2022

BENEFITS GUIDE

HISD | Benefits Office
BRINGING BENEFITS TO LIFE

BUILDING RESILIENCE. WELLBEING. MINDFULNESS.

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. Sientase con la libertad de compartir estos materiales con los miembros de su familia que están cubiertos bajo un plan.

TABLE OF CONTENTS

What's new and notable in 2022 04

Preventive health care 07

Choose your plan 18

Medical plan options 23

Prescription benefits 30

Compare Coverage Options 34

Voluntary options 38
- Dental 40
- EyeMed 47
- Life and AD&D 52
- Legal 56
- AFLAC 63

Enroll For Coverage 70

Wellness Resources 72

Aetna Programs 77

Employee Assistance Plan (EAP) 88

Retirement 90

Coverage Costs 93

Provider Contacts 98

WHAT'S NEW AND NOTABLE IN BENEFITS FOR 2022

THINGS TO CONSIDER

- Annual enrollment ends November 19, 2021
- Be sure to review your beneficiaries
- Be sure to review and verify your eligible dependents
- We have an Aetna onsite representative to help you work through medical issues, find medical providers, and discuss healthcare plans and options
- Your Cigna dental onsite can assist you with your detnal questions and complex issues.

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.

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

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

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)

DEPENDENT VERIFICATION SERVICES

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.

DEPENDENT VERIFICATION LETTER AND EMAIL

4400 West 18th Street
Attention: Benefits Department
Houston, TX 77092

04/22/2021

000005
DVSHSDE
T34KU 0005
DINA L VERIFICATION
2211 DEPENDENT DR
BENEFIT, UT 84071

VERIFICATION DEADLINE
05/22/2021

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 or 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 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

DEPLTR ADD 70
T34KU 0005 002 007

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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."

No.	Name	Dependent Type	Not Eligible
1	Thomas Verification	Spouse	❑
2	Wallie Verification	Child	❑

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 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**

Do not write below this line

6126000000000411745

VERIFICATION DEADLINE
05/22/2021
FAX THIS PAGE ON TOP

DEPLTR ADD 70

T34KU 0005 004 007

DEPENDENT VERIFICATION SERVICES

***** PLEASE DO NOT REPLY TO THIS E-MAIL *****

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.

61260000000000411745 DEPLTR ADD 70

aetna™

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:

Screenings for:

- 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-dosage 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
- 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

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 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...

- **Going to Aetna.com**
- **Click (bottom, right side) on Find A Doctor**
- **Under Guests, Select Plan from an employer**
- **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.

THE PLUS PLAN

has higher premiums than the Basic plan, but 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.

Important: 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	Memorial Hermann Plus ACO
RATES			
Based on 24 pay periods	Employee only	$19.25	$38.79
	Employee + spouse	$100.19	$135.25
	Employee + child(ren)	$96.37	$130.10
	Employee + family	$173.27	$233.91
PLAN LIMITS			
Annual deductible	Individual	$2,500	$1,750
	Family	$5,000	$3,500
Annual out-of-pocket max (includes all medical and pharmacy deductibles, copays, and coinsurance)	Individual	$6,900	$5,150
	Family	$13,800	$10,300
COST FOR COVERED SERVICES AFTER YOUR DEDUCTIBLE HAS BEEN MET			
Preventive care exams[6]		Free	Free
Office visits	Primary care (PCP)	25%	20%
	Specialists	25%	20%
	HISD clinics[2]	Free	Free
Inpatient—hospital[3]		25%	20%
Outpatient—hospital[3]		25%	20%
Outpatient—freestanding and surgical center[3]		25%	20%
Emergency care		25% + $300 copay (Copay waived if admitted)	20% + $300 copay (Copay waived if admitted)
Virtual Health/Telemedicine	Kelsey Telemedicine	Free	Free
		N/A	N/A
Urgent care facility		25%	20%
Lab, X-ray, diagnostic mammogram		25%	20%
Diagnostic scans (MRI, MRA, CAT, PET)		25%	20%
Maternity—delivery		25%	20%
Mental health and substance abuse—inpatient		25%	20%
Mental health and substance abuse—outpatient		25%	20%

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.

KELSEY-SEYBOLD ACO PLANS

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.

		Kelsey Basic ACO	Kelsey Plus ACO
RATES			
Based on 24 pay periods	Employee only	$19.25	$38.79
	Employee + spouse	$100.19	$135.25
	Employee + child(ren)	$96.37	$130.10
	Employee + family	$173.26	$233.90
PLAN LIMITS			
Annual deductible	Individual	$2,500	$1,750
	Family	$5,000	$3,500
Annual out-of-pocket max (includes all medical and pharmacy deductibles, copays, and coinsurance)	Individual	$6,900	$5,150
	Family	$13,800	$10,300
COST FOR COVERED SERVICES AFTER YOUR DEDUCTIBLE HAS BEEN MET			
Preventive care exams[6]		Free	Free
Office visits	Primary care (PCP)	$30 copay [1]	$30 copay [1]
	Specialists	$65 copay [1]	$65 copay [1]
	HISD clinics[2]	Free	Free
Inpatient—hospital[3]		25%	20%
Outpatient—hospital[3]		25%	20%
Outpatient—freestanding and surgical center[3]		25%	20%
Emergency care		25% + $300 copay (Copay waived if admitted)	20% + $300 copay (Copay waived if admitted)
Virtual Health/Telemedicine		N/A	N/A
	Kelsey Telemedicine	$20 PCP/$55 Specialist[1]	$20 PCP/$55 Specialist[1]
Urgent care facility		25%	20%
Lab, X-ray, diagnostic mammogram		25%	20%
Diagnostic scans (MRI, MRA, CAT, PET)		25%	20%
Maternity—delivery		25%	20%
Mental health and substance abuse—inpatient		25%	20%
Mental health and substance abuse—outpatient		$65 Copay[1]	$65 Copay[1]

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.

TEXAS MEDICAL NEIGHBORHOOD PLANS

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 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.

