your beneficiary designation when significant life events occur such as marriage, divorce, birth of a child, death of a spouse or designated beneficiary, or if the beneficiary becomes eligible for Medicaid or other “needs-based” assistance programs.

IT IS NEVER TOO LATE TO START SAVING!
Some retirement savings is better than no retirement savings. Choose a provider and open an account today.

HAVE QUESTIONS?
Attend the Retirement Storefront Choice Session to learn more.
Contact HISD Benefits Support
Ph: 713-695-5561
Fax: 713-695-5723

Manage your TRS account online at TRS.Texas.gov

TRS is a governmental, tax-exempt benefit retirement plan. This pension trust fund provides service and disability retirement, as well as death and survivor benefits, to eligible Texas public education employees and their beneficiaries.
VOLUNTARY RETIREMENT SAVINGS PLANS: 403(B) AND 457

VISIT THE HISD RETIREMENT STOREFRONT WEBSITE

For a list of providers, enrollment details, and voluntary retirement plan information.

How to visit the website
1. Log into myHISD
2. Scroll down to Employee Resources
3. Click on the “403(b)/457 Plan administration” link

What is a 403(b) or 457 retirement plan?
All active HISD employees are eligible to voluntarily participate in the 403(b) and 457 retirement plans sponsored by the district, which are like a 401(k). Both type of plans allows for tax deferred growth, meaning more money can accumulate without paying taxes on the interest or growth each year.

How does a 403(b) and 457 Plan work?
HISD employees voluntarily elect to set aside pre-tax money from their paychecks to save for retirement. HISD sends the money directly to the employee’s chosen financial institution. Each employee chooses the account type that’s right for them, including interest bearing or equity (stock market) accounts. The money grows without paying taxes (tax deferred) until withdrawal, preferably after retirement.

Who may contribute to the 403(b) and 457 Plan?
You may choose to contribute to the 403(b) or 457 plan or both. Voluntary retirement plans are funded by employee contributions only. No contributions are made by the district.

How do I choose a provider?
Each provider and each product is different so it’s important to understand how the 403(b)/457 contract works. Know the costs to get ‘in and out’ of the contract. Ask questions to understand multiple options (not just the one sold by the representative). You should receive clear answers to your questions and know what’s happening with your money.

WHICH IS BETTER – A 403(B) OR A 457 PLAN?
Speak with your provider(s) for details on which plan best suits your personal financial goals and circumstances. Plan features provided here may not be offered by all provider contracts.
## HISD Voluntary Retirement Plan Comparison Table 2022

<table>
<thead>
<tr>
<th></th>
<th>403(b)</th>
<th>457</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Eligibility</td>
<td>All Employees</td>
<td>All Employees</td>
</tr>
<tr>
<td>Number of Providers</td>
<td>33</td>
<td>3</td>
</tr>
<tr>
<td>Pre-Tax Contribution</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tax Deferred Interest and Earnings</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>After-Tax Roth Contributions*</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Minimum Contribution Requirement</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Contribution Limit: Under Age 50</td>
<td>$20,500</td>
<td>$20,500</td>
</tr>
<tr>
<td>Contribution Limit: Age 50 and Over</td>
<td>$27,000</td>
<td>$27,000</td>
</tr>
<tr>
<td>Loan Availability</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IRS 10% Excise Tax (Early Withdrawal Penalty) ***</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Unrestricted In-Service Distribution Age (For withdrawal by active employees)</td>
<td>59 ½</td>
<td>70 ½</td>
</tr>
</tbody>
</table>

*The after-tax Roth feature is offered in the HISD 403(b) but not in the 457. Contributions to a Roth 403(b) are after-tax, and the interest & investment returns are tax free upon withdrawal when two conditions are met:
- Participant is at least age 59 ½
- Roth 403(b) has been open at least 5 years

**If employed at HISD and under age 59 ½, withdrawals are called “hardship distributions”.

***Withdrawals from the 403(b) by separated employees under age 59 ½ may be subject to an IRS 10% early withdrawal penalty. Please contact a financial advisor for more information or visit the HISD Benefits portal.

