DENTON ISD

BENEFIT GUIDE

EFFECTIVE: 09/01/2021 - 8/31/2022

WWW.MYBENEFITSHUB.COM/DENTONISD

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Benefit Contact Information

DENTON ISD BENEFIT SERVICES

Financial Benefit Services
866-914-5202
www.mybenefitshub.com/dentonisd

TRS SCOTT & WHITE HMO MEDICAL

(844) 633-5325
Fax (254) 298-3385
Nurse Advice Line (877) 505-7947
https://trs.swhp.org/

DISABILTY

The Hartford
Group #G681062
(800) 523-2233
www.thehartford.com

To file a claim: 940-369-0028 or disdinsurance@dentonisd.org

DENTON ISD INSURANCE DEPARTMENT

Denton ISD Insurance Department
(940) 369-0028
disdinsurance@dentonisd.org
PO Box 1951
1307 N Locust St
Denton, TX. 76201
www.dentonisd.org/Domain/74

DENTAL

Cigna
Group #3340946
(800) 244-6224
www.mycigna.com

CANCER

American Public Life
Group #20031
(800) 256-8606
www.ampublic.com

TRS ACTIVECARE MEDICAL

Customer Service (866)355-5999
www.bcbstx.com/trsactivecare
Beginning Right Maternity Management Program
(888)421-7781

VISION

Superior Vision
Group # 31823
PO Box 967, Rancho Cordova, CA 95741
(800) 507-3800
www.superiorvision.com

NBS FLEXIBLE SPENDING ACCOUNTS

National Benefit Services
(800) 274-0503
www.nbsbenefits.com
Employer #: NBS563887

TRS ACTIVECARE CAREMARK

Caremark Prescription Benefits:
(866) 355-5999
https://info.caremark.com/trsactivecare

BASIC/VOLUNTARY LIFE AND AD&D

AUL a OneAmerica Company
Group #G 615927
(800) 537-6442
www.oneamerica.com

EAP

AUL a OneAmerica Company
Call: 855-365-4754
TDD: 800-697-0353
Online: guidanceresources.com
Company ID: ONEAMERICA6

TEXAS SCHOOL HEALTH BENEFIT PROGRAM (TSHB)

Care Coordinator Support Team
(888) 803-0081
www.tshbp.org

HEALTH SAVINGS ACCOUNT (HSA)

EECU
(817) 882- 0800
www.eecu.org

EMERGENCY MEDICAL TRANSPORTATION

MASA
Group #B2BDenton
(800) 423-3226

Disclaimer

Enrollment Guide General Disclaimer:

This summary of benefits for employees is meant *only* as a brief description of some of the programs for which employees *may* be eligible. This summary does not include specific plan details.

You must refer to the specific plan documentation for specific plan details such as benefits, limitations, exclusions, and other plan terms, which can be found on the Denton ISD Benefits Website.

This summary does not replace or amend the underlying plan documentation. In the event of a discrepancy between this summary and the plan documentation the plan documentation governs. All plans and benefits described in this summary may be discontinued, increased, decreased, or altered at any time with or without notice.

If any discrepancy exists between this booklet and the official documents, the official documents SPD will prevail.

For more information please contact:
Financial Benefit Services
866-914-5202

Or

Denton ISD Employee Insurance Benefits Department
940-369-0028
disdinsurance@dentonisd.org

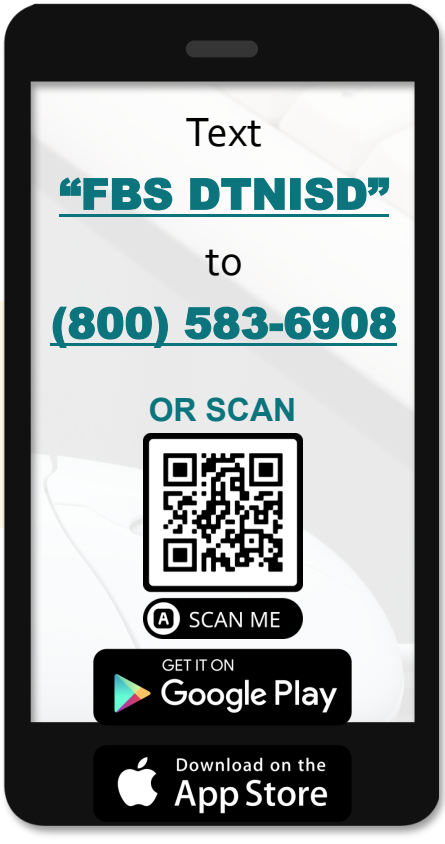
MOBILE APP DOWNLOAD

Enrollment made simple through the new **FBS Benefits App!**

Access to everything you need to complete your benefits enrollment:

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

App Group #:
FBSDTNISD



How to Log In

1. www.mybenefitshub.com/dentonisd
2. CLICK LOGIN
3. ENTER USERNAME & PASSWORD

Username:

The first six (6) characters of your last name, followed by the first letter of your first name, followed by the last four (4) digits of your Social Security Number.

If you have six (6) or less characters in your last name, use your full last name, followed by the first letter of your first name, followed by the last four (4) digits of your Social Security Number.

Default Password:

Last Name (lowercase, excluding punctuation) followed by the last four (4) digits of your Social Security Number.

Enrollment Information

SUMMARY PAGES

Benefit Updates:

TEXAS SCHOOLS HEALTH BENEFITS PROGRAM (TSHBP)

TSHBP offers two medical plans, a High Deductible Plan (HD) and a Copay Plan (CPP). Plans Include:

- In an Out-of-Network Benefits
- No PCP selection required or referral to a specialist.
- A Care Coordinator service
- Preventative Services are paid at 100%
- Once deductible is met, plan pays 100%
- No rate increase for the 2021-2022 Plan Year

TRS-ACTIVECARE

TRS offers four medical plans to new enrollees. Key plan highlights and changes for the 2021-2022 plan year include the following.

AC Primary

This plan has the lowest monthly costs and copays of the Active Care plans. Your Primary Care Provider copay is $30, and TRS Virtual Health is $0.

- Rate increase for all coverage groups (EE, ES, EC, FAM)
- No Benefits changes

AC Primary+

This plan has copays and the lowest deductibles, maximum out-of-pockets, and coinsurance rates of the Active Care Plans. Your Primary Care Provider copay is $30, and TRS Virtual Health is $0.

- Rate Increase for all coverage groups (EE, ES, EC, FAM)
- No Benefit Changes

AC HD

This high deductible plan has the following changes for the new plan year:

- Rate increase for all coverage groups (EE, ES, EC, FAM)
- In-network deductible rose by $200 for individuals and $400 for families.
- In-network coinsurance rates rose from 20% to 30%
- Out-of-network coinsurance rates rose from 40% to 50%.
- In- network maximum out-of-pocket rose by $100 for individuals and $200 for families.

*All Changes are for medical only. There are no changes to prescription and coinsurance rates.

AC 2

This plan is closed to new enrollees. Current enrollees can choose to stay in the plan.

- Rate Increase for all coverage groups (EE, ES, EC, FAM)
- No Benefit Changes

Central and North Texas Scott & White Care Plan

This plan has the following changes for the new plan year:

- Rate decrease for EE, ES, EC coverage
- Rate Increase for Family Coverage
- Deductible increasing to $1,150 Individual/$3,450 Family.
- Rx D deductible increasing to $200 (excludes generics).
- Generic copays increase to $10/$25.

BASIC LIFE WITH AD&D

Denton ISD offers $15,000 life insurance with AD&D coverage to all full-time eligible employees at no cost to you. You must add a beneficiary to avoid funds being assigned to your Estate.

NEW 2021 HSA CONTRIBUTION LIMITS:

Individual Limit: $3600
Family Limit: $7200
Including 55+ catch-up contribution of $1000:
Individual Limit: $4600
Family Limit: $8200

CIGNA DENTAL

All Dental Rates increased slightly this year. To view dental rates, turn to the Dental section of the Benefit Guide, or log in to the employee benefits portal.

You will be required to provide the name, date of birth and social security number for any dependents (this includes spouse) that are listed. You will not be allowed to enroll without all the required information.

Due to the Affordable Care Act (ACA), you are required to enroll in or waive coverage in a medical plan within 31 calendar days of your hire/contract start date. An enrollment or waive in coverage cannot be processed by telephone or email, it must be done online.

Section 125 Cafeteria Plan Guidelines

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

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

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

Open Enrollment

During your open enrollment period, you have the opportunity enroll in or waive your benefit elections each plan year.

- Changes are not permitted during the plan year (outside of open enrollment) unless a qualifying event occurs.
- Employees must review their personal information and verify that dependents they wish to provide coverage for are included in the dependent profile and eligible for coverage. Additionally, you must notify your Insurance Department of any discrepancy in personal and/or benefit information.
- Employees must confirm on each benefit screen (medical, dental, vision, etc.) that each dependent to be covered is selected in order to be included in the coverage for that particular benefit.

New Hire Enrollment

All new hire enrollment elections must be completed in the online enrollment system within the first 31 days of your hire/ contract start date. Failure to complete elections during this timeframe will result in you having Basic Life insurance only, (if eligible).

Q&A

Who do I contact with Questions?

For benefit questions, you can contact your Insurance Department at 940-369-0028 or you can call Financial Benefit Services at 800-583-6908 or email disdinsurance@dentonisd.org for assistance.

Where can I find forms?

For benefit summaries and claim forms, go to your benefit website: www.mybenefitshub.com/dentonisd. Then click the benefit plan you need information on (i.e., Dental) and you can find the forms you need under the Benefits and Forms section.

How can I find a Network Provider?

Go to your benefits website: www.mybenefitshub.com/dentonisd. Click on the benefit plan you need information on (i.e., Dental) and you can find provider search links and directions under the Quick Links section.

When will I receive ID cards?

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

Employee Eligibility Requirements

An Eligible employee who is an active contributing TRS member and is scheduled to work 15 or more hours per week is eligible for all benefits including district contributions.

Part-time employees scheduled to work 10-14 hours per week and auxiliary substitutes are eligible for Medical coverage only with no district medical contribution. Premiums will not be payroll deducted for those employees.

Eligible employees must be actively at work on the plan effective date for benefits to be effective, meaning you are physically capable of performing the functions of your job on the first day of work concurrent with the plan effective date. For example, if your benefits become effective on September 1, you must be actively-at-work on September 1 to be eligible for your benefits.

Dependent Eligibility Requirements

You can cover eligible dependent children under a benefit that offers dependent coverage, provided you participate in the same benefit, through the maximum age listed below. Dependents cannot be double covered by married spouses within Denton ISD.

- A spouse, including a common law spouse (A common law spouse is not considered eligible unless there is a Declaration of Informal Marriage filed with an authorized government agency.)
- A child under the age of 26, who is one of the following:
  - A natural child
  - An adopted child or a child who is lawfully placed for legal adoption
  - A stepchild
  - A foster child
  - A child under the legal guardianship of the employee
- "Any other child" (other than those listed above) under the age of 26 in a regular parent-child relationship with the employee, meeting all four of the following requirements:
  - The child's primary residence is the household of the employee;
  - The employee provides at least 50% of the child's support;
  - Neither of the child's natural parents resides in that household; and
  - The employee has the legal right to make decisions regarding the child's medical care.*

*This requirement does not apply to dependents age 18 and over.