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	TX Medical Neighborhood Plus
RATES			
Based on 24 pay periods	Employee only	$33.59	$67.63
	Employee + spouse	$174.68	$225.32
	Employee + child(ren)	$168.05	$217.47
	Employee + family	$302.12	$365.43
PLAN LIMITS			
Annual deductible	Individual	$2,500	$1,750
	Family	$5,000	$3,500
Annual out-of-pocket max (includes all medical and pharmacy deductibles, copays, and coinsurance)	Individual	$6,900	$5,150
	Family	$13,800	$10,300
COST FOR COVERED SERVICES AFTER YOUR DEDUCTIBLE HAS BEEN MET			
Preventive care exams[6]		Free	Free
Office visits	Primary care (PCP)	25%	20%
	Specialists	25%/45%	20%/40%
	HISD clinics[2]	Free	Free
Inpatient—hospital[3]		25%	20%
Outpatient—hospital[3]		25%	20%
Outpatient—freestanding and surgical center[3]		25%	20%
Emergency care		25% + $300 copay (Copay waived if admitted)	20% + $300 copay (Copay waived if admitted)
Virtual Health/Telemedicine		Free	Free
CareAceess Live		N/A	N/A
Urgent care facility		25%	20%
Lab, X-ray, diagnostic mammogram		25%	20%
Diagnostic scans (MRI, MRA, CAT, PET)		25%	20%
Maternity—delivery		25%/45%[4]	20%/40%[4]
Mental health and substance abuse—inpatient		25%	20%
Mental health and substance abuse—outpatient		25%	20%

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 choicefor filling long-term prescriptions, including those for maintenance medications provided at no charge. To use the mail order service:

- Go to **HISDBenefits.or**g 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 are 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 limit 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.

EXPRESS SCRIPTS®

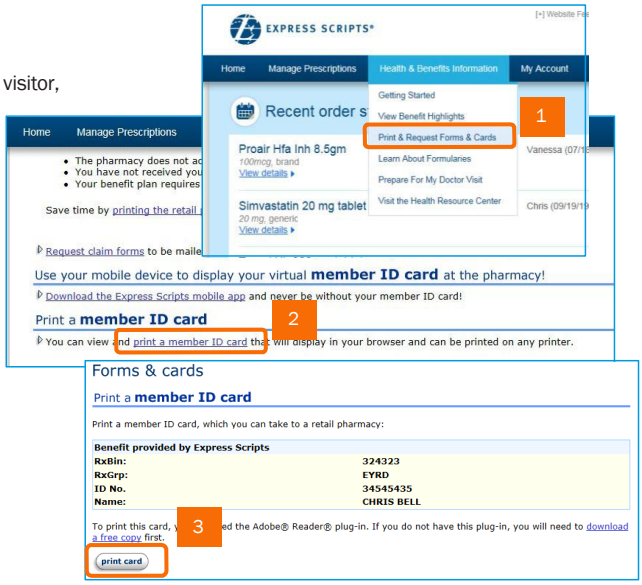
Print and Virtual Member ID Cards

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**

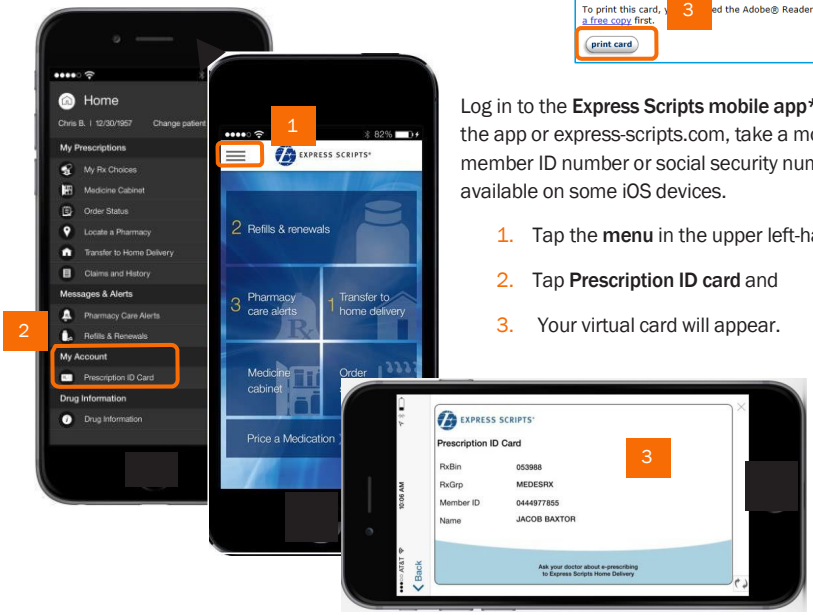
Print a member ID card

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®, Amazon™ and BlackBerry® mobile devices. Search for "Express Scripts" in your app store and download the app for free.

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COMPARE YOUR COVERAGE OPTIONS

2022 MEDICAL PLAN COMPARISON

		Kelsey Basic ACO	Memorial Hermann Basic ACO
RATES			
Based on 24 pay periods	Employee only	$19.25	$21.18
	Employee + spouse	$100.19	$110.21
	Employee + child(ren)	$96.37	$106.01
	Employee + family	$173.26	$190.60
PLAN LIMITS			
Annual deductible	Individual	$2,500	$2,500
	Family	$5,000	$5,000
Annual out-of-pocket max (includes all medical and pharmacy deductibles, copays, and coinsurance)	Individual	$6,900	$6,900
	Family	$13,800	$13,800
COST FOR COVERED SERVICES AFTER YOUR DEDUCTIBLE HAS BEEN MET			
Preventive care exams[6]		Free	Free
Office visits	Primary care (PCP)	$30 copay [1,7]	25%
	Specialists	$65 copay [1,7]	25%
	HISD clinics[2]	Free	Free
Inpatient—hospital[3]		25%	25%
Outpatient—hospital[3]		25%	25%
Outpatient—freestanding and surgical center[3]		25%	25%
Emergency care		25% + $300 copay (Copay waived if admitted)	25% + $300 copay (Copay waived if admitted)
Virtual Health/Telemedicine	Kelsey Telemedicine CareAceess Live	$20 PCP/$55 Specialist[1]	CareAcess Live
Urgent care facility		25%	25%
Lab, X-ray, diagnostic mammogram		25%	25%
Diagnostic scans (MRI, MRA, CAT, PET)		25%	25%
Maternity—delivery		25%	25%
Mental health and substance abuse—inpatient		25%	25%
Mental health and substance abuse—outpatient		$65 Copay[1]	25%

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

	TX Medical Neighborhood Basic	Kelsey Plus ACO	Memorial Hermann Plus ACO	TX Medical Neighborhood Plus
	$33.59	$38.79	$42.67	$67.63
	$174.68	$135.25	$148.78	$225.32
	$168.05	$130.10	$143.11	$217.47
	$302.12	$233.90	$257.30	$365.43
	$2,500	$1,750	$1,750	$1,750
	$5,000	$3,500	$3,500	$3,500
	$6,900	$5,150	$5,150	$5,150
	$13,800	$10,300	$10,300	$10,300
	Free	Free	Free	Free
	25%	$30 copay [1,7]	20%	20%
	25%/45%	$65 copay [1,7]	20%	20%/40%
	Free	Free	Free	Free
	25%	20%	20%	20%
	25%	20%	20%	20%
	25%	20%	20%	20%
	25% + $300 copay (Copay waived if admitted)	20% + $300 copay (Copay waived if admitted)	20% + $300 copay (Copay waived if admitted)	20% + $300 copay (Copay waived if admitted)
	CareAcess Live	$20 PCP/$55 Specialist[1]	CareAcess Live	CareAcess Live
	25%	20%	20%	20%
	25%	20%	20%	20%
	25%	20%	20%	20%
	25%/45%[4]	20%	20%	20%/40%[4]
	25%	20%	20%	20%
	25%	$65 Copay[1]	20%	20%