### How do I access my 403(b) or 457 retirement money?

Active employees under age 59 ½ have limited access to 403(b)/457 plan money. Taking a retirement plan loan is usually the first option to access the funds. Many providers offer loans, some do not.

Active employees may not withdraw funds from a 457 plan until age 70 ½. Instead, active employees may access funds through loans and unforeseeable emergency withdrawals based on IRS rules.

Penalty-free distributions from a 403(b) may occur under certain circumstances. Please see a financial advisor or visit the HISD Benefits portal.

Special provisions have been made for distributions related to COVID-19, according to section 2202 of the CARES ACT.
### Medical Plans

<table>
<thead>
<tr>
<th></th>
<th>Kelsey Basic ACO</th>
<th>Memorial Hermann Basic ACO</th>
<th>TX Medical Neighborhood Basic</th>
<th>Kelsey Plus ACO</th>
<th>Memorial Hermann Plus ACO</th>
<th>TX Medical Neighborhood Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$19.25</td>
<td>$21.18</td>
<td>$33.59</td>
<td>$38.79</td>
<td>$42.67</td>
<td>$67.63</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$100.19</td>
<td>$110.21</td>
<td>$174.68</td>
<td>$135.25</td>
<td>$148.78</td>
<td>$225.32</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$96.37</td>
<td>$106.01</td>
<td>$168.05</td>
<td>$130.10</td>
<td>$143.11</td>
<td>$217.47</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$173.26</td>
<td>$190.60</td>
<td>$302.12</td>
<td>$233.90</td>
<td>$257.30</td>
<td>$365.43</td>
</tr>
</tbody>
</table>

### Dental Plans

<table>
<thead>
<tr>
<th></th>
<th>HMO Plus</th>
<th>PPO</th>
<th>PPO BUYUP</th>
<th>Discount Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$6.90</td>
<td>$18.68</td>
<td>$20.71</td>
<td>$2.50</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$13.13</td>
<td>$37.01</td>
<td>$41.03</td>
<td>$5.00</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$13.13</td>
<td>$36.92</td>
<td>$40.93</td>
<td>$5.00</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$16.87</td>
<td>$57.75</td>
<td>$64.02</td>
<td>$5.00</td>
</tr>
</tbody>
</table>

### Vision Plans

<table>
<thead>
<tr>
<th></th>
<th>Basic</th>
<th>Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$1.83</td>
<td>$2.86</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$3.46</td>
<td>$5.67</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$3.62</td>
<td>$5.95</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$6.76</td>
<td>$9.12</td>
</tr>
</tbody>
</table>

*Rates shown are per paycheck based on 24 pay periods.*
### SUPPLEMENTAL LIFE AND AD&D

<table>
<thead>
<tr>
<th>Your age (January 1 of plan year)</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>$0.020</td>
</tr>
<tr>
<td>30 – 34</td>
<td>$0.020</td>
</tr>
<tr>
<td>35 – 39</td>
<td>$0.020</td>
</tr>
<tr>
<td>40 – 44</td>
<td>$0.034</td>
</tr>
<tr>
<td>45 – 49</td>
<td>$0.058</td>
</tr>
<tr>
<td>50 – 54</td>
<td>$0.086</td>
</tr>
<tr>
<td>55 – 59</td>
<td>$0.148</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$0.176</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$0.305</td>
</tr>
<tr>
<td>70+</td>
<td>$0.462</td>
</tr>
</tbody>
</table>

AD&D rate is included in employee rates. If your spouse also works for the district, you may each have employee supplemental life and AD&D and the other have spouse life and AD&D, but not both.

### SPouse LIFE AND AD&D

<table>
<thead>
<tr>
<th>Your age (January 1 of plan year)</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>$0.0395</td>
</tr>
<tr>
<td>30 – 34</td>
<td>$0.0495</td>
</tr>
<tr>
<td>35 – 39</td>
<td>$0.0545</td>
</tr>
<tr>
<td>40 – 44</td>
<td>$0.0745</td>
</tr>
<tr>
<td>45 – 49</td>
<td>$0.1295</td>
</tr>
<tr>
<td>50 – 54</td>
<td>$0.1995</td>
</tr>
<tr>
<td>55 – 59</td>
<td>$0.3295</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$0.3845</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$0.6695</td>
</tr>
<tr>
<td>70+</td>
<td>$1.0395</td>
</tr>
</tbody>
</table>

AD&D rate is included in spouse rates. The benefit is based on your benefit level and salary, up to the maximum benefit—the lesser of employee supplemental life and AD&D coverage or $250,000.