- A grandchild under age 26 whose primary residence is the household of the employee and who is a dependent of the employee for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.
- A child, age 26 or over, of a covered employee may be eligible for dependent coverage, provided that the child is either mentally or physically incapacitated to such an extent that they are dependent on the employee on a regular basis as determined by TRS, and meet other requirements as determined by TRS.
- A dependent does not include a brother or a sister of an employee, unless the brother or sister is an individual under age 26 who is either: (1) under the legal guardianship of an employee, or (2) in a regular parent-child relationship with an employee, as defined in the "any other child" category above. Parents and grandparents of the covered employee do not meet the definition of an eligible dependent.

PLAN	CARRIER	MAXIMUM AGE
Medical	BCBSTX	To age 26
Medical	Scott and White HMO	To age 26
Dental	Cigna	To age 26
Vision	Superior Vision	To age 26
Life	AUL a OneAmerica Company	To age 26
Cancer	APL	To age 26

If your dependent is disabled, coverage may be able to continue past the maximum age under certain plans. If you have a disabled dependent who is reaching an ineligible age, you must provide a physician's statement confirming your dependent's disability. Contact your Insurance Department/ Benefit Administrator to request information on continuation of coverage.

Helpful Information

SUMMARY PAGES

Actively at Work

You are performing your regular occupation for the employer on a full -time basis, either at one of the employer's usual places of business or at some location to which the employer's business requires you to travel.

Open Enrollment

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

Plan Year

September 1st through August 31st

Plan Year Deductible

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

Co-insurance

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

Guaranteed Coverage

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

In-Network

On both TSHBP plans, and the TRS medical plans ActiveCare HD and ActiveCare 2, you do have out of network benefits if you decide to use out of network providers. However, they are at a reduced benefit amount and are based on out of network allowable amount for the charges. This can increase your portion of the costs.

On the TRS medical plan TRS ActiveCare Primary and Primary+, there are no benefits if you decide to use out of network providers.

Out of Pocket Maximum

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered expenses.

Pre-Existing Conditions

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

Who do I contact for assistance in filing a disability claim?

Denton ISD insurance department. 940-369-0028 or DISDinsurance@dentonisd.org

Do deductibles, coinsurance and copays apply to my out of pocket maximum?

Yes, effective 9/1/2020 deductibles, coinsurance and copays apply to the plan year out of pocket maximum.

Where do I find network providers on the medical plans?

To locate an in network provider for a TRS ActiveCare medical plan go to: www.bcbstx.com/trsactivecare or call BCBS at (866)-355-5999.
To locate an in network provider for the Scott & White HMO medical plan go to: https://trs.swhp.org/ or call 1-800-321-7947.

Can I sign up for or drop insurance at any time?

No. There are only certain times you can add or drop insurance plans:

- During the Open Enrollment
- Within 31 calendar days of your hire/contract start date
- Within 31 calendar days of the loss of other eligible insurance coverage(s)
- Within 31 calendar days of a life changing event (marriage, divorce, child birth, death)
- Documentation of the event is required. Please contact the Insurance Dept. or visit our website for information.

Where can I see what benefits I'm signed up for?

You can log into the online enrollment system and view the benefits you signed up for at any time: www.mybenefitshub.com/dentonisd .

DESIGNATION OF INDIVIDUALS WITH WHOM BENEFITS PERSONNEL MAY COMMUNICATE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. The Denton ISD insurance department who work with our group health plans may sometimes need to disclose medical information or payment information protected by HIPAA in relation to Denton ISD medical and voluntary/supplemental benefits to your family members or close friends involved in your health care. For example, your spouse may need to contact us for assistance in filing a claim for reimbursement for medical services under the Group Medical Plan if you are incapacitated. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your medical, voluntary/supplemental and/or payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may or may not discuss your medical, voluntary/supplemental and/or payment information with under our plans.

Employee Name: _____ Employee ID Number: _____

Address: _____ Social Security # _____

_____

Phone: _____

☐ You may communicate with the following individuals relating to my medical or payment information under the group health plans:

Name	Relationship	DOB	Social Security #

☐ Please do not discuss my medical or payment information with the following individuals:

Name	Relationship	DOB	Social Security #

☐ Please do not discuss my medical or payment information with anyone.

_____
Signature

_____
Date

Please return the completed, signed & dated form to:
Denton ISD Insurance Department
disdinsurance@dentonisd.org

Revised 2021-6-14

2021 - 2022 Medical Plan Rates

TRS ActiveCare Medical Plan Name	Monthly Premium	District Contribution per Month	Monthly Paid Employees Payroll Deduction	24 Pay Periods Deductions Payroll Deduction	16 Pay Periods Deductions Payroll Deduction	PART-TIME 10-14 SUBS (NO DISTRICT CONTRIBUTION) Ineligible for payroll deductions
ActiveCare HD						
EE (employee only)	$429.00	$260.00	$169.00	$84.50	$126.75	$429.00
ES (employee + spouse)	$1,209.00	$260.00	$949.00	$474.50	$711.75	$1,209.00
EC (employee + child(ren)	$772.00	$260.00	$512.00	$256.00	$384.00	$772.00
FAM (family)	$1,445.00	$260.00	$1,185.00	$592.50	$888.75	$1,445.00
ActiveCare HD Split Premium	SPOUSE WORKS IN A DIFFERENT PARTICIPATING DISTRICT					
ES (employee + spouse)	$604.50	$260.00	$344.50	$172.25	$258.38	
FAM (family)	$722.50	$260.00	$462.50	$231.25	$346.88	
ActiveCare HD Pooling	BOTH WORK FOR DISD AND ONE DECLINES COVERAGE					
ES (employee + spouse)	$1,209.00	$520.00	$689.00	$344.50	$516.75	
FAM (family)	$1,445.00	$520.00	$925.00	$462.50	$693.75	
ActiveCare Primary						
EE (employee only)	$417.00	$260.00	$157.00	$78.50	$117.75	$417.00
ES (employee + spouse)	$1,176.00	$260.00	$916.00	$458.00	$687.00	$1,176.00
EC (employee + child(ren)	$751.00	$260.00	$491.00	$245.50	$368.25	$751.00
FAM (family)	$1,405.00	$260.00	$1,145.00	$572.50	$858.75	$1,405.00
ActiveCare Primary Split Premium	SPOUSE WORKS IN A DIFFERENT PARTICIPATING DISTRICT					
ES (employee + spouse)	$588.00	$260.00	$328.00	$164.00	$246.00	
FAM (family)	$702.50	$260.00	$442.50	$221.25	$331.88	
ActiveCare Primary Pooling	BOTH WORK FOR DISD AND ONE DECLINES COVERAGE					
ES (employee + spouse)	$1,176.00	$520.00	$656.00	$328.00	$492.00	
FAM (family)	$1,405.00	$520.00	$885.00	$442.50	$663.75	
ActiveCare Primary+						
EE (employee only)	$542.00	$260.00	$282.00	$141.00	$211.50	$542.00
ES (employee + spouse)	$1,334.00	$260.00	$1,074.00	$537.00	$805.50	$1,334.00
EC (employee + child(ren)	$879.00	$260.00	$619.00	$309.50	$464.25	$879.00
FAM (family)	$1,675.00	$260.00	$1,415.00	$707.50	$1,061.25	$1,675.00
ActiveCare Primary+ Split Premium	SPOUSE WORKS IN A DIFFERENT PARTICIPATING DISTRICT					
ES (employee + spouse)	$667.00	$260.00	$407.00	$203.50	$305.25	
FAM (family)	$837.50	$260.00	$577.50	$288.75	$433.13	
ActiveCare Primary+ Pooling	BOTH WORK FOR DISD AND ONE DECLINES COVERAGE					
ES (employee + spouse)	$1,334.00	$520.00	$814.00	$407.00	$610.50	
FAM (family)	$1,675.00	$520.00	$1,155.00	$577.50	$866.25	
ActiveCare 2 **Closed to New Enrollments**						
EE (employee only)	$1,013.00	$260.00	$753.00	$376.50	$564.75	$1,013.00
ES (employee + spouse)	$2,402.00	$260.00	$2,142.00	$1,071.00	$1,606.50	$2,402.00
EC (employee + child(ren)	$1,507.00	$260.00	$1,247.00	$623.50	$935.25	$1,507.00
FAM (family)	$2,841.00	$260.00	$2,581.00	$1,290.50	$1,935.75	$2,841.00
ActiveCare 2 Split Premium	SPOUSE WORKS IN A DIFFERENT PARTICIPATING DISTRICT					
ES (employee + spouse)	$1,201.00	$260.00	$941.00	$470.50	$705.75	
FAM (family)	$1,420.50	$260.00	$1,160.50	$580.25	$870.38	
ActiveCare 2 Pooling	BOTH WORK FOR DISD AND ONE DECLINES COVERAGE					
ES (employee + spouse)	$2,402.00	$520.00	$1,882.00	$941.00	$1,411.50	
FAM (family)	$2,841.00	$520.00	$2,321.00	$1,160.50	$1,740.75	

2021 - 2022 Medical Plan Rates

Medical Plan Name	Monthly Premium	District Contribution per Month	Monthly Paid Employees Payroll Deduction	24 Pay Periods Deductions Payroll Deduction	16 Pay Periods Deductions Payroll Deduction	PART-TIME 10-14 SUBS (NO DISTRICT CONTRIBUTION) Ineligible for payroll deductions
HMO - Scott & White Health Plan						
EE (employee only)	$542.48	$260.00	$282.48	$141.24	$211.86	$542.48
ES (employee + spouse)	$1,362.70	$260.00	$1,102.70	$551.35	$827.03	$1,362.70
EC (employee + child(ren)	$872.16	$260.00	$612.16	$306.08	$459.12	$872.16
FAM (family)	$1,568.42	$260.00	$1,308.42	$654.21	$981.32	$1,568.42
Scott & White Split Premium	SPOUSE WORKS IN A DIFFERENT PARTICIPATING DISTRICT					
ES (employee + spouse)	$681.35	$260.00	$421.35	$210.68	$316.01	
FAM (family)	$784.21	$260.00	$524.21	$262.11	$393.16	
Scott & White Pooling	BOTH WORK FOR DISD AND ONE DECLINES COVERAGE					
ES (employee + spouse)	$1,362.70	$520.00	$842.70	$421.35	$632.03	
FAM (family)	$1,568.42	$520.00	$1,048.42	$524.21	$786.32	
Texas Schools Health Benefits (TSHB) HDHP						
EE (employee only)	$342.00	$260.00	$82.00	$41.00	$61.50	
ES (employee + spouse)	$972.00	$260.00	$712.00	$356.00	$534.00	
EC (employee + child(ren)	$651.00	$260.00	$391.00	$195.50	$293.25	
FAM (family)	$1,292.00	$260.00	$1,032.00	$516.00	$774.00	
TSHB HDHP Pooling	BOTH WORK FOR DISD AND ONE DECLINES COVERAGE					
ES (employee + spouse)	$972.00	$520.00	$452.00	$226.00	$339.00	
FAM (family)	$1,292.00	$520.00	$772.00	$386.00	$579.00	
Texas Schools Health Benefits (TSHB) CoPay Plan						
EE (employee only)	$497.00	$260.00	$237.00	$118.50	$177.75	
ES (employee + spouse)	$1,251.00	$260.00	$991.00	$495.50	$743.25	
EC (employee + child(ren)	$795.00	$260.00	$535.00	$267.50	$401.25	
FAM (family)	$1,550.00	$260.00	$1,290.00	$645.00	$967.50	
TSHB CoPay Plan Pooling	BOTH WORK FOR DISD AND ONE DECLINES COVERAGE					
ES (employee + spouse)	$1,251.00	$520.00	$731.00	$365.50	$548.25	
FAM (family)	$1,550.00	$520.00	$1,030.00	$515.00	$772.50	

2021-22 TRS-ActiveCare Plan Highlights Sept. 1, 2021

How to Calculate Your Monthly Premium

Total Monthly Premium
− Your District and State Contributions
= **Your Premium**

Ask your Benefits Administrator for your district's premiums.