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

PRESCRIPTION		Kelsey Basic ACO	Memorial Herma Basic ACO
Annual pharmacy deductible		$50 per person	$50 per person
Prescription drugs (30-day retail)[5]	Generic	$20	$20
	Preferred brand	$50	$50
	Non-preferred brand generic	$70	$70
Prescription drugs (90-day mail or retail)[5]	Generic	$50	$50
	Preferred brand	$125	$125
	Non-preferred brand generic	$175	$175
Specialty (30-day supply)[5]		$150	$150

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.

nn	TX Medical Neighborhood Basic	Kelsey Plus ACO	Memorial Hermann Plus ACO	TX Medical Neighborhood Plus
	$50 per person	$50 per person	$50 per person	$50 per person
	$20	$15	$15	$15
	$50	$40	$40	$40
	$70	$60	$60	$60
	$50	$37.50	$37.50	$37.50
	$125	$100	$100	$100
	$175	$150	$150	$150
	$150	$100	$100	$100

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 DAY-CARE FSA

- You and your spouse can set up a combined total of up to $5,000 pre-tax to pay for day-care 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 day care, 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.

HISD PPO PLAN

Receiving regular dental care can not only catch minor problems before they become major and expensive to treat - it may even help improve your overall health. Gum disease is increasingly being linked to complications for pre-term birth, heart disease, stroke, diabetes, osteoporosis and other health issues. That's why this dental plan includes **Cigna Dental WellnessPlus**SM features. When you or your family members receive any preventive care service in one plan year, the annual dollar maximum will increase in the following plan year. When you or your family members remain enrolled in the plan and continue to receive preventive care, the annual dollar maximum will increase in the following plan year, until it reaches the level specified below. Please refer to your plan materials for additional information on this plan feature. **Your plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental Choice Plan				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Out-of-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Progressive Maximum Benefit: Progressive Benefit Year 2: Increase contingent upon receiving Preventive Services in Plan Year 1. Progressive Benefit Year 3: Increase contingent upon receiving Preventive Services in Plan Years 1 and 2. Progressive Benefit Year 4: Increase contingent upon receiving Preventive Services in Plan Years 2 and 3.				
Calendar Year Benefits Maximum Applies to: Class I, II, III & IX expenses	Year 1: $1,350 Year 2: $1,450 Year 3: $1,550 Year 4: $1,650		Year 1: $1,350 Year 2: $1,450 Year 3: $1,550 Year 4: $1,650	
Calendar Year Deductible Individual Family	$50 $150		$50 $150	
Benefit Highlights	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic	100% After Deductible	0% After Deductible	100% After Deductible	0% After Deductible
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Emergency Care to Relieve Pain	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Employee and All Dependents Lifetime Benefits Maximum: $2,000	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IX: Implants	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
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.			

A Cigna Dental Health Connect® solution

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.®

Cigna®

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?:[1]

Condition	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	ALS	Huntington's disease	Opioid misuse and addiction
Gum treatment[1,2] D4341 D4342 D4910	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gum evaluation[1,3] D0180				✓										
Oral evaluation[1,5] D0120 D0140 D0150				✓										✓
Cleaning[1,4] D1110				✓										
Deep cleaning and plaque removal[1,4] D4346				✓										
Emergency pain relief treatment[1,5] D9110				✓										
Fluoride and fluoride varnish[1,6] D1206					✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Fluoride (no varnish)[1,6] D1208					✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sealants[6] D1351					✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sealant repair[6] D1353					✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Interim caries arresting medicament application D1354					✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Caries preventive medicament application D1355					✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

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.

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.

he 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 enefit maximums and other exclusions and limitations. For costs and details of coverage, contact your Cigna representative or see your plan documents.

ll Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut eneral Life Insurance Company (CGLIC), Cigna HealthCare of Connecticut, Inc., Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C., and Cigna Dental Health, Inc. and its subsidiaries, including Cigna ental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., a repaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, Cigna Dental Health of Kansas, Inc., Cigna Dental Health of Kentucky, Inc., Cigna Dental Health of laryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of ennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national igna DPPO network. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. Policy forms: OK – Indemnity/DPPO: HP-POL99 (CHLIC) and GM6000 ELI288 et l (CGLIC). DHMO: POL115 (CHLIC) and GM6000 DEN201V1 (CGLIC); TN – Indemnity/DPPO: HP-POL69/HC-CER2V1 et al. DHMO: HP-POL134/HC-CER17V1 et al (CHLIC). The Cigna name, logo, and other

HISD PPO BUY-UP PLAN

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.**

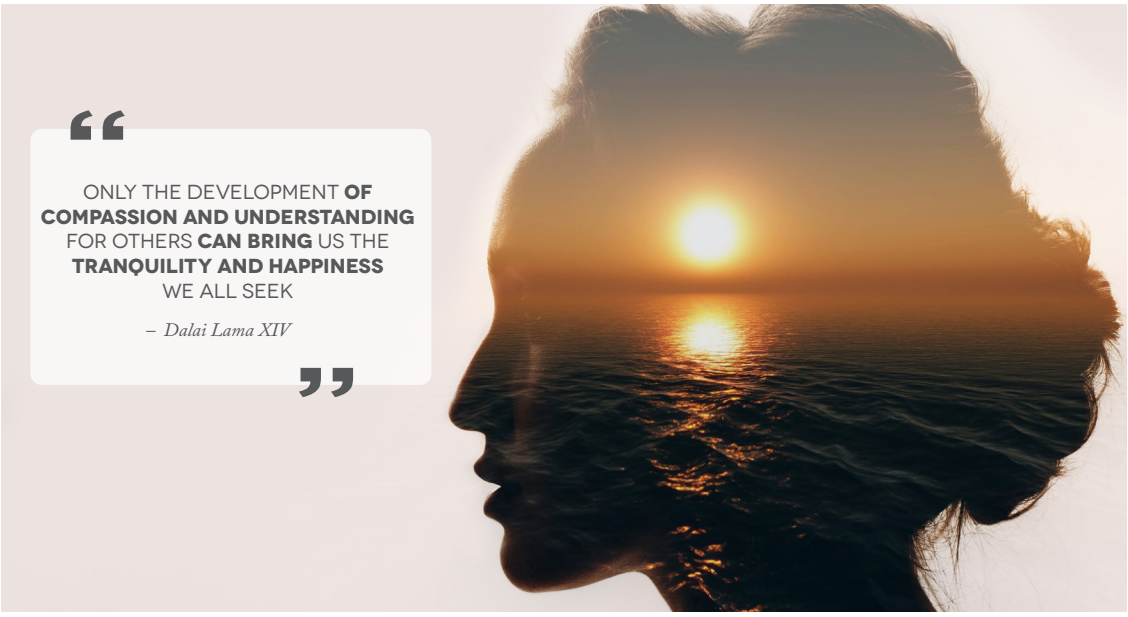
Cigna Dental Choice Plan				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Out-of-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II, III & IX expenses	$2,000		$2,000	
Calendar Year Deductible Individual Family	$50 $150		$50 $150	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Employee and All Dependents Lifetime Benefits Maximum: $2,000	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible
Class IX: Implants	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
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.