### DEPENDENT LIFE AND AD&D

<table>
<thead>
<tr>
<th>Benefit level</th>
<th>$5,000</th>
<th>$10,000</th>
<th>$15,000</th>
<th>$20,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>$0.25</td>
<td>$0.50</td>
<td>$0.75</td>
<td>$1.00</td>
</tr>
</tbody>
</table>

*RATES SHOWN ARE PER PAYCHECK BASED ON 24 PAY PERIODS.*
## DISABILITY

<table>
<thead>
<tr>
<th>Elimination period</th>
<th>Option</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40%</td>
<td>$0.186 \times \text{annual salary} \div 1200</td>
</tr>
<tr>
<td>30 days</td>
<td>50%</td>
<td>$0.239 \times \text{annual salary} \div 1200</td>
</tr>
<tr>
<td></td>
<td>67.67%</td>
<td>$0.642 \times \text{annual salary} \div 1200</td>
</tr>
<tr>
<td></td>
<td>40%</td>
<td>$0.138 \times \text{annual salary} \div 1200</td>
</tr>
<tr>
<td>60 days</td>
<td>50%</td>
<td>$0.206 \times \text{annual salary} \div 1200</td>
</tr>
<tr>
<td></td>
<td>66.67%</td>
<td>$0.404 \times \text{annual salary} \div 1200</td>
</tr>
<tr>
<td></td>
<td>40%</td>
<td>$0.125 \times \text{annual salary} \div 1200</td>
</tr>
<tr>
<td>90 days</td>
<td>50%</td>
<td>$0.170 \times \text{annual salary} \div 1200</td>
</tr>
<tr>
<td></td>
<td>67.67%</td>
<td>$0.327 \times \text{annual salary} \div 1200</td>
</tr>
<tr>
<td></td>
<td>40%</td>
<td>$0.065 \times \text{annual salary} \div 1200</td>
</tr>
<tr>
<td>180 days</td>
<td>50%</td>
<td>$0.081 \times \text{annual salary} \div 1200</td>
</tr>
<tr>
<td></td>
<td>67.67%</td>
<td>$0.190 \times \text{annual salary} \div 1200</td>
</tr>
</tbody>
</table>

## CANCER AND SPECIFIED DISEASES

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Low + ICU</th>
<th>High</th>
<th>High + ICU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$5.18</td>
<td>$8.18</td>
<td>$9.42</td>
<td>$12.42</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$8.64</td>
<td>$14.81</td>
<td>$17.10</td>
<td>$23.28</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$6.63</td>
<td>$12.82</td>
<td>$12.48</td>
<td>$18.66</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$8.64</td>
<td>$14.81</td>
<td>$17.10</td>
<td>$23.28</td>
</tr>
</tbody>
</table>