Wellness Benefits at No Extra Cost

Being healthy is easy with:

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

Available for all plans.
See your Benefits Booklet for more details.

Things to Know

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

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

	TRS-ActiveCare Primary	TRS-
Plan summary	• Lowest premium of the plans • Copays for doctor visits before you meet deductible • Statewide network • PCP referrals required to see specialists • Not compatible with a health savings account (HSA) • No out-of-network coverage	• Lower deductible t • Copays for many s • Higher premium th • Statewide network • PCP referrals requi • Not compatible wit • No out-of-network

Monthly Premiums	Total Premium	Your Premium	Total Premi
Employee Only	$417	$ 157	$542
Employee and Spouse	$1,176	$ 916	$1,334
Employee and Children	$751	$ 491	$879
Employee and Family	$1,405	$ 1,145	$1,675

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

Doctor Visits		
Primary Care	$30 copay	
Specialist	$70 copay	
TRS Virtual Health	$0 per consultation	

Immediate Care		
Urgent Care	$50 copay	
Emergency Care	You pay 30% after deductible	Yo
TRS Virtual Health	$0 per consultation	

Prescription Drugs		
Drug Deductible	Integrated with medical	
Generics (30-Day Supply/90-Day Supply)	$15/$45 copay; $0 for certain generics	
Preferred Brand	You pay 30% after deductible	Yo
Non-preferred Brand	You pay 50% after deductible	Yo
Specialty	You pay 30% after deductible	Yo

Each includes a wide range of wellness benefits.

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

um	Your Premium	Total Premium	Your Premium
	$ 282	$429	$ 169
	$ 1,074	$1,209	$ 949
	$ 619	$772	$ 512
	$ 1,415	$1,445	$ 1,185

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

$30 copay	You pay 30% after deductible	You pay 50% after deductible
$70 copay	You pay 30% after deductible	You pay 50% after deductible
$0 per consultation	$30 per consultation	

$50 copay	You pay 30% after deductible	You pay 50% after deductible
u pay 20% after deductible	You pay 30% after deductible	
$0 per consultation	$30 per consultation	

$200 brand deductible	Integrated with medical
$15/$45 copay	You pay 20% after deductible; $0 for certain generics
u pay 25% after deductible	You pay 25% after deductible
u pay 50% after deductible	You pay 50% after deductible
u pay 20% after deductible	You pay 20% after deductible

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

TRS-ActiveCare 2

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

Total Premium	Your Premium
$1,013	$ 753
$2,402	$ 2,142
$1,507	$ 1,247
$2,841	$ 2,581

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

$30 copay	You pay 40% after deductible
$70 copay	You pay 40% after deductible
$0 per consultation	

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

$200 brand deductible
$20/$45 copay
You pay 25% after deductible ($40 min/$80 max)/ You pay 25% after deductible ($105 min/$210 max)
You pay 50% after deductible ($100 min/$200 max)/ You pay 50% after deductible ($215 min/$430 max)
You pay 20% after deductible ($200 min/$900 max)

Compare Prices for Common Medical Services

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

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

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

my Benefits Summary

Scott&White CARE PLANS PART OF BAYLOR SCOTT & WHITE HEALTH | TRS ActiveCare TEACHER RETIREMENT SYSTEM OF TEXAS

Fully Covered Healthcare Services	
Preventive Services	**No Charge**
Standard Lab and X-Ray	**No Charge**
Disease Management and Complex Case Management	No Charge
Well Child Care Annual Exams	**No Charge**
Immunizations (age appropriate)	No Charge
Nurse Advice Line	1-877-505-7947
Telehealth (MyBSWHealth and MDLIVE)	**$0 copay go to trs.swhp.org**
Plan Provisions	
Annual Deductible	**$1,150 Individual/ $3,450 Family**
Annual out-of-pocket maximum (including medical and prescription co-pays and co-insurance)	**$7,450 Individual/ $14,900 Family** (includes combined Medical and Rx copays, deductibles and coinsurance)
Lifetime Paid Benefit Maximum	None
Outpatient Services	
Primary Care[1]	**$20 Copay** First Primary Care Visit for Illness - $0 Copay[2]
Primary Care Dependents[1] (under age 19)	**$0 Copay [2]**
After-Hours Primary Care Clinics	$20 copay
Specialty Care	$70 copay
Other Outpatient Services	20% after deductible[3]
Diagnostic/Radiology Procedures	20% after deductible
Eye Exam (one annually)	No Charge
Allergy Serum & Injections	20% after deductible
Inpatient Services	
Overnight hospital stay: includes all medical services including semi-private room or intensive care	20% of charges after deductible
Maternity Care	
Prenatal Care	No Charge
Inpatient Delivery	20% of charges after deductible
Expecting the Best® Maternity Program[6]	**No Charge**
Equipment and Supplies	
Preferred Diabetic Supplies and Equipment - Rx only	$10/$25 copay; no deductible
Non-Preferred Diabetic Supplies and Equipment - Rx only	30% after Rx deductible
Durable Medical Equipment/ Prosthetics	20% after deductible

Home Health Services	
Home Health Care Visit	$70 copay
Worldwide Emergency Care	
Ambulance and Helicopter	$40 copay and 20% of charges after deductible
Emergency Room[5]	$500 copay after deductible
Urgent Care Facility	$50 copay
Prescription Drugs	
Annual Benefit Maximum	Unlimited
Rx Deductible per Individual Does not apply to preferred generic drugs	$200

Ask an SWHP Pharmacy representative how to save money on your prescriptions.	**Retail Quantity** (Up to a 30-day supply)	**Maintenance Quantity** (Up to a 90-day supply) Available at BSW Pharmacies, in-network retail pharmacies and mail order
ACA Preventive*	**$0 copay**	**$0 copay**
Preferred Generic	**$10 copay**	**$25 copay**
Preferred Brand	30% after Rx deductible	30% after Rx deductible
Non-Preferred	50% after Rx deductible	50% after Rx deductible
Online Refills	trs.swhp.org	
Mail Order	BSWH: 855.388.3090 OptumRx: 855.205.9182	

Specialty Medications (up to a 30-day supply)	
Tier 1	15% after Rx deductible
Tier 2	15% after Rx deductible
Tier 3	25% after Rx deductible
Diagnostic & Therapeutic Services	
Physical and Speech Therapy	$70 copay
Manipulative Therapy[4]	20% without office visit $40 plus 20% with office visit
Wellness	
Wondr Health™[6]	**No Charge**
Well-Being Assessment[6]	**No Charge**
Digital Health Coaching[6]	**No Charge**

[1]Including all services billed with office visit

[2]Does not apply to wellness or preventive visits

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

[4]35 visits per year maximum

[5]Copay waived if admitted within 24 hours

[6]See member guide for additional information

*See list of ACA preventive drugs on the Pharmacy Benefits page at **trs.swhp.org.**

Shared Medical -Pooled or Split Premium Options

Plan Summary

Pooled Employee

Spouses both working for the same participating entity/district, may pool/combine their District contribution.

- One employee needs to be designated as the primary/insured and the other will be secondary/waive.
- As primary, the total premium minus both district contributions will be deducted from your paycheck.
- The primary employee must select Pooled Primary "Employee/Spouse" or "Employee/Family" coverage.
- The secondary employee must select "I am Pooled under my Spouse".
- To participate in a Pooling option, both employees must notify the DISD Ins. Dept. by email to disdinsurance@dentonisd.org prior to enrolling so that the system can be updated for you. Otherwise, you will not have an option to Pool available.
- The deadline for notification to Pool for the 2021 - 2022 plan year is before 5:00 p.m. on August 14, 2021.

Split Employee

Spouses working for different **TRS ActiveCare participating** entity/district may split premium costs between the two of them.

- The DISD Insurance Benefits Administrator (Insurance Specialist/Ins. Dept.) must complete a 2021 - 2022 Application to Split Premiums for the Primary insured employee. The deadline to notify your Benefits Administrator by email at disdinsurance@dentonisd.org is before 5:00 p.m. on August 1, 2021.
- The Primary/insured employee will select the plan and which family members are to be covered upon enrollment.
- The spouse employee will be the secondary. The Secondary will waive/decline a medical plan.
- If the deadline is not met, the Application may be denied, and the full premium will be deducted from the Primary insured's pay.
- The payroll deductions for the plan selected by the Primary will be adjusted if TRS ActiveCare approves the Application to Split Premium and notification has been received and processed.
- Credit will not be given for any deductions taken prior to the effective date of a Split Premium application approval and processing.

IMPORTANT INFORMATION – SPLIT PREMIUM OPTION

Approved Split Premium billing arrangements will automatically end on 8/31 of each plan year. To participate in or continue a split premium option, a new application must be submitted by the Primary Insured employee Benefits Administrator (Insurance Specialist) prior to the above noted deadline during open enrollment or within the 31- calendar day deadline of a new employee's date of hire/contract start date.

NOTES

TSHBP

Alternative Medical Plan

YOUR BENEFITS PACKAGE

About this Benefit

The TSHBP is proud to offer a variety of plans and benefits to meet school district needs. Plans for 2021-22 include our High Deductible Health Plan (HDHP) and our CoPay Plan (CPP). Both plans are designed so members can easily navigate through their health medical needs.

tshb℠ PROGRAM

This is a general overview of your plan benefits. If the terms of this outline differ from your policy, the policy will govern. Additional plan details on covered expenses, limitations and exclusions are included in the summary plan description located on the Denton ISD Benefits Website: www.mybenefitshub.com/dentonisd

Texas Schools Health Benefits Program

About Texas Schools Health Benefits Program (TSHBP)

The Texas Schools Health Benefits Program is a regionally rated program developed for Texas school districts. Our purpose is to support the school children of Texas. We do this by providing health benefit solutions to our dedicated teachers, administrators, and support staff so they can concentrate on what they do best – teaching and supporting our kids. It is our desire to increase member health and well-being and provide tools necessary to identify and manage the health of each and every member.

TSHBP plans are available for school district employees who are employed by participating districts and are active, contributing TRS members.