EYE MED BASIC OPTION

Vision Care Services	Member Cost In-Network	Out-of-Network Reimbursement*
Exam with Dilation as Necessary	$10 Copay	$40
Retinal Imaging Benefit	Up to $39	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to $40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price	N/A
Frames: Any available frame at provider location	$0 Copay; $150 Allowance, 20% off balance over $150	$45
Standard Plastic Lenses		
Single Vision	$20 Copay	$40
Bifocal	$20 Copay	$60
Trifocal	$20 Copay	$80
Lenticular	$20 Copay	$80
Standard Progressive Lens	$85 Copay	$60
Premium Progressive Lens	See attached Fixed Premium Progressive price list	$60
Lens Options:		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$0 Copay	$8
Standard Polycarbonate - Adults	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Photocromatic / Transitions Plastic	$75	N/A
Premium Anti-Reflective	See attached Fixed Premium Anti-Reflective Coating list	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses *(Contact lens allowance includes materials only)*		
Conventional	$0 Copay; $125 allowance, 15% off balance over $125	$125
Disposable	$0 Copay; $125 allowance, plus balance over $125	$125
Medically Necessary	$0 Copay, Paid-in-Full	$210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
Monthly Rate		
Subscriber	$3.66	
Subscriber + Spouse	$6.91	
Subscriber + Child(ren)	$7.23	
Subscriber + Family	$13.51	

Progressive Price List*	Member Cost In-Network (Includes Lens Copay)
Standard Progressive	$85 Copay
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*	Member Cost In-Network
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	Member Cost In-Network
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.

EYE MED PLUS OPTION

Vision Care Services	Member Cost In-Network	Out-of-Network Reimbursement*
Exam with Dilation as Necessary	$10 Copay	$40
Retinal Imaging Benefit	Up to $39	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to $40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price	N/A
Frames: Any available frame at provider location	$0 Copay; $150 Allowance, 20% off balance over $150	$45
Standard Plastic Lenses		
Single Vision	$10 Copay	$40
Bifocal	$10 Copay	$60
Trifocal	$10 Copay	$80
Lenticular	$10 Copay	$80
Standard Progressive Lens	$75 Copay	$60
Premium Progressive Lens	See attached Fixed Premium Progressive price list	$60
Lens Options:		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$0 Copay	$8
Standard Polycarbonate - Adults	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Photocromatic / Transitions Plastic	$75	N/A
Premium Anti-Reflective	See attached Fixed Premium Anti-Reflective Coating list	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses *(Contact lens allowance includes materials only)*		
Conventional	$0 Copay; $125 allowance, 15% off balance over $125	$125
Disposable	$0 Copay; $125 allowance, plus balance over $125	$125
Medically Necessary	$0 Copay, Paid-in-Full	$210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Monthly Rate		
Subscriber	$5.71	
Subscriber + Spouse	$11.33	
Subscriber + Child(ren)	$11.89	
Subscriber + Family	$18.24	

Progressive Price List*	Member Cost In-Network (Includes Lens Copay)
Standard Progressive	$75 Copay
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
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	Member Cost In-Network
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.

LOVE THE EXAM, LOVE YOUR EYES

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 and or other blood disorders.[5]

LOVE THE EXAM, LOVE YOUR EYES

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 vison 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.

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9. "Eye Exams for Children," by Gary Heiting, AllABoutVision.com, May 2018, https://www.allaboutvision.com/eye-exam/children.htm, *Accessed Dec. 13, 2018*
10. "What are the Causes of Vision Loss? What Puts a Child at Risk?" MyChildWithoutLimits.org, http://www.mychildwithoutlimits.org/understand/vision-loss/what-are-the-causes-of-vision-loss/, *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, you're your eyes—and possibly your whole body—stay well.

1. American Academy of Ophthalmology, "Frequency of Ocular Examinations," 2009.
2. American Optometric Association, "Comprehensive Eye and Vision Examination," 2010.
3. Harvard Medical School, "Eye Exams, High Blood Pressure Symptoms & Diabetes Symptoms," 2005.

CONSIDER YOUR VOLUNTARY OPTION

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. Vist 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

Employee	1x, 2x, 3x, 4x, 5x, 6x, 7x, 8x annual base salary up to $1 million
Spouse	1x, 2x, 3x your annual base salary up to amount of employee supplemental life or $250,000, whichever is less
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.

Money Matters	• Debt Collection Defense • Financial Education Workshops[1] • ***Identity Management Services***[2]	• Identity Theft Defense • Negotiations with Creditors • Personal Bankruptcy	• ***Promissory Notes*** • Tax Audit Representation • Tax Collection Defense
Home & Real Estate	• ***Deeds*** • Eviction Defense • Foreclosure	• ***Mortgages*** • Security Deposit Assistance	• Tenant Negotiations • Zoning Applications
Estate Planning	• ***Codicils*** • ***Complex Wills*** • ***Healthcare Proxies*** • ***Living Wills***	• ***Powers of Attorney (Healthcare, Financial, Childcare, Immigration)***	• Revocable & Irrevocable Trusts • ***Simple Wills***
Family & Personal	• Adoption • ***Affidavits*** • Conservatorship • ***Demand Letters*** • Divorce (20 hours) • Garnishment Defense • Guardianship	• Immigration Assistance • Juvenile Court Defense, Including Criminal Matters • Name Change • Parental Responsibility Matters • Personal Property Issues	• Prenuptial Agreement • Protection from Domestic Violence • ***Review of ANY Personal Legal Document*** • School Hearings
Civil Lawsuits	• Administrative Hearings • Civil Litigation Defense	• Disputes Over Consumer Goods & Services • Incompetency Defense	• Pet Liabilities • Small Claims Assistance
Elder-Care Issues	***Consultation & Document Review for Issues Related to Your Parents:*** • ***Deeds*** • ***Leases***	• ***Medicaid*** • ***Medicare*** • ***Notes*** • ***Nursing Home Agreements***	• ***Powers of Attorney*** • ***Prescription Plans*** • ***Wills***
Traffic & Criminal Matters	• Defense of Traffic Tickets[3] • Driving Privileges Restoration • Driving Under the Influence Defense	• Felony Defense • Habeas Corpus • License Suspension Due to DUI	• Misdemeanor Defense • Repossession

*Exclusions apply. Please see page 13 for more details.