*RATES SHOWN ARE PER PAYCHECK BASED ON 24 PAY PERIODS.*
### CRITICAL ILLNESS: LOW

<table>
<thead>
<tr>
<th>Your age (January 1 of plan year)</th>
<th>Employee only</th>
<th>Employee + spouse</th>
<th>Employee + child(ren)</th>
<th>Employee + family</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – 24</td>
<td>$1.21</td>
<td>$2.10</td>
<td>$1.21</td>
<td>$2.10</td>
</tr>
<tr>
<td>25 – 29</td>
<td>$1.57</td>
<td>$2.64</td>
<td>$1.57</td>
<td>$2.64</td>
</tr>
<tr>
<td>30 – 34</td>
<td>$1.73</td>
<td>$2.88</td>
<td>$1.73</td>
<td>$2.88</td>
</tr>
<tr>
<td>35 – 39</td>
<td>$2.53</td>
<td>$4.08</td>
<td>$2.53</td>
<td>$4.08</td>
</tr>
<tr>
<td>40 – 44</td>
<td>$3.41</td>
<td>$5.40</td>
<td>$3.41</td>
<td>$5.40</td>
</tr>
<tr>
<td>45 – 49</td>
<td>$4.93</td>
<td>$7.68</td>
<td>$4.93</td>
<td>$7.68</td>
</tr>
<tr>
<td>50 – 54</td>
<td>$5.41</td>
<td>$8.40</td>
<td>$5.41</td>
<td>$8.40</td>
</tr>
<tr>
<td>55 – 59</td>
<td>$10.21</td>
<td>$15.60</td>
<td>$10.21</td>
<td>$15.60</td>
</tr>
<tr>
<td>60+</td>
<td>$20.01</td>
<td>$30.30</td>
<td>$20.01</td>
<td>$30.30</td>
</tr>
</tbody>
</table>

### CRITICAL ILLNESS: HIGH

<table>
<thead>
<tr>
<th>Your age (January 1 of plan year)</th>
<th>Employee only</th>
<th>Employee + spouse</th>
<th>Employee + child(ren)</th>
<th>Employee + family</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – 24</td>
<td>$2.17</td>
<td>$3.54</td>
<td>$2.17</td>
<td>$3.54</td>
</tr>
<tr>
<td>25 – 29</td>
<td>$3.07</td>
<td>$4.89</td>
<td>$3.07</td>
<td>$4.89</td>
</tr>
<tr>
<td>30 – 34</td>
<td>$3.47</td>
<td>$5.49</td>
<td>$3.47</td>
<td>$5.49</td>
</tr>
<tr>
<td>35 – 39</td>
<td>$5.47</td>
<td>$8.49</td>
<td>$5.47</td>
<td>$8.49</td>
</tr>
<tr>
<td>40 – 44</td>
<td>$7.67</td>
<td>$11.79</td>
<td>$7.67</td>
<td>$11.79</td>
</tr>
<tr>
<td>45 – 49</td>
<td>$11.47</td>
<td>$17.49</td>
<td>$11.47</td>
<td>$17.49</td>
</tr>
<tr>
<td>50 – 54</td>
<td>$12.67</td>
<td>$19.29</td>
<td>$12.67</td>
<td>$19.29</td>
</tr>
<tr>
<td>55 – 59</td>
<td>$24.67</td>
<td>$37.29</td>
<td>$24.67</td>
<td>$37.29</td>
</tr>
<tr>
<td>60+</td>
<td>$49.17</td>
<td>$74.04</td>
<td>$49.17</td>
<td>$74.04</td>
</tr>
</tbody>
</table>

*RATES SHOWN ARE PER PAYCHECK BASED ON 24 PAY PERIODS.*
### HOSPITAL INDEMNITY

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$2.36</td>
<td>$4.48</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$4.42</td>
<td>$8.40</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$4.17</td>
<td>$7.79</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$6.23</td>
<td>$11.71</td>
</tr>
</tbody>
</table>

### ACCIDENT

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$3.08</td>
<td>$5.33</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$4.95</td>
<td>$8.45</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$5.99</td>
<td>$10.10</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$7.86</td>
<td>$13.22</td>
</tr>
</tbody>
</table>

### PERSONAL LEGAL

<table>
<thead>
<tr>
<th></th>
<th>Basic</th>
<th>Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$4.77</td>
<td>$7.77</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$6.72</td>
<td>$9.72</td>
</tr>
</tbody>
</table>

*RATES SHOWN ARE PER PAYCHECK BASED ON 24 PAY PERIODS.*
PROVIDER CONTACTS

24/7 Nurse Line
877-780-HISD (4473)

Affordable Care Act/
Health Reform Information
Healthcare.gov

Aetna Medical Plan
Aetna.com
877-224–6857

Benefits Service Center
1-877-780-4473

Cancer and specified diseases, critical illness,
hospital indemnity, accident plans
AFLAC
AFLACgroupinsurance.com
800-433-3036