Both TSHBP Plans Include

- A **Nationwide Network** for Physician and Ancillary Services. Both In and Out of Network physician and Ancillary Services are covered
- No primary care provider required or referral to a specialist. A member can **use any provider** in the network or out of the network
- A **Care Coordinator service (personal concierge)** to support members with all their medical needs and specifically assist them with all facility care
- Specialty drugs over $670 (30 day supply) are not covered, but the plan offers **Patient Assistance and Co-Pay assistance**
- A **patient advocate** to help members with any balance bill and to pay the bill on the members behalf if necessary
- **ACA Preventative Services** are paid at 100% and all copays and deductibles are waived

TSHBP High Deductible Highlights

- Significantly lower premium rates compared to the TRS-ActiveCare HD plan
- Lower out-of-pocket maximums since a member-only have to meet their deductible (no coinsurance)
    - TSHBP HD - $3,000
    - In comparison with TRSAC HD - $7,000
- Telehealth at a $30 Consultation Fee
- All eligible prescriptions are paid at 100% after the deductible

TSHBP Co-Pay Highlights

- A unique plan that members pay only copayments for service. All copayments apply to the deductible
- Lower out-of-pocket maximums since a member-only have to meet their deductible (no coinsurance)
    - TSHBP CoPay - $3,500
    - In comparison with TRSAC Primary - $8,150
- Telehealth at $0 Copay
- $0 copay for generic drugs at CVS, HEB, Wal-Mart, Sam's, and Costco ($10 copay at other network pharmacies)

Texas Schools Health Benefits Plan—HD Plan

HOW DOES TSHBP COMPARE TO TRS?

Our unique embedded deductible health plans offer members lower out-of - pocket maximums, bringing substantial savings without sacrificing care or quality.

WHAT ARE CARE COORDINATORS?

The Care Coordinators act as a personal concierge for all TSHBP plans and members, and their job is to support the member as their healthcare advocate. *Watch the below video to learn more.*

SCAN ME

https://tshbp.info/CCVideo

Plan Summary TSHBP HD Plan

Plan Features	In-Network Coverage	Out-of-Network Coverage
Network	HealthSmart - National	N/A
Plan Deductible Feature	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
Individual/Family Deductible	$3,000/$9,000	$3,500/$9,500
Individual/Family Maximum Out-of- Pocket	$3,000/$9,000	$3,500/$9,500
Health Savings Account (HSA) Eligible	Yes	Yes
Required - Primary Care Provider (PCP)	No	No
Required - PCP Referral to Specialist	No	No
Prescription Drug Benefits	Yes - Deductible, then Plan pays 100%	Yes - Deductible, then Plan pays 100%
Doctor Visits		
Preventive Care	Yes - $0 copay	Yes - $0 copay
Virtual Health - Teladoc	$30 per consultation	$30 per consultation
Primary Care	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
Specialist	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
Office Services		
Allergy Injections	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
Allergy Serum	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
Chiropractic Services	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
Office Surgery	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
MRI's, Cat Scans, and Pet Scans	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
Urgent Care Facility	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
Care Facilities		
Urgent Care Facility	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
Freestanding Emergency Room	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
Hospital Emergency Room	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
Ambulance Services	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%
Outpatient Surgery	Deductible, then Plan pays 100%	In-Network Only
Hospital Services	Deductible, then Plan pays 100%	In-Network Only
Surgeon Fees	Deductible, then Plan pays 100%	In-Network Only
Maternity and Newborn Services		
Maternity Charges (prenatal and postnatal care)	Deductible, then Plan pays 100%	In-Network Only
Routine Newborn Care	Deductible, then Plan pays 100%	In-Network Only
Rehabilitation/Therapy		
Occupational/Speech/Physical	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%*
Cardiac Rehabilitation	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%*
Chemotherapy, Radiation, Dialysis	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%*
Home Health Care	Deductible, then Plan pays 100%	Deductible, then Plan pays 100%*
Skilled Nursing	Deductible, then Plan pays 100%	In-Network Only

Care Coordinator*

The Care Coordinator program must be used to access facility services or no benefits will be available under the Plan.

These services include routine colonoscopy and related services; hospital providers for MRIs, Cat Scans, and Pet Scans; hospital providers for outpatient Lab/Radiology Services; Inpatient Hospital Admissions; Outpatient Hospital/Ambulatory Surgical Facility Services; Maternity and Newborn Services; Rehabilitation/Therapy Services; Extended Care Services; and Other Services including durable medical equipment/supplies, orthotics/ prosthetics, facilities for diabetic self-management training, and sleep disorder services. To review the complete plan document and services that require access through the Care Coordinator program, please call 888-803-0081.

Texas Schools Health Benefits Plan—CoPay Plan

HOW DOES TSHBP COMPARE TO TRS?

Our unique embedded deductible health plans offer members lower out-of - pocket maximums, bringing substantial savings without sacrificing care or quality.

WHAT ARE CARE COORDINATORS?

The Care Coordinators act as a personal concierge for all TSHBP plans and members, and their job is to support the member as their healthcare advocate. *Watch the below video to learn more.*

SCAN ME

https://tshbp.info/CCVideo

Plan Summary TSHBP CoPay Plan

Plan Features	In-Network Coverage	Out-of-Network Coverage
Network	HealthSmart - National	N/A
Plan Deductible Feature	Copayments, then Plan pays 100%	Copayments, then Plan pays 100%
Individual/Family Deductible	$3,500/$10,500	$4,000/$11,000
Individual/Family Maximum Out-of- Pocket	$3,500/$10,500	$4,000/$11,000
Health Savings Account (HSA) Eligible	No	No
Required - Primary Care Provider (PCP)	No	No
Required - PCP Referral to Specialist	No	No
Prescription Drug Benefits	Yes - Copayments, then Plan pays 100%	Yes - Copayments, then Plan pays 100%
Doctor Visits		
Preventive Care	Yes - $0 copay	Yes - $0 copay
Virtual Health - Teladoc	$0 per consultation	$0 per consultation
Primary Care	$35 copay	$40 copay
Specialist	$35 copay	$40 copay
Office Services		
Allergy Injections	$5 copay	$10 copay
Allergy Serum	$35 copay	$40 copay
Chiropractic Services	$35 copay	$40 copay
Office Surgery	$110 copay	$125 copay
MRI's, Cat Scans, and Pet Scans	$275 copay	$325 copay
Urgent Care Facility	$50 copay	$75 copay
Care Facilities		
Urgent Care Facility	$50 copay	$75 copay
Freestanding Emergency Room	$500 copay	$500 copay
Hospital Emergency Room	$500 copay	$500 copay
Ambulance Services	$220 copay	$220 copay
Outpatient Surgery	$500 copay	In-Network Only
Hospital Services	$500 copay	In-Network Only
Surgeon Fees	$100 copay	In-Network Only
Maternity and Newborn Services		
Maternity Charges (prenatal and postnatal care)	$500 copay	In-Network Only
Routine Newborn Care	$250 copay	In-Network Only
Rehabilitation/Therapy		
Occupational/Speech/Physical	$55 copay	$65 copay*
Cardiac Rehabilitation	$110 copay	$125 copay*
Chemotherapy, Radiation, Dialysis	$110 copay	$125 copay*
Home Health Care	$55 copay	$75 copay*
Skilled Nursing	$500 copay	In-Network Only

Care Coordinator*

The Care Coordinator program must be used to access facility services or no benefits will be available under the Plan.

These services include routine colonoscopy and related services; hospital providers for MRIs, Cat Scans, and Pet Scans; hospital providers for outpatient Lab/Radiology Services; Inpatient Hospital Admissions; Outpatient Hospital/Ambulatory Surgical Facility Services; Maternity and Newborn Services; Rehabilitation/Therapy Services; Extended Care Services; and Other Services including durable medical equipment/supplies, orthotics/ prosthetics, facilities for diabetic self-management training, and sleep disorder services. To review the complete plan document and services that require access through the Care Coordinator program, please call 888-803-0081.

Denton ISD

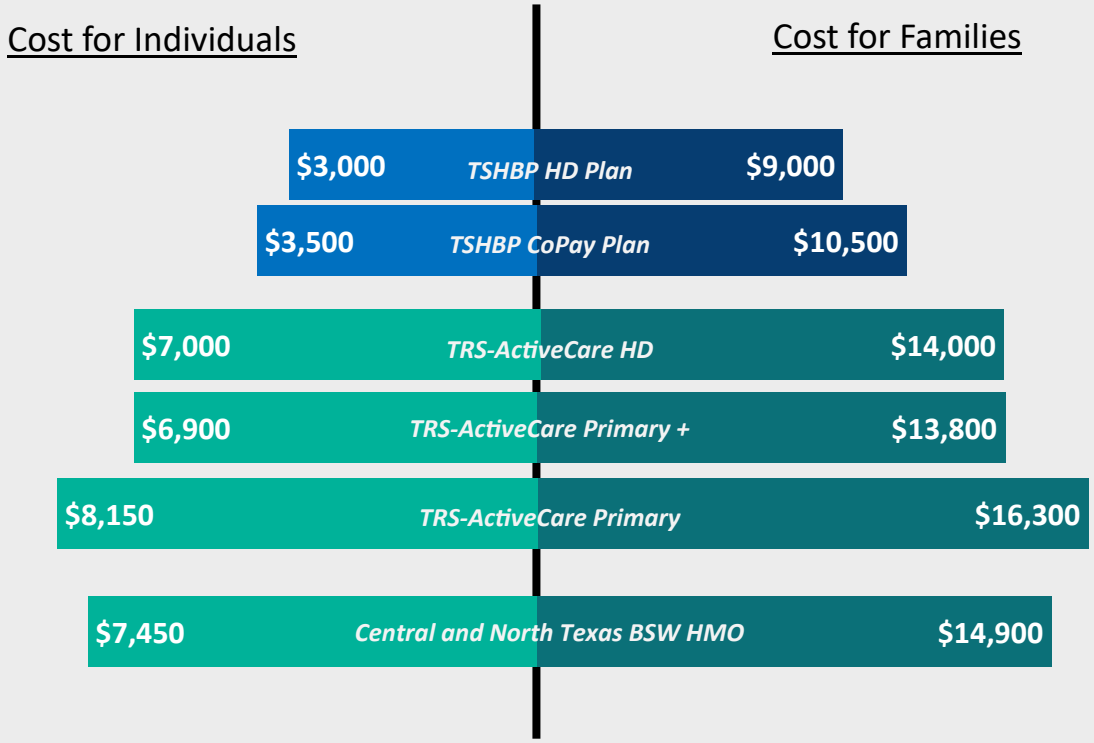
Medical Rates 2021-22

The rates below are not inclusive of your district's medical contribution. Please visit your benefit website for more information regarding your district's medical contribution amounts.