Rate:[4] Price per month for employee	Legal Plan: *Covers spouse and dependents*	Proposed Plus Parents Buy Up Rate: The option to add Plus Parents for an additional $6 per month *Covers spouse, dependents, employee's and spouse's parents*
Single Rate	**$9.54 per month**	**$9.54 per month + $6.00 per month = $15.54 per month**
Famiy Rate	**$13.44 per month**	**$13.44 per month + $6.00 per month = $19.44 per month**

Additional Features: Telephone advice and office consultations on an unlimited number of personal legal matters. Trials for covered matters are covered from beginning to end, regardless of length, when using a network attorney. Access to a digital estate planning solution for wills, living wills, power of attorney and living trusts.

Reduced Fees: For personal injury, probate & estate administration matters, provided by network attorneys.

E-services: Attorney locator; Law Firm E-Panel®; Self-Help Documents.

As a part of our legal plan, we also offer:
Rate guarantees: Five years.
Usage reports: Usage reports, and analysis and evaluation of the reports.
Portability: Offers additional ease of use and flexibility for employees.

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 defintions and reimbursements can be found on the pages that follow.

New Coverages	In-Network	Out-of-Network
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.		
• Uncontested	Fully Covered	$650
• Contested	Fully Covered	$1,500
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Prenuptial Agreement: 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.	Fully Covered	$750
Tax Audit Representation: This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has 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.		
• Negotiation and Settlement	Fully Covered	$500
• Audit Hearing	Fully Covered	$1,200
Zoning Applications: 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 surveys, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning.		
• Preparation of Documentation	Fully Covered	$250
• Documentation/Attending Hearing	Fully Covered	$500

Advice and Consultation	In-Network	Out-of-Network
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.	Fully Covered	$70
Telephone Advice (see Office Consultation definition)	Fully Covered	$70
Consumer Protection Matters	**In-Network**	**Out-of-Network**
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, Ending 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)	In-Network	Out-of-Network
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.	Fully Covered	$125
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.	Fully Covered	$200
Defense of Civil Lawsuits	**In-Network**	**Out-of-Network**
Administrative Hearing Representation: This service covers participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It 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.		
• Negotiation and Settlement	Fully Covered	$500
• Contested Hearings Ending in Settlement or Judgment	Fully Covered	$1,800
• Plus Trial Supplement for Out-of-Network Service*		$100,000
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.		
• Negotiation and Settlement	Fully Covered	$650
• Filing Answer, Litigation Ending in Settlement or Judgment	Fully Covered	$2,000
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Incompetency Defense: This service covers the participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the participant incompetent.		
• Negotiation and Settlement	Fully Covered	$500
• Trial	Fully Covered	$1,800
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Document Preparation and Review	**In-Network**	**Out-of-Network**
Affidavits: This service covers preparation of any affidavit in which the participant is the person making the statement.	Fully Covered	$75
Deeds: This service covers the preparation of any deed for which the participant is either the grantor or grantee.	Fully Covered	$100
Demand Letters: 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

Elder Law Matters: This service covers counseling the participant over the phone or in the office on any personal issues relating to the participant's parents as they affect the participant. The service includes reviewing documents of the parents to advise the participant on the effect on the participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the participant is either the grantor or grantee, and preparing promissory notes involving the parents when the participant is the payor or payee.	Fully Covered	$140
Mortgages: This service covers the preparation of any mortgage or deed of trust for which the participant is the mortgagor.	Fully Covered	$70
Promissory Notes: This service covers the preparation of any promissory note for which the participant is the payor or payee.	Fully Covered	$70

Benefit Definitions & Reimbursements (Continued)

Estate Planning Documents	In-Network	Out-of-Network
Living Wills: This service covers the preparation of a living will for the participant.		
· Individual	Fully Covered	$75
· Member and Spouse	Fully Covered	$80
Powers of Attorney: This service covers the preparation of any power of attorney when the participant is granting the power.		
· Individual	Fully Covered	$65
· Member and Spouse	Fully Covered	$75
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.		
· Individual	Fully Covered	$325
· Member and Spouse	Fully Covered	$450
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.		
· Individual	Fully Covered	$150
· Member and Spouse	Fully Covered	$200
Family Law	**In-Network**	**Out-of-Network**
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.		
· Uncontested	Fully Covered	$650
· Contested	Fully Covered	$1,500
· Plus Trial Supplement for Out-of-Network Service*		$100,000
Divorce, Dissolution, and Annulment (Contested & 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 decree is issued. It is the Plan Member's responsibility to pay fees beyond the first twenty hours.		
· Uncontested	Fully Covered	$1,800
· Contested	Fully Covered	$1,800
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.		
· Uncontested	Fully Covered	$650
· Contested	Fully Covered	$1,500
· Plus Trial Supplement for Out-of-Network Service*		$100,000

Benefit Definitions & Reimbursements (Continued)

Family Law (continued)	In-Network	Out-of-Network
Name Change: This service covers the participant for all necessary pleadings and court hearings for a legal name change.	Fully Covered	$400
Prenuptial Agreement: 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.	Fully Covered	$750
Protection from Domestic Violence: 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.	Fully Covered	$425

Financial Matters	In-Network	Out-of-Network
Debt Collection Defense: 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.		
Debt Collection Defense (Consumer Debts)		
· Negotiation and Settlement	Fully Covered	$350
· Negotiation and Settlement after Complaint and Answer Filed	Fully Covered	$600
· Trial	Fully Covered	$1,050
· Plus Trial Supplement for Out-of-Network Service*		$100,000
Debt Collection Defense (Foreclosures)		
· Negotiation	Fully Covered	$500
· Complaint and Answer Filed, Settlement Negotiations	Fully Covered	$850
· Trial	Fully Covered	$1,500
· Plus Trial Supplement for Out-of-Network Service*		$100,000
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.	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 identity 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.	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.		
· Chapter 7 Individual or Member/Spouse	Fully Covered	$850
· Chapter 13 Individual or Member/Spouse	Fully Covered	$1,400

Benefit Definitions & Reimbursements (Continued)

Financial Matters (continued)	In-Network	Out-of-Network
Tax Audit Representation: This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has 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.		
· Negotiation and Settlement	Fully Covered	$500
· Audit Hearing	Fully Covered	$1,200

Immigration	In-Network	Out-of-Network
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.	Fully Covered	$500

Juvenile Matters	In-Network	Out-of-Network
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 Participants and the dependent child. In that event, this service provides an attorney for the plan member only, including services for parental responsibility.		
· Negotiation and Settlement	Fully Covered	$500
· Trial	Fully Covered	$1,200
· Plus Trial Supplement for Out-of-Network Service*		$100,000

Personal Injury	In-Network	Out-of-Network
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.		