Dental HMO/PPO
Cigna Dental
Cigna.com
1-800-244-6224

Discount Dental
Cigna Dental
CignaPlusSavings.com
1-877-521-0244

Disability
Unum
Unum.com
800-858-6843

Employee Assistance Program (EAP)
ComPsych
guidanceresources.com
To access website:
Click Register
Organization Web ID-HISD
833-812-5181

Flexible Spending Accounts
Healthcare FSA
Dependent day-care FSA
payflex.com
888-678-8242

HISD Employee Health &
Wellness Centers
Hattie Mae White
Educational Support Center
4400 West 18th Street
Houston, Texas 77092
281-869-3630

Attucks Middle School
4330 Bellfort Street
Houston, Texas 77051
281-869-3630

IRS
IRS.Gov/publications/index.html
800-TAX-FORM (829-3676)

Life and Accidental Death
and Dismemberment
Securian Financial
Securian.com
Medical underwriting: 800-872-2214
Claims: 888-658-0193

Personal Legal
Hyatt Legal
legalplans.com
800-821-6400
Passwords for login:
3720010 (family coverage)
3730010 (single coverage)

Prescription Drug Benefits
Express Scripts
Express-Scripts.com
855-712-0331

Accredo Specialty Pharmacy
Accredo.com
877-222-7336

Vision
EyeMed
EyeMed.com
844-409-3402
**KNOW YOUR NUMBERS**

Here is a way to keep track of the results of some annual physicals.

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Test</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td></td>
<td>Cholesterol</td>
<td></td>
</tr>
<tr>
<td>Glucose</td>
<td></td>
<td>A1C</td>
<td></td>
</tr>
<tr>
<td>Annual Physical</td>
<td></td>
<td>Weight</td>
<td></td>
</tr>
<tr>
<td>Annual Well Woman</td>
<td></td>
<td>Mammogram</td>
<td></td>
</tr>
<tr>
<td>Annual Well Male</td>
<td></td>
<td>PSA</td>
<td></td>
</tr>
</tbody>
</table>

**Blood Pressure:**

**Glucose:**

**Annual Physical:**

**Annual Well Woman:**

**Annual Well Male:**

**Cholesterol:**

**A1C:**

**Weight:**

**Mammogram:**

**PSA:**
**KNOW YOUR NUMBERS**
Here is a way to keep track of the results of some annual physicals.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Date</th>
<th>Parameter</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure:</td>
<td></td>
<td>Cholesterol:</td>
<td></td>
</tr>
<tr>
<td>Glucose:</td>
<td></td>
<td>A1C:</td>
<td></td>
</tr>
<tr>
<td>Annual Physical:</td>
<td></td>
<td>Weight:</td>
<td></td>
</tr>
<tr>
<td>Annual Well Woman:</td>
<td></td>
<td>Mammogram:</td>
<td></td>
</tr>
<tr>
<td>Annual Well Male:</td>
<td></td>
<td>PSA:</td>
<td></td>
</tr>
</tbody>
</table>

| Blood Pressure:            |               | Cholesterol:               |               |
| Glucose:                   |               | A1C:                       |               |
| Annual Physical:           |               | Weight:                    |               |
| Annual Well Woman:         |               | Mammogram:                 |               |
| Annual Well Male:          |               | PSA:                       |               |

| Blood Pressure:            |               | Cholesterol:               |               |
| Glucose:                   |               | A1C:                       |               |
| Annual Physical:           |               | Weight:                    |               |
| Annual Well Woman:         |               | Mammogram:                 |               |
| Annual Well Male:          |               | PSA:                       |               |

| Blood Pressure:            |               | Cholesterol:               |               |
| Glucose:                   |               | A1C:                       |               |
| Annual Physical:           |               | Weight:                    |               |
| Annual Well Woman:         |               | Mammogram:                 |               |
| Annual Well Male:          |               | PSA:                       |               |

| Blood Pressure:            |               | Cholesterol:               |               |
| Glucose:                   |               | A1C:                       |               |
| Annual Physical:           |               | Weight:                    |               |
| Annual Well Woman:         |               | Mammogram:                 |               |
| Annual Well Male:          |               | PSA:                       |               |