	EO	EC	ES	EF
TRS-ActiveCare HD	$429	$772	$1,209	$1,445
TRS-ActiveCare Primary +	$542	$879	$1,334	$1,675
TRS-ActiveCare Primary	$417	$751	$1,176	$1,405
Central and North Texas BSW HMO	$542	$872	$1,363	$1,568

TSHBP	EO	EC	ES	EF
HD Plan	$342	$651	$972	$1,292
CoPay Plan	$497	$795	$1,251	$1,550

Maximum Out-of-Pocket Costs (In-Network) For 2021-22



Texas Schools Health Benefits Cost Examples

PEG IS HAVING A BABY

	TRS			TSHBP	
	HD	Primary	Primary+	HD	Co Pay
Deductible	$3,000	$2,500	$1,200	$3,000	$3,500
Specialist Coinsurance/Copayment	30%	$70	$70	0%	$35
Hospital Coinsurance/Copayment	30%	30%	20%	0%	$500
Other Coinsurance/Copayment	30%	30%	20%	0%	$250
Total Example Cost	$12,800	$12,800	$12,800	$12,800	$12,800
Deductibles	$3,000	$2,500	$1,200	$3,000	$0
Copayments	$0	$70	$70	$0	$1,285
Coinsurance	$2,940	$3,000	$2,300	$0	$0
Limits or Exclusions	$60	$60	$60	$0	$0
Total Cost	$6,000	$5,630	$3,630	$3,000	$1,285

Compared to TRS-AC HD (savings)	$3,000
Compared to TRS-AC Primary (savings)	$2,345
Compared to TRS-AC Primary + (savings)	$4,345

TOM'S KNEE REPLACEMENT

	TRS			TSHBP	
	HD	Primary	Primary+	HD	Co Pay
Deductible	$3,000	$2,500	$1,200	$3,000	$3,500
Specialist Coinsurance/Copayment	30%	$70	$70	0%	$35
Hospital Coinsurance/Copayment	30%	30%	20%	0%	$500
Other Coinsurance/Copayment	30%	30%	20%	0%	$250
Total Example Cost	$38,000	$38,000	$38,000	$38,000	$38,000
Deductibles	$3,000	$2,500	$1,200	$3,000	$0
Copayments	$0	$70	$70	$0	$1,385
Coinsurance	$10,500	$10,650	$7,360	$0	$0
Limits or Exclusions	$60	$60	$60	$0	$0
Total Cost	$7,000*	$8,150*	$6,900*	$3,000	$1,385

Compared to TRS-AC HD (savings)	$4,000
Compared to TRS-AC Primary (savings)	$6,785
Compared to TRS-AC Primary + (savings)	$5,535

**Out-of-pocket limit*

EECU

HSA (Health Savings Account)

YOUR BENEFITS PACKAGE

About this Benefit

A Health Savings Account is a tax-advantaged medical savings account available to employees who are enrolled in a high-deductible health plan. The funds contributed to the account are not subject to federal income tax at the time of deposit. Unlike a flexible spending account (FSA), funds roll over and accumulate year to year if not spent.

The interest earned in an HSA is tax free.

Money withdrawn for medical spending never falls under taxable income.

This is a general overview of your plan benefits. If the terms of this outline differ from your policy, the policy will govern. Additional plan details on covered expenses, limitations and exclusions are included in the summary plan description located on the Denton ISD Benefits Website: www.mybenefitshub.com/dentonisd

HSA (Health Savings Account)

What is an HSA?

Health Savings Account (HSA) enables you to save for and conveniently pay for qualified healthcare expenses, while you earn tax-free interest and pay no monthly service fees.

Opening a Health Savings Account provides both immediate and long term benefits. The money in your HSA is always yours, even if you change jobs, switch your health plan, become unemployed or retire. Your unused HSA balance rolls over from year to year. And best of all, HSAs have tax-free deposits, tax-free earnings and tax-free withdrawals. And after age 65, you can withdraw funds from your HSA penalty-free for any purpose*.

EECU HSA Benefits

- **Save money tax-free for healthcare expenses** – contributions are not subject to federal income taxes and can be made by you, your employer or a third party*
- **No monthly service fee** – so you can save more and earn more
- **Earn competitive dividends on your entire balance –** compounded daily and paid monthly from deposit to withdrawal
- **Conveniently pay for qualified healthcare expenses –** with a free, no annual fee EECU HSA Debit Mastercard® or via EECU's free online bill pay. (HSA checks are also available upon request, for a nominal fee**)
- **Free online, mobile and branch access** – allows you to actively manage your account however you prefer
- **Comprehensive service and support** – to assist you in optimizing your healthcare saving and spending
- **Federally insured** – to at least $250,000 by NCUA

2021 Annual HSA Contribution Limits

Individual: $3,600

Family: $7,200

Catch-Up Contributions: Accountholders who meet the qualifications noted below are eligible to make an HSA catch-up contribution of an additional $1,000.

- Health Savings accountholder
- Age 55 or older (regardless of when in the year an accountholder turns 55)
- Not enrolled in Medicare (if an accountholder enrolls in Medicare mid-year, catch-up contributions should be prorated)

Authorized Signers who are 55 or older must have their own HSA in order to make the catch-up contribution

How to Use Your Funds

- **HSA Debit Card** – use your EECU HSA Mastercard® debit card to pay healthcare providers at point-of-sale or by following the instructions provided on a bill from a medical provider.

- **Online Bill Pay** – sign up, at eecu.org, and use EECU's free online banking and bill pay to make payments to medical providers directly from your HSA.
- **Online Transfers** – use EECU's online banking or mobile app; reimburse yourself for out-of-pocket expenses by making a transfer from your HSA to your personal checking or savings account.
- **Check** – optional HSA checks can be ordered upon request for a fee. You can use these checks to pay healthcare providers and suppliers.

Save your receipts *– for all qualified medical expenses. EECU does not verify eligibility. You are responsible for making sure payments are for qualified medical expenses.*

How To Manage Your Account

- Online - check your balance, pay healthcare providers and arrange deposits; sign-up for online banking at www.eecu.org.
- Mobile - EECU's mobile app allows you to manage your account on the go; download "EECU Mobile Banking" in Apple's App Store and Google Play.
- Contact Member Service – call 817-882-0800 for help with your HSA questions or transactions. You can also chat with us online at eecu.org or use our secure email. Member Service is available Monday through Friday from 8:00am – 7:00pm CT, Saturdays from 9am – 1pm CT and closed on Sunday.
- Account Statements – monthly account statements show all your account activity for that period. You can receive free online statements or printed statements.

* Contributions, investment earnings, and distributions are tax free for federal tax purposes if used to pay for qualified medical expenses, and may or may not be subject to state taxation. A list of Eligible Medical Expenses can be found in IRS Publication 502, http://www.irs.gov/pub/irs-pdf/p502.pdf. As described in IRS publication 969, http://www.irs.gov/pub/irs-pdf/p969.pdf, certain over-the-counter medications (when prescribed by a doctor) are considered eligible medical expenses for HSA purposes. If an individual is 65 or older, there is no penalty to withdraw HSA funds. However, income taxes will apply if the distribution is not used for qualified medical expenses. For more information consult a tax adviser or your state department of revenue. All contributions and distributions are your responsibility and must be within IRS regulatory limits.

** Call 817-882-0800 or stop-by an EECU branch to order standard checks at no charge (excludes shipping and handling) or order custom checks - prices vary.

CIGNA

Dental

YOUR BENEFITS PACKAGE

About this Benefit

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

Good dental care may improve your overall health.

Also

Women with gum disease may be at greater risk of giving birth to a preterm or low birth weight baby.

This is a general overview of your plan benefits. If the terms of this outline differ from your policy, the policy will govern. Additional plan details on covered expenses, limitations and exclusions are included in the summary plan description located on the Denton ISD Benefits Website: www.mybenefitshub.com/dentonisd

Dental - High PPO

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	
Policy Year Benefits Maximum Applies to: Class II & III expenses	$2,000		$2,000	
Policy Year Deductible Individual Family	$50 Unlimited		$50 Unlimited	
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: Dentures	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 Denture Relines, Rebases and Adjustments	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 19 Lifetime Benefits Maximum: $1,500	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible

Monthly Premiums	
EE Only	$51.69
EE + Spouse	$110.43
EE + Children	$100.08
EE + Family	$186.52

Cigna Dental Benefit Summary

Denton ISD #3340946

High Plan Renewal Date: 09/01/2021

Insured by: Cigna Health and Life Insurance Company

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.

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 90th percentile of all provider charges 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.
Policy Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Policy Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.

Dental PPO - High PPO

Benefit Plan Provisions:	
Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III and IV services for 12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program – those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the plan deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations	2 per policy year
X-rays (routine)	Bitewings: 2 per policy year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 consecutive months
Diagnostic Casts	Payable only in conjunction with orthodontic workup
Cleanings	2 per policy year, including periodontal maintenance procedures following active therapy
Fluoride Application	1 per policy year for children under age 19
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once
Denture Adjustments, Rebases and Relines	Covered if more than 6 months after installation
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges
Benefit Exclusions: Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting;	
Prosthodontic: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;	
Implants: implants or implant related services;	
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;	
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;	
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs	
Charges in excess of the Maximum Reimbursable Charge.	

Dental - Low PPO

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 Allowable Charge	
Policy Year Benefits Maximum Applies to: Class II & III expenses	$1,250		$1,250	
Policy Year Deductible Individual Family	$50 Unlimited		$50 Unlimited	
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	90% No Deductible	10% No Deductible	90% No Deductible	10% No Deductible
Class II: Basic Restorative Restorative: fillings Oral Surgery: simple extractions only X-rays: non-routine	70% After Deductible	30% After Deductible	70% After Deductible	30% 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 Oral Surgery: all except simple extractions Extractions of Impacted Teeth Anesthesia: general and IV sedation Endodontics: minor and major Periodontics: minor and major Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments	40% After Deductible	60% After Deductible	40% After Deductible	60% After Deductible

Monthly Premiums	
EE Only	$21.09
EE + Spouse	$41.95
EE + Children	$45.47
EE + Family	$66.36

Cigna Dental Benefit Summary

Denton ISD #3340946

High Plan Renewal Date: 09/01/2021

Insured by: Cigna Health and Life Insurance Company

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.

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 Allowable Charge. 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.
Policy Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Policy Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.

Dental PPO - Low PPO

Benefit Plan Provisions:	
Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III and IV services for 12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program – those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the plan deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations	2 per policy year
X-rays (routine)	Bitewings: 2 per policy year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 consecutive months
Cleanings	2 per policy year, including periodontal maintenance procedures following active therapy
Fluoride Application	1 per policy year for children under age 19
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once
Denture Adjustments, Rebases and Relines	Covered if more than 6 months after installation
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Benefit Exclusions: Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting;	
Prosthodontic: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;	
Implants: implants or implant related services;	
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;	
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;	
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs	
Charges in excess of the Maximum Allowable Charge.	

Dental - DHMO

CIGNA DENTAL CARE® DHMO
Your healthy smile starts here

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

Monthly Premiums	
EE Only	$14.54
EE + Spouse	$28.95
EE + Children	$31.26
EE + Family	$45.66

Regular dental care is important for a healthy smile. And a healthy body. With Cigna Dental Care® DHMO, you get comprehensive dental coverage that's easy to use. At a wallet-friendly price. Now that's something to smile about.

Get to know DHMO

This information will help you learn more about Cigna DHMO. Like what's included, how it works and how to enroll. Review your plan materials so you can get the most from your benefits. Remember, we're here for you every step of the way.
If you have questions, call **800.Cigna24** (800.244.6224).

How the plan works

You must choose a network general dentist to manage your overall dental care. Covered family members can choose their own network general dentists. You can pick a location near their home, work or school. **Remember to always pick a network general dentist who's within 25 miles of your location to ensure adequate access.**

We make it easy to find a convenient location. Our DHMO1 network is one of the largest in the U.S.2

- Specialty care. For some specialty care, your network general dentist will refer you to a network specialist. (Except pediatric for children under, orthodontic and endodontic.)
- Pediatric dentist. Children under age 7 don't need a referral to see a network pediatric dentist.
- Orthodontics. No referral is needed to see a network orthodontist. (Check your plan materials to see if you have orthodontic coverage).
- In-network dentists. Is your current dentist not part of the DHMO network? We're happy to consider adding new dentists to our network. In the meantime, you must choose a network dentist for coverage to apply. If you see a dentist outside Cigna's DHMO network, your plan will not pay. (Unless it is an emergency.)[3]
- No deductibles. You don't have to reach an out-of-pocket cost before your insurance starts. Coverage starts on the first day.
- No dollar maximums. Your coverage isn't limited by an annual maximum. No matter the amount of your covered expenses.