Probate	In-Network	Out-of-Network
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.		

Real Estate Matters	In-Network	Out-of-Network
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.		
· Correspondence and Negotiations	Fully Covered	$280
· Eviction Trial Defense	Fully Covered	$840
· Plus Trial Supplement for Out-of-Network Service*		$100,000
Security Deposit Assistance: This service covers counseling 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 witness; 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.		
· Demand Letter/Negotiations	Fully Covered	$250
· Counseling on Preparing Small Claims Complaint and Trial Preparation	Fully Covered	$150
Zoning Applications: 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 surveys, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning.		
· Preparation of Documentation	Fully Covered	$250
· Documentation/Attending Hearing	Fully Covered	$500

Benefit Definitions & Reimbursements (Continued)

Traffic & Criminal Matters	In-Network	Out-of-Network
Driving Under the Influence Defense: This service covers representation of the Participant in defense of any driving under the influence or 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.		
· 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.		
· 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.	Fully Covered	$420
Misdemeanor Defense: This service covers representation for Participants in defense of any criminal misdemeanor charge except those relating to traffic or driving under influence charges. Representation includes court hearings, negotiation with the prosecutor and trial. It does not include representation of a felony charge that is subsequently reduced to a misdemeanor. This service also does not cover any post-sentencing proceeding, probation violation hearing or appeals by either party.		
· Negotiation and Settlement	Fully Covered	$500
· 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 $800 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) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) costs and fines; 8) frivolous 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.

COVID-19 AND YOUR AFLAC BENEFITS

PLEASE REVIEW THE FAQS BELOW FOR ANSWERS TO YOUR QUESTIONS CONCERNING YOUR AFLAC BENEFITS AND COVID-19.

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.

AFLAC GROUP CANCER PLAN

HOSPITAL CONFINEMENT (first continuous 30 days) 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	$200	$300
HOSPITAL CONFINEMENT (31st day and thereafter) We will pay the amount shown after the 31st day for hospital confinement due to Internal Cancer. Benefit: Per Day / No Lifetime Limit	$400	$600
SURGICAL BENEFIT 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	$95 – $3,000	$100 – $5,000
SECOND SURGICAL OPINION 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	$200	$250
FIRST OCCURRENCE BENEFIT 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.	$1,500	$5,000
CANCER SCREENING/WELLNESS BENEFIT 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 Sigmoidoscopy · Hemocult Stool Analysis · Mammography · Pap Smear · PSA (blood test for prostate cancer) · Serum Protein Electrophoresis (blood test for myeloma) · Thermography No Lifetime Limit	$50	$100
RADIATION AND CHEMOTHERAPY 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	$200	$300
EXPERIMENTAL TREATMENT 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	$200	$300
SKIN CANCER SURGERY 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	$100	$600
IN-HOSPITAL BLOOD AND PLASMA 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	$50	$100

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. Benefit: Per Day / No Lifetime Limit	$200	$250
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. Benefit: Per Device	Incurred charges up to: $2,500	Incurred charges up to: $3,000
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 round trip	Automobile: $0.50 per mile up to $1,500 Airfare or other commercial travel: up to $1,500 round trip
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. Benefit: Per Day / Lifetime limit 60 days per covered person	$50	$60

	BOTH PLANS
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	$500
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. Benefit: Per Procedure / No Lifetime Limit	25% of surgery
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. Benefit: Per Month / No Lifetime Limit	$100
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	$100
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.	Incurred charges up to $50 per day

AFLAC GROUP INSURANCE PLANS

	BOTH 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. Benefit: Per Day / Lifetime limit of $12,000 per insured	$100 per day/first 60 days $50 per day thereafter
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 Nurses 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. Benefit: Per Day / Lifetime limit of 365 days per insured	$100

AMBULANCE 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	Incurred Charges
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	Incurred charges up to: $10,000 in-hospital $5,000 outpatient $1,000 donor indemnity
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	Incurred charges up to: $2,500

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, Rabies, Scleroderma, Sickle cell anemia, Systemic lupus, Tetanus, 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
INSURANCE

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.	$500 per confinement	$300 per confinement
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.	$150 per day	$75 per day
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.	$300 per day	$150 per day
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.	$100 per calendar year	$50 per calendar year

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

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
MAJOR ORGAN TRANSPLANT (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)	100%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%

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.

REOCCURRENCE
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.

OPTIONAL BENEFITS RIDER	Percentage of Face Amount
BENIGN BRAIN TUMOR	100%
ADVANCED ALZHEIMER'S DISEASE	25%
ADVANCED PARKINSON'S DISEASE	25%
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.	

PROGRESSIVE DISEASES RIDER	
AMYOTROPHIC LATERAL SCLEROSIS (ALS or Lou Gehrig's Disease)	25%
SUSTAINED MULTIPLE SCLEROSIS	25%
This benefit is paid based on your selected Progressive Disease Benefit amount. We will pay the benefit shown upon diagnosis of one of the covered diseases if the date of diagnosis is while the rider is in force.	

SPECIFIED DISEASES RIDER	
HUMAN CORONAVIRUS SPECIFIED DISEASE BENEFIT 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 10% Hospitalization: 10 or more days 25% Hospitalization: ICU 40%
ADDITIONAL SPECIFIED DISEASES BENEFITS We will pay the benefit an insured is diagnosed with one of the diseases listed if the date of diagnosis is while the rider is in force. Payment of 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. Addison's Disease, Cerebrospinal Meningitis, Cerebral Palsy, Cystic Fibrosis, Encephalitis, Diphtheria, Huntington's Chorea, Legionnaire's Disease, Malaria, Muscular Dystrophy, Myasthenia Gravis, Necrotizing Fasciitis, Osteomyelitis, Poliomyelitis (Polio), Rabies, Sickle Cell Anemia, Systemic Lupus, Systemic Sclerosis (Scleroderma), Tetanus, Tuberculosis	25%

AFLAC GROUP ACCIDENT ADVANTAGE PLUS INSURANCE

GROUP ACCIDENTAL INJURY INSURANCE – 24–HOUR PLAN

- 24-Hour Coverage.
- No limit on the number of claims.
- Supplements and pays regardless of any other insurance program.
- Benefits available for spouse and/or dependent children.
- Benefits for both inpatient and outpatient treatment of covered accidents.
- Guaranteed Issue – No underwriting required to qualify for coverage.
- Waiver of Premium.