Finding a network dentist is easy

Once you select DHMO as your plan, you can:

- Go to myCigna.com and search the dentist directory. It's updated weekly.
- Call 800.Cigna24 (800.244.6224) to speak with a customer service representative. You can ask for a customized network directory via email.

What's covered

With your DHMO plan, you can save money on dental services, including:

- Preventive care – cleanings, fluoride, sealants, bitewing x-rays, full mouth x-rays and more.
- Basic care – tooth-colored fillings (called resin or composite). And silver-colored fillings (called amalgam).
- Major services – crowns, bridges and dentures (including those placed over implants). Also root canals, oral surgery, extractions, treatment for periodontal (gum) disease and more.
- Orthodontic care – many plans have coverage for braces for children and adults. Check your plan materials.
- Teeth whitening – using take-home bleaching trays and gel.
- Athletic mouth guard – including creation and adjustments.
- General anesthesia – when medically necessary.
- Temporomandibular joint (TMJ) – diagnosis and treatment, including cone beam x-ray and appliance.

Alternate coverage provisions may apply for covered services if noted on your Patient Charge Schedule (PCS).4 Review your enrollment materials for more details.

What's not covered

All plans have exclusions and limitations. Please note:

- In most states, services must go through a network general dentist for coverage to apply. (Except in case of emergency.)
- Prior authorization may be needed for certain specialty care treatments.
- Only procedures that are medically necessary and listed on the plan's PCS are covered.

Here are some examples of services that aren't covered:[5]

- Experimental and cosmetic dentistry.
- Treatments or surgery if associated with a poor or hopeless diagnosis.
- Recementation of crowns, inlays and onlays, posts and cores, and veneers - within 180 days of initial placement.
- Crowns, bridges and implant supported prostheses used only for splinting.
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS.

Dental - DHMO

- Work already in progress. This refers to treatment that began under a different plan and continues into the new Cigna plan coverage period. Includes crowns, bridges, dentures, root canal treatment or implant supported prostheses.[3]

More about your DHMO plan

- Easy to understand plan. Your share of out-of-pocket costs is clearly listed on your PCS. Only covered procedures are listed.
- No claim forms. No forms to file and no waiting periods for coverage.
- Pre-existing conditions aren't excluded.

As long as the procedures are covered under your PCS. However, work already in progress for crowns, bridges, dentures, root canal treatment or implant supported prostheses is excluded.[6]

- No age limit on sealants, which help prevent tooth decay.
- Oral cancer detection. Your preventive care coverage includes dental procedures to help find oral cancer in its early stages.

The Cigna Dental Oral Health Integration Program®

This program offers enhanced dental coverage for customers with these medical conditions:

- Diabetes
- Heart disease
- Stroke
- Maternity
- Head and neck cancer radiation
- Organ transplants
- Chronic kidney disease

If you qualify, you're reimbursed 100% of eligible out-of-pocket costs for certain dental procedures.

We're there for you, when you need it most

Your DHMO plan includes extra support at no added cost to you. These programs and services are included in your coverage:

- Dental Information Line. Trained professionals are on hand 24/7/365 to answer your dental questions.
- Cigna's Identity Theft Program.7 We're here for you 24/7/365 to help resolve critical identity theft issues, such as:
    - Credit card fraud
    - Financial and/or medical identity theft

After you enroll

Here's what you can expect when you sign up for Cigna DHMO coverage:

- You'll get an ID card, a PCS and other plan materials.
- At the time of service, you're responsible for paying for covered services. See your PCS for more detail.
- You may change your dental office for any reason. The change will take effect the first day of the next month.* To make the change, visit myCigna.com. Or call the number on your ID card or 800.Cigna24 (800.244.6224). You can speak with a representative or use our automated Quick Transfer option.
- You can get a second opinion from a different network general dentist. Just call customer service. They will help you make arrangements.
- Your dentist selection must be made by the 15th day of the month for the change to take effect on the first of the following month.

Enrollment is easy – follow these simple steps:

- Review your plan materials to understand your choices.
- Select your network general dentist.
- Enroll. Complete and sign the paper enrollment form and return it to your employer. (If your employer has a different enrollment process, follow your employer's instructions.)
- Register on myCigna.com. You can access information to help you get the most out of your plan.

When it comes to dental care, we've got you covered. To learn more about Cigna DHMO, go to Cigna.com before you enroll. Or to your personalized website, myCigna.com, after you sign up. To speak to customer service, call the number on your ID card or 800.Cigna24 (800.244.6224).

1. "DHMO"is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans and plans with open access features. The Cigna DHMO is not available in the following states: AK, HI, ME, MT, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY.
2. 7,382 locations. NetMinder. DHMO data as of March 2016 and is subject to change.The Ignition Group makes no warranty regarding the performance of the data and the results that will be obtained by using.
3. Minnesota residents: If you enroll in the Cigna Dental Care (DHMO) plan, you must visit your selected network dentist in order for the charges on the Patient Charge Schedule to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We will pay 50% of the value of your network benefit for those services. You'll pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Service for more information. Oklahoma residents: DHMO for Oklahoma is an Employer Group Prepaid Dental Plan. You may also visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We pay non-network dentists the same amount we'd pay network dentists for covered services. You'll pay less if you visit a network dentist in the Cigna Dental Care network. Call customer service for more information.
4. Covered services may cost less than alternative services suggested by the dentist. You can receive the dental procedure

of your choice. However, if you choose the higher cost procedure, you will be responsible for paying the Patient Charge for the covered procedure plus the difference in cost between the dentist's usual charges for the less costly procedure and higher cost procedure.
5. Unless otherwise listed on the Patient Charge Schedule (PCS) or required by law. This is not a complete list. Actual terms of coverage may vary by state. For a more complete list of both covered and not covered services, including benefits required by your state, refer to the rest of your enrollment materials or call 800.Cigna24 (800.244.6224) if you have questions or need more information.
6. California and Texas residents: Treatment already in progress on the effective date of your coverage is not excluded if otherwise covered under your PCS.
7. This program is NOT insurance and does not provide for reimbursement of financial losses. Cigna's Identity Theft services are provided under a contract with Generali Global Assistance, Inc. Full term, conditions and exclusions are contained in Cigna's Identity Theft Program service agreement.
All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. Cigna Dental Care (DHMO) plans are insured by Cigna Dental 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 Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, Cigna Dental Health of Kansas, Inc. (KS & NE), Cigna Dental Health of Kentucky, Inc. (KY & IL), Cigna Dental Health of Maryland, 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 Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, Cigna Dental Care plans are insured by Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company (CGLIC), or Cigna HealthCare of Connecticut, Inc., and administered by Cigna Dental Health, Inc. Policy forms: OK - HP-POL115 (CHLIC), GM6000 DEN201V1 (CGLIC); TN – HP-POL134/HC-CER17V1 et al (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.
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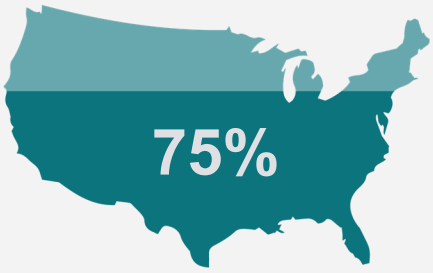
SUPERIOR VISION

Vision

YOUR BENEFITS PACKAGE

About this Benefit

Vision insurance provides coverage for routine eye examinations and may cover all or part of the costs associated with contact lenses, eyeglasses and vision correction, depending on the plan.

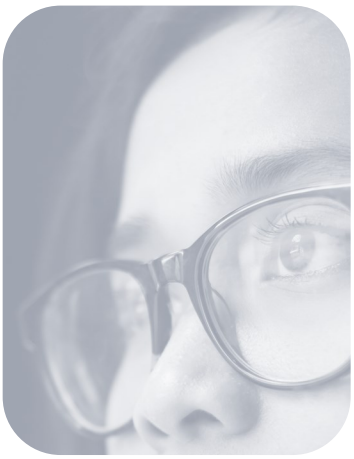


of U.S. residents between age 25 and 64 require some sort of vision correction.

This is a general overview of your plan benefits. If the terms of this outline differ from your policy, the policy will govern. Additional plan details on covered expenses, limitations and exclusions are included in the summary plan description located on the Denton ISD Benefits Website: www.mybenefitshub.com/dentonisd

Vision - Superior National Network

You have the option of choosing either the high option or the low option plan. The high option allows you to receive the contact lens allowance **AND** one complete pair of glasses every 12 months. The low option allows you to receive the contact lens allowance **OR** the frame allowance every 12 months.



High Option Plan	
Co-Pays	
Exam	$10
Materials[1]	$20
Contact Lens Fitting	$25
Monthly Premiums	
Emp. Only	$16.95
Emp. + spouse	$36.48
Emp. + child(ren)	$27.45
Emp. + family	$50.10
Services/Frequency	
Exam	12 months
Frames	12 months
Contact Lens Fitting	12 months
Lenses	12 months
Contact Lenses	12 months

Low Option Plan	
Co-Pays	
Exam	$15
Materials[1]	$20
Contact Lens Fitting	$25
Monthly Premiums	
Emp. Only	$9.04
Emp. + spouse	$19.46
Emp. + child(ren)	$14.63
Emp. + family	$26.71
Services/Frequency	
Exam	12 months
Frames	12 months
Contact Lens Fitting	12 months
Lenses	12 months
Contact Lenses	12 months

Benefits through Superior National Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam (MD)	Covered in full	Up to $42	Covered in full	Up to $42
Exam (OD)	Covered in full	Up to $37	Covered in full	Up to $37
Frames	$150 retail allowance	Up to $60	$125 retail allowance	Up to $50
Contact Lens Fitting (standard[2])	Covered in full	Not covered	Covered in full	Not covered
Contact Lens Fitting (specialty[2])	$50 retail allowance	Not covered	$50 retail allowance	Not covered
Lenses (standard) per pair				
Single Vision	Covered in full	Up to $26	Covered in full	Up to $26
Bifocal	Covered in full	Up to $34	Covered in full	Up to $34
Trifocal	Covered in full	Up to $50	Covered in full	Up to $50
Progressive lens upgrade	See description[3]	Up to $50	See description[3]	Up to $50
Photochromic	Covered in full	Not covered	Not covered	Not covered
Polycarbonate	Covered in full	Not covered	Not covered	Not covered
Factory scratch coat	Covered in full	Not covered	Not covered	Not covered
Contact Lenses	$150 retail allowance	Up to $100	$150 retail allowance[4]	Up to $100

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

1 Materials co-pay applies to lenses and frames only, not contact lenses

2 See your benefits materials for definitions of standard and specialty contact lens fittings

3 Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay

4 Contact lenses are in lieu of eyeglass lenses and frames benefit

Discount Features

Look for providers in the Provider Directory who accept discounts, as some do not; please verify their services and discounts (range from 10%-30%) prior to service as they vary.

Discounts on Covered Materials

Frames: 20% off amount over allowance

Lens options: 20% off retail

Progressives: 20% off amount over retail lined trifocal lens, including lens options

The following options have out-of-pocket maximums[5] on standard (not premium, brand, or progressive) lenses.

	Maximum Member Out-of-Pocket	
	Single Vision	**Bifocal & Trifocal**
Ultraviolet coat	$15	$15
Tints, solid or gradients	$25	$25
Anti-reflective coat	$50	$50
High index 1.6	$55	20% off retail

[5] Discounts and maximums may vary by lens type. Please check with your provider.

Discounts on Non-Covered Exam and Materials

Exams, frames, and prescription lenses:	30% off retail
Lens options, contacts, other prescription materials:	20% off retail
Disposable contact lenses:	10% off retail

Refractive Surgery

Superior Vision has a nationwide network of refractive surgeons and leading LASIK networks who offer members a discount. These discounts range from 15%-50%, and are the best possible discounts available to Superior Vision.

The Plan discount features are not insurance.
All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.
Discounts are subject to change without notice.
Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your vision plan. Please check with your Human Resources department if you have any questions.
Superior Vision Services, Inc. P.O. Box 967 Rancho Cordova, CA 95741 800.507.3800
SuperiorVision.com The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, AKA The Guardian or Guardian Life

AUL A ONEAMERICA COMPANY

Life and AD&D

YOUR BENEFITS PACKAGE

About this Benefit

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

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

Motor vehicle crashes are the

cause of accidental deaths in the US, followed by poisoning, falls, drowning, and choking.

This is a general overview of your plan benefits. If the terms of this outline differ from your policy, the policy will govern. Additional plan details on covered expenses, limitations and exclusions are included in the summary plan description located on the Denton ISD Benefits Website: www.mybenefitshub.com/dentonisd

Life and AD&D

What you need to know:

Are you eligible?
Benefits are available to employees who are actively at work on the effective date of coverage and working the minimum number of hours per week stated in the contract.

Your premiums and benefits may vary.
Actual premiums and benefit amounts will be calculated by OneAmerica and may change upon reaching certain ages, according to contract terms, and are subject to change. Volumes and benefit amounts shown may be subject to reductions due to age.

Enroll timely for guaranteed issue coverage.
You may be eligible for coverage without having to answer any health questions if you enroll during the initial enrollment period when benefits are first offered by OneAmerica®, or if you enroll as a newly hired employee within 31 days after any applicable waiting period.

Enrolling later requires approval.
If you decline coverage now, you will lose your only chance to apply for group insurance coverage without having to first undergo medical underwriting. If you decide to enroll later, you will need to submit a Statement of Insurability form for review. OneAmerica will then decide to approve or deny your coverage based on your health history. You may not be approved for any type of coverage at a later date if you have any current or future medical conditions.

What you need to do:

Carefully review the contents of this packet.
Enclosed is personal information about the benefits offered to you by OneAmerica on behalf of your employer. This is your opportunity to learn more about group insurance from OneAmerica, but it is not a complete explanation of benefits. For more information, consult the contract about exclusions, limitations, reduction of benefits, and terms under which the contract may be continued in force or discontinued.

Review the Notices and Limitations.
Visit www.employeebenefits.aul.com to find the Notices and Limitations, G-14320 (05 Prudent) 12/28/12. Go to Forms, Policy/Employee Admin, and Notices and Limitations.

Note: Products issued and underwritten by American United Life Insurance Company® (AUL), a OneAmerica company. Not available in all states or may vary by state.

Protecting the ones you care about most

"How will my loved ones be taken care of when I'm gone?" This question isn't something anyone wants to think about, but if someone depends on you for financial support, then life insurance is your answer.

Income protection for your loved ones
No matter what your current situation is: single, married, with or without children; life insurance helps replace your income, and will assist your family in paying final expenses. It will also allow your loved ones to continue any future plans, such as college education or savings.

Why you need it
There are several reasons you need life insurance. In addition to paying for burial expenses, consider life insurance an option to pay for the mortgage, medical expenses and fund college education. If you work or have savings, then you have the income to pay these bills. However, consider what happens when your loved ones no longer have your financial support.

How much is enough
Figuring out how much life insurance you need is hard to decide. You want to make sure you have enough to protect your family. To help you answer this question, use the calculator to estimate your expenses to think about which bills would need income protection.

Estimate your expenses below	
Income and possessions	**Amount**
Annual income	
Number of years until retirement	
Subtotal *(annual income x years)*	
Debt and final expenses	
Mortgage/rent	
Credit card(s), car payment(s), etc.	
Funeral and burial expenses ($7,000 is a good estimate)	
Subtotal *(debt)*	
Educational costs	
College expenses *(Approximately $32,405/year for private, $9,410 for state residents at public schools and $23,893 for out-of -state residents attending public universities)*	
Subtotal *(education)*	
Total needed for your life insurance	**$**

Typically, life insurance offered through work is less expensive than if you purchased it on your own. Consider purchasing life insurance today.

What you need to know about your Basic Life and AD&D Benefits

Guaranteed Issue: Employee: $15,000
Accidental Death and Dismemberment (AD&D):
Additional life insurance benefits may be payable in the event of an accident which results in death or dismemberment as defined in the contract. Additional AD&D benefits include seat belt, air bag, repatriation, child higher education, child care, paralysis/ loss of use, severe burns, disappearance, and exposure.

Life and AD&D

Accelerated Life Benefit:
If diagnosed with a terminal illness and have less than 12 months to live, you may apply to receive 25%, 50% or 75% of your life insurance benefit to use for whatever you choose.

Basic Employee Life and AD&D Coverage

Your Life and AD&D insurance coverage amount is $15,000. Coverage is provided at no cost to you

What you need to know about your Basic Life and AD&D Benefits

Flexible Options:
Employee: $10,000 to $500,000, in $10,000 increments
Spouse: $5,000 to $250,000, in $5,000 increments, not to exceed 100% of the employee's amount

Guaranteed Issue:

Employee	$250,000
Spouse	$50,000
Child	$10,000

Dependent Life Coverage:
Optional dependent life coverage is available to eligible employees. You must select employee coverage in order to cover your spouse and/or child(ren).

Accidental Death and Dismemberment (AD&D):
You must select Life coverage in order to select any AD&D coverage. Additional life insurance benefits may be payable in the event of an accident which results in death or dismemberment as defined in the contract.

Accelerated Life Benefit:
If diagnosed with a terminal illness and have less than 12 months to live, you may apply to receive 25%, 50% or 75% of your life insurance benefit to use for whatever you choose.

Annual Increase In Benefit:
You and your spouse may be eligible to increase your coverage annually until you reach the guaranteed issue amount without providing evidence of insurability.

PAYROLL DEDUCTION ILLUSTRATION: MONTHLY EMPLOYEE OPTIONS

Life & AD&D	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$.70	$.70	$.70	$.80	$.90	$1.30	$1.70	$2.60	$3.90	$6.00	$11.60	$11.60	$11.60
$30,000	$2.10	$2.10	$2.10	$2.40	$2.70	$3.90	$5.10	$7.80	$11.70	$18.00	$34.80	$34.80	$34.80
$50,000	$3.50	$3.50	$3.50	$4.00	$4.50	$6.50	$8.50	$13.00	$19.50	$30.00	$58.00	$58.00	$58.00
$60,000	$4.20	$4.20	$4.20	$4.80	$5.40	$7.80	$10.20	$15.60	$23.40	$36.00	$69.60	$69.60	$69.60
$80,000	$5.60	$5.60	$5.60	$6.40	$7.20	$10.40	$13.60	$20.80	$31.20	$48.00	$92.80	$92.80	$92.80
$100,000	$7.00	$7.00	$7.00	$8.00	$9.00	$13.00	$17.00	$26.00	$39.00	$60.00	$116.00	$116.00	$116.00
$120,000	$8.40	$8.40	$8.40	$9.60	$10.80	$15.60	$20.40	$31.20	$46.80	$72.00	$139.20	$139.20	$139.20
$150,000	$10.50	$10.50	$10.50	$12.00	$13.50	$19.50	$25.50	$39.00	$58.50	$90.00	$174.00	$174.00	$174.00
$200,000	$14.00	$14.00	$14.00	$16.00	$18.00	$26.00	$34.00	$52.00	$78.00	$120.00	$232.00	$232.00	$232.00
$250,000	$17.50	$17.50	$17.50	$20.00	$22.50	$32.50	$42.50	$65.00	$97.50	$150.00	$290.00	$290.00	$290.00

SPOUSE OPTIONS

Life & AD&D	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$5,000	$.35	$.35	$.35	$.40	$.45	$.65	$.85	$1.30	$1.95	$3.00	$5.80	$5.80	$5.80
$10,000	$.70	$.70	$.70	$.80	$.90	$1.30	$1.70	$2.60	$3.90	$6.00	$11.60	$11.60	$11.60
$15,000	$1.05	$1.05	$1.05	$1.20	$1.35	$1.95	$2.55	$3.90	$5.85	$9.00	$17.40	$17.40	$17.40
$20,000	$1.40	$1.40	$1.40	$1.60	$1.80	$2.60	$3.40	$5.20	$7.80	$12.00	$23.20	$23.20	$23.20
$25,000	$1.75	$1.75	$1.75	$2.00	$2.25	$3.25	$4.25	$6.50	$9.75	$15.00	$29.00	$29.00	$29.00

CHILD(REN) OPTIONS

Life & AD&D	Child(ren) 6 months to age 26	Child(ren) live birth to 6 months	Deduction Amount Child(ren)
Option 1:	$10,000	$1,000	$2.00

Note: Employee premiums are based on your age as of 09/01. Spouse premiums are based on your spouse's age as of 09/01. Child premiums are for all eligible children combined.

ComPsych GuidanceResources® Program– EAP

"EMPLOYEE ASSISTANCE PROGRAM" this benefit is provided by DISD at no charge to the employee.

Your ComPsych® GuidanceResources® Program

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. Your GuidanceResources program provides support, resources and information for personal and work-life issues. The program is company-sponsored, confidential and provided at no charge to you and your dependents. This flyer explains how GuidanceResources can help you and your family deal with everyday challenges.

Confidential Counseling

6 Session Plan

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultantsSM —highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling (up to 6 sessions per issue per year) and other resources for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Problems with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

Legal Support and Resources

Expert info when you need it.

Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

Work-Life Solutions

Delegate your "to-do" list.

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- Child and elder care
- Moving and relocation
- Making major purchases
- College planning
- Pet care
- Home repair

GuidanceResources® Online

Knowledge at your fingertips.

GuidanceResources Online is your one stop for expert information on the issues that matter most to you...relationships, work, school, children, wellness, legal, financial, free time and more.

- Timely articles, HelpSheetsSM , tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches

Free Online Will Preparation

Get peace of mind.

EstateGuidance® lets you quickly and easily write a will on your computer. Just go to www.guidanceresources.com and click on the EstateGuidance link. Follow the prompts to create and download your will at no cost. Online support and instructions for executing and filing your will are included. You can:

- Name an executor to manage your estate
- Choose a guardian for your children
- Specify your wishes for your property
- Provide funeral and burial instructions

Call 855.387.9727
OR GO TO
www.guidanceresources.com
Use Web ID: ONEAMERICA6

Peace of Mind When Traveling

Travel assistance

Emergencies happen, but help is now only a phone call or email away. Generali Global Assistance® offers a suite of services to help you in your time of need — from small inconveniences like losing your medication to life-threatening situations — all delivered with a caring, human touch.