HOSPITAL ADMISSION 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

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
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.	$250 for employee/ spouse $125 children	$125 for employee/ spouse $62.50 children
PARALYSIS (lasting 90 days or more and diagnosed by a physician within 90 days)		
Quadriplegia	$10,000	$5,000
Paraplegia	$5,000	$2,500
Paralysis means the permanent loss of movement of two or more limbs. If you are injured in a covered accident and the injury causes paralysis which lasts more than 90 days and is diagnosed by a physician within 90 days after the accident, we will pay the appropriate amount shown. The amount paid will be based on the number of limbs paralyzed. 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.		

ACCIDENTAL DEATH AND DISMEMBERMENT	HIGH	LOW
Accidental Common Carrier Death (Plane, Train, Boat or Ship)	$100,000 EMPLOYEE $100,000 SPOUSE $50,000 CHILD	$50,000 EMPLOYEE $50,000 SPOUSE $10,000 CHILD
Accidental Death	$50,000 EMPLOYEE $50,000 SPOUSE $10,000 CHILD	$25,000 EMPLOYEE $25,000 SPOUSE $5,000 CHILD
Loss of hand, foot, or sight-single loss	$6,250 EMPLOYEE $6,250 SPOUSE $1,250 CHILD	$3,125 EMPLOYEE $3,125 SPOUSE $625 CHILD
Loss of hand, foot, or sight-double loss	$25,000 EMPLOYEE $25,000 SPOUSE $5,000 CHILD	$12,500 EMPLOYEE $12,500 SPOUSE $2,500 CHILD
Loss of one or more fingers or toes	$1,250 EMPLOYEE $1,250 SPOUSE $250 CHILD	$625 EMPLOYEE $625 SPOUSE $125 CHILD
Partial Amputation of finger(s) or toe(s) including at least one joint	$100	$100

Dismemberment - If you are injured in a covered accident and the injury causes loss of a hand, foot or sight within 90 days after the accident, we will pay the amount shown.

If a covered accident causes you to lose one hand, foot or the sight of one eye, we will pay the single loss dismemberment benefit shown. If you lose both hands, feet, the sight of both eyes, or a combination of any two, we will pay the Double Dismemberment Benefit shown.

If you lose one or more fingers or toes in a covered accident, we will pay the finger/toe benefit shown.

Dismemberment means loss of a hand: the hand is cut off at or above the wrist joint; or loss of a foot: the foot is cut off at or above the ankle; or loss of sight: at least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable or loss of a finger/toe: the finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If you do not qualify for the Dismemberment Benefit but lose at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit.

If this benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate Accidental-Death Benefit less any amounts paid under this benefit.

* If you are injured in a covered accident and the injury causes death within 90 days after the accident, we will pay the Accidental-Death Benefit shown. If the Accidental-Death Benefit is paid, we will not pay the Accidental Common Carrier Death Benefit.

If you are injured in a covered accident as a result of traveling as a fare-paying passenger on a common carrier and the injury causes death days after the accident, we will pay the Accidental Common Carrier Death Benefit in the amount shown.

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.

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.

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

MAJOR INJURIES / DISLOCATIONS / OPEN REDUCTION	HIGH	LOW
Hip	$4,050	$2,025
Knee (not knee cap)	$2,925	$1,462.50
Shoulder	$2,250	$1,125
Foot/Ankle	$1,800	$900
Hand	$1,575	$787.50
Lower Jaw	$1,350	$675
Wrist	$1,125	$562.50
Elbow	$900	$450
Finger/Toe	$360	$180

- 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 are for open reduction. See certificate schedule for closed reduction amounts.
- A chip facture 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.

RUPTURED DISC (treatment within 60 days; surgical repair within one year)		
Injury occurring during first certificate year	$100	$100
Injury occurring after first certificate year	$400	$400
TENDONS/LIGAMENTS (within 60 days; surgical repair within 90 days)		
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. 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.	$600 (Multiple) $400 (Single)	$600 (Multiple) $400 (Single)
TORN KNEE CARTILAGE (treatment within 60 days; surgical repair within one year)		
Injury occurring during first certificate year	$100	$250
Injury occurring after first certificate year	$400	$400
EYE INJURIES		
Treatment and surgical repair within 90 days	$250	$125
Removal of foreign body, with or without anesthesia	$50	$25
CONCUSSION (a head injury resulting in electroencephalogram abnormality)	$400	$200
COMA (a state of profound unconsciousness lasting more than 30 days)	$10,000	$5,000
EMERGENCY DENTAL (injury to sound natural teeth)		
Repaired with crown	$150	$100
Resulting in extraction	$50	$25
BURNS (treatment within 72 hours and based on percent of body surface burned / First-degree burns are not covered.)		
Second-Degree Burns		
Less than 10%	$180	$180
At least 10%, but less than 25%	$360	$360
At least 25%, but less than 35%	$900	$900
35% or more	$1,800	$1,800

LACERATIONS (treatment and repair within 72 hours)		
2" to 5" long	$200	$100
Lacerations not requiring stitches	$25	$25

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.	$100	$50
AMBULANCE **AIR AMBULANCE** If you require transportation to a hospital by a professional ambulance or air ambulance service within 90 days after a covered accident, we will pay the amount shown.	$500 $1,500	$250 $750
BLOOD/PLASMA If you receive blood or plasma within 90 days following a covered accident, we will pay the amount shown.	$400	$200
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.	$100	$50
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.	$1,200	$750
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.	$50	$35
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.	$400	$200
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.	$1,000	$500
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.	$75	$50
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.	$300 (train/plane) $300 (bus)	$150 (train/plane) $150 (bus)
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.	$100	$50
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.	$400	$200
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 30 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.	$150 per day	$75 per day

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.**

WELLNESS RESOURCES

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; FLD, 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

HISD Benefits Office
BRINGING BENEFITS TO LIFE

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

next level URGENT CARE

HISDBENEFITS HISDBENEFITS HOUSTONISDBENEFITS

WELLNESS RESOURCES

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.

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.

24-Hour Nurse Line

A 24-hour information line for your health questions

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.

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.

*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.

Get the information you need

We asked our members what they liked about the 24-Hour Nurse Line.[1] 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.

[1]24-Hour Nurse Line (formerly known as the Informed Health® Line) Member Satisfaction Survey. 2018.

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 HPol-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.

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.

Able To 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
- Breast or prostate cancer recovery
- Heart issues
- Diabetes
- Digestive health issues
- Pain management
- Breathing problems
- Alcohol or substance use disorder
- Depression, anxiety or panic
- Postpartum depression
- Caregiving stress (child, elder or autism)
- Grief and loss
- Military transitions

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%

95% of AbleTo graduates recommend the program to others.[1]

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.

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

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.

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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.*

Available on the App Store

GET IT ON Google Play

*Terms and conditions: **Bit.ly/2nlJFYG**. 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.

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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.

EMPLOYEE ASSISTANCE PROGRAM

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.

GuidanceResources®

HISD | Benefits Office
BRINGING BENEFITS TO LIFE

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

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RETIREMENT

RETIREMENT STOREFRONT

TEACHER RETIREMENT SYSTEM OF TEXAS

403(B) 457 PLAN

TRS is a governmental, tax-exempt benefit retirement plan.
This pension trust fund provides service anddisability retirement, as well as death and survivor benefits, to eligible Texas public education employeesand their beneficiaries

Eligible HISD employees are automatically enrolled

Mandatory Contribution: 8.35% from each paycheck

Before Tax: 7.7% is applied to your membership account (tax deferred; refundable upon resignation)

After Tax: 0.65% is applied to a general insurance fund (non-refundable)

Manage your TRS account online at TRS.Texas.gov

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

VOLUNTARY RETIREMENT SAVINGS PLANS: 403(B) AND 457

VISIT THE HISD RETIREMENT STOREFRONT WEBSITE

For a list of providers, enrollment details, and voluntary retirementplan 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 nancial institution. Each employee chooses the account type that's right for them, including interest bearing or equity (stock market) accounts. e money grows without paying taxes (taxdeferred) 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 dierent 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 2020

	403(b)	457
Plan Eligibility	All Employees	All Employees
Number of Providers	33	3
Pre-Tax Contribution	Yes	Yes
Tax Deferred Interest and Earnings	Yes	Yes
After-Tax Roth Contributions*	Yes	No
Minimum Contribution Requirement	No	No
Contribution Limit: Under Age 50	$19,500	$19,500
Contribution Limit: Age 50 and Over	$26,000	$26,000 (Special 3-year Catch-Up -$39,000)
Loan Availability	Yes	Yes
In-Service Hardship Distribution Availability**	1. Funeral/Burial Expenses 2. Post-Secondary Education 3. Prevent Eviction or Foreclosure 4. Purchase Principal Residence 5. Uninsured Home Repairs Due to Peril 6. Unreimbursed Medical	Unforeseeable emergency causing severe financial hardship
IRS 10% Excise Tax (Early Withdrawal Penalty) ***	Yes	No
Unrestricted In-Service Distribution Age (For withdrawal by active employees)	59 ½	70 ½

*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.

COVERAGE COSTS

MEDICAL PLANS

	Kelsey Basic ACO	Memorial Hermann Basic ACO	T X Medical Neighborhood Basic	Kelsey Plus ACO	Memorial Hermann Plus ACO	T X Medical Neighborhood Plus
Employee only	$19.25	$21.18	$33.59	$38.79	$42.67	$67.63
Employee + spouse	$100.19	$110.21	$174.68	$135.25	$148.78	$225.32
Employee + child(ren)	$96.37	$106.01	$168.05	$130.10	$143.11	$217.47
Employee + family	$173.26	$190.60	$302.12	$233.90	$257.30	$365.43

DENTAL PLANS

	HMO Plus	PPO	PPO BUYUP	Discount Dental
Employee only	$6.90	$18.68	$20.71	$2.50
Employee + spouse	$13.13	$37.01	$41.03	$5.00
Employee + child(ren)	$13.13	$36.92	$40.93	$5.00
Employee + family	$16.87	$57.75	$64.02	$5.00

VISION PLANS

	Basic	Plus
Employee only	$1.83	$2.86
Employee + spouse	$3.46	$5.67
Employee + child(ren)	$3.62	$5.95
Employee + family	$6.76	$9.12

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

SUPPLEMENTAL LIFE AND AD&D

Your age (January 1 of plan year)	Rate
< 30	$0.020
30 – 34	$0.020
35 – 39	$0.020
40 – 44	$0.034
45 – 49	$0.058
50 – 54	$0.086
55 – 59	$0.148
60 – 64	$0.176
65 – 69	$0.305
70+	$0.462

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

Your age (January 1 of plan year)	Rate
< 30	$0.0395
30 – 34	$0.0495
35 – 39	$0.0545
40 – 44	$0.0745
45 – 49	$0.1295
50 – 54	$0.1995
55 – 59	$0.3295
60 – 64	$0.3845
65 – 69	$0.6695
70+	$1.0395

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

Benefit level	$5,000	$10,000	$15,000	$20,000
Rate	$0.25	$0.50	$0.75	$1.00

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

DISABILITY

Elimination period	Option	Cost
30 days	40%	$0.186 x annual salary ÷ 1200
	50%	$0.239 x annual salary ÷ 1200
	67.67%	$0.642 x annual salary ÷ 1200
60 days	40%	$0.138 x annual salary ÷ 1200
	50%	$0.206 x annual salary ÷ 1200
	66.67%	$0.404 x annual salary ÷ 1200
90 days	40%	$0.125 x annual salary ÷ 1200
	50%	$0.170 x annual salary ÷ 1200
	67.67%	$0.327 x annual salary ÷ 1200
180 days	40%	$0.065 x annual salary ÷ 1200
	50%	$0.081 x annual salary ÷ 1200
	67.67%	$0.190 x annual salary ÷ 1200

CANCER AND SPECIFIED DISEASES

	Low	Low + ICU	High	High + ICU
Employee only	$5.18	$8.18	$9.42	$12.42
Employee + spouse	$8.64	$14.81	$17.10	$23.28
Employee + child(ren)	$6.63	$12.82	$12.48	$18.66
Employee + family	$8.64	$14.81	$17.10	$23.28

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

CRITICAL ILLNESS: **LOW**

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

CRITICAL ILLNESS: **HIGH**

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

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

HOSPITAL INDEMNITY

	Low	High
Employee only	$2.36	$4.48
Employee + spouse	$4.42	$8.40
Employee + child(ren)	$4.17	$7.79
Employee + family	$6.23	$11.71

ACCIDENT

	Low	High
Employee only	$3.08	$5.33
Employee + spouse	$4.95	$8.45
Employee + child(ren)	$5.99	$10.10
Employee + family	$7.86	$13.22

PERSONAL LEGAL

	Basic	Plus
Employee only	$4.77	$7.77
Employee + family	$6.72	$9.72

***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
Cigna*Plus*Savings.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

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