Find comfort in knowing you and your loved ones are protected by the Travel Assistance benefit when traveling more than 100 miles from home on a trip that lasts 90 days or less for business or pleasure. The Travel Assistance benefit protects you when covered under a OneAmerica® group life insurance contract. It also extends coverage to your spouse, domestic partner and children, even when they are traveling without you. The Travel Assistance benefit requires no additional premium; however, exclusions do apply.

Medical assistance services

Pre-trip plan to provide up-to-date information regarding required vaccinations, health risks, travel restrictions and weather conditions.

Medical monitoring and review of documentation utilizing professional case managers and medical professionals to ensure appropriate care is received.

24-hour nurse help line to provide clinical assessment, education and general health information.

Replacement of prescriptions and eyeglasses that have been lost or stolen by consulting with the prescribing provider to transfer prescription to or arranging an appointment with a local provider.

Medical, behavioral or mental health, dental and pharmacy referrals to assist in finding care providers and medical facilities.

Coordination of benefits by requesting health information from the participant and attempting to coordinate benefits during an active travel assistance case.

Emergency medical evacuation to arrange and coordinate air and/or ground transportation and medical care during transportation to the nearest hospital where appropriate care is available.

Medical repatriation to arrange the transport of the participant with a qualified medical attendant, if medically necessary, to their residence or home hospital.

Return of remains to arrange the transportation of a participant's remains to their home in the event of their death while traveling.

Travel assistance services

- Pre-trip information
- 24/7 emergency travel arrangements
- Translator and interpreter referral
- Emergency travel funds assistance
- Legal consultation and referral
- Lost or stolen travel documents assistance
- Emergency messaging
- Lost luggage assistance

24-hour travel assistance

Travel Assistance is made available through OneAmerica® by an agreement with On Call International®

1-800-575-5014 (US/Canada)
1-603-898-9172 (call collect from other locations)
Email: **mail@oncallinternational.com**

When contacting On Call International, be prepared to provide:

- The name of your employer
- A phone number where you can be reached

Note: Group life products are issued and underwritten by American United Life Insurance Company® (AUL), Indianapolis, IN., a OneAmerica company. Not available in all states or may vary by state. Travel assistance provided by On Call International®, On Call International is not an affiliate of AUL, and is not a OneAmerica company. On Call International provides noted services for covered individuals and approved dependents. Services may be unavailable in countries currently under U.S. economic or trade santions. Please refer to your policy for covered limits and eligibility details. This is a brief summary of coverage for insured participants. This is not a contract of insurance. Coverage is governed by an insurance policy issued to OneAmerica®. The policy is underwritten by International Insurance Co. of Hannover Ltd. Complete information on the insurance is contained in the Certificate of Insurance on file with OneAmerica. If there is a difference between this program description and the certificate wording, the certificate controls.

Sally is buying life insurance because she understands that...

- 80% of people over estimate the true cost of life insurance
- 1 in 4 people say they do not have enough life insurance
- 30% of American households have NO life insurance
- You can elect up to your GI amount with no medical history questions

THE HARTFORD

Long Term Disability Insurance

YOUR BENEFITS PACKAGE

About this Benefit

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

Just over 1 in 4 of today's 20 year -olds will become disabled before they retire.

34.6

months is the duration of the

This is a general overview of your plan benefits. If the terms of this outline differ from your policy, the policy will govern. Additional plan details on covered expenses, limitations and exclusions are included in the summary plan description located on the Denton ISD Benefits Website: www.mybenefitshub.com/dentonisd

Long Term Disability Insurance

BENEFIT HIGHLIGHTS FOR: DENTON INDEPENDENT SCHOOL DISTRICT

What is Long-Term Disability Insurance?

Long-Term Disability Insurance pays you a portion of your earnings if you cannot work because of a disabling illness or injury. You have the opportunity to purchase Long-Term Disability Insurance through your employer. This highlight sheet is an overview of your Long-Term Disability Insurance. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

Why do I need Long-Term Disability Coverage?

Most accidents and injuries that keep people off the job happen outside the workplace and therefore are not covered by worker's compensation. When you consider that nearly three in 10 workers entering the workforce today will become disabled before retiring1, it's protection you won't want to be without.

[1] Social Security Administration, Fact Sheet 2009.

What is disability?

Disability is defined in The Hartford's* contract with your employer. Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical condition covered by the insurance, and as a result, your current monthly earnings are 80% or less of your pre-disability earnings.

Once you have been disabled for 24 months, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your current monthly earnings are 66 2/3% or less of your pre-disability earnings.

Am I eligible?

You are eligible if you are an active employee who works at least 15 hours per week on a regularly scheduled basis.

How much coverage would I have?

You may purchase coverage that will pay you a monthly flat dollar benefit in $100 increments between $200 and $8,000 that cannot exceed 66 2/3% of your current monthly earnings. Your plan includes a minimum benefit of $100.

Earnings are defined in The Hartford's contract with your employer.

When can I enroll?

If you choose not to elect coverage during your annual enrollment period, you will not be eligible to elect coverage until the next annual enrollment period without a qualifying change in family status.

When is it effective?

Coverage goes into effect subject to the terms and conditions of the policy. You must satisfy the definition of Actively at Work with your employer on the day your coverage takes effect.

What is does "Actively at Work" mean?

You must be at work with your Employer on your regularly scheduled workday. On that day, you must be performing for wage or profit all of your regular duties in the usual way and for your usual number of hours. If school is not in session due to normal vacation or school break(s), Actively at Work shall mean you are able to report for work with your Employer, performing all of the regular duties of Your Occupation in the usual way for your usual number of hours as if school was in session.

How long do I have to wait before I can receive my benefit?

You must be disabled for at least the number of days indicated by the elimination period that you select before you can receive a Long-Term Disability benefit payment.

For those employees electing an elimination period of 30 days or less, if your are confined to a hospital for 24 hours or more due to a disability, the elimination period will be waived, and benefits will be payable from the first day of disability.

What is an elimination period?

The elimination period that you select consists of two numbers. The first number shows the number of days you must be disabled by an accident before your benefits can begin. The second number indicates the number of days you must be disabled by a sickness before your benefits can begin.

I already have Disability coverage; do I have to do anything?

If you want to purchase Long-Term Disability insurance please be sure to complete the online enrollment, which indicates your election. All employees must elect coverage during annual enrollment each year.

What other benefits are included in my disability coverage?

- Workplace Modification provides for reasonable modifications made to a workplace to accommodate your disability and allow you to return to active full-time employment.
- Survivor Benefit - If you die while receiving disability benefits, a benefit will be paid to your spouse or in equal shares to your surviving children under the age of 25, equal to three times the last monthly gross benefit.
- Travel Assistance Program – Available 24/7, this program provides assistance to employees and their dependents who travel 100 miles from their home for 90 days or less. Services include pre-trip information, emergency medical assistance and emergency personal services.
- Waiver of Premium – Once your disability claim is approved and you have satisfied your elimination period, your coverage premiums will be waived.
- Identity Theft Protection – An array of identity fraud support services to help victims restore their identity. Benefits include 24/7 access to an 800 number; direct contact with a certified caseworker who follows the case until it's resolved; and a personalized fraud resolution kit with instructions and resources for ID theft victims.

How long will my disability payments continue? Can the duration of my benefit be reduced?

Benefit Duration is the maximum time for which we pay benefits for disability resulting from sickness or injury. Depending on the schedule selected and the age at which disability occurs, the maximum duration may vary. Please see the applicable schedules below based on your election of either the Gold or Silver benefit option.

Long Term Disability Insurance

How long will my disability benefits continue if I elect the Premium benefit option?

Gold Option: For the 65 Year Sickness benefit option – the table below applies to disabilities resulting from sickness or injury:

Age Disabled	Benefits Payable
Prior to Age 63	To Normal Retirement Age or 48 months if greater
Age 63	To Normal Retirement Age or 42 months if greater
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and older	18 months

How long will my disability benefits continue if I elect the Select benefit option?

Silver Option: For the 3 Year Sickness benefit option – see the tables below for the applicable benefit duration based on whether your disability is a result of injury or sickness.

Age Disabled	Benefits Payable
Prior to Age 63	To Normal Retirement Age or 48 months if greater
Age 63	To Normal Retirement Age or 42 months if greater
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and older	18 months

Schedule for disability caused by sickness:

Age Disabled	Benefits Payable
Prior to Age 65	3 Years
Age 65 to 69	To Age 70, but not less than one year
Age 69 and older	1 Year

Important Details

Exclusions: You cannot receive Disability benefit payments for disabilities that are caused or contributed to by:

- War or act of war (declared or not)
- Military service for any country engaged in war or other armed conflict
- The commission of, or attempt to commit a felony
- An intentionally self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability
- You must be under the regular care of a physician to receive benefits.

Mental Illness, Alcoholism and Substance Abuse:

- You can receive benefit payments for Long-Term Disabilities resulting from mental illness, alcoholism and substance abuse for a total of 12 months for all disability periods during your lifetime.
- Any period of time that you are confined in a hospital or other facility licensed to provide medical care for mental illness, alcoholism and substance abuse does not count toward the 12 month lifetime limit.

Pre-existing Conditions: Your policy limits the benefits you can receive for a disability caused by a pre-existing condition. In general, if you were diagnosed or received care for a disabling condition within the 3 consecutive months just prior to the effective date of this policy, your benefit payment will be limited, unless: You have not received treatment for the disabling condition within 3 months, while insured under this policy, before the disability begins, or You have been insured under this policy for 12 months before your disability begins. You may also be covered if you have already satisfied the pre-existing condition requirement of your previous insurer. If your disability is a result of a pre-existing condition we will pay benefits for a maximum of 4 weeks.

Your benefit payments may be reduced by other income you receive or are eligible to receive due to your disability, such as:

- Social Security Disability Insurance (please see next section for exceptions)
- Workers' Compensation
- Other employer-based Insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (such as a pension plan.)

Your benefit payments will not be reduced by certain kinds of other income, such as:

- Retirement benefits if you were already receiving them before you became disabled
- The portion of your Long -Term Disability payment that you place in an IRS-approved account to fund your future retirement.
- Your personal savings, investments, IRAs or Keoghs
- Profit-sharing
- Most personal disability policies
- Social Security increases

This Benefit Highlights Sheet is an overview of the Long-Term Disability Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the Insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Benefit Highlights Sheet and the Insurance policy, the terms of the Insurance policy apply.
Underwritten by: Hartford Life and Accident Insurance Company 200 Hopmeadow Street Simsbury, CT 06089

Long Term Disability Insurance

Premium Option

65 YEAR SICKNESS—MONTHLY PREMIUM COST (based on 12 payments per year)								
			Accident / Sickness Elimination Period in Days					
Annual Earnings	Monthly Earnings	Monthly Benefit	0 / 7	14 / 14	30 / 30	60 / 60	90 / 90	180 / 180
$3,600	$300	$200	$7.18	$6.32	$5.36	$3.48	$3.00	$2.20
$5,400	$450	$300	$10.77	$9.48	$8.04	$5.22	$4.50	$3.30
$7,200	$600	$400	$14.36	$12.64	$10.72	$6.96	$6.00	$4.40
$9,000	$750	$500	$17.95	$15.80	$13.40	$8.70	$7.50	$5.50
$10,800	$900	$600	$21.54	$18.96	$16.08	$10.44	$9.00	$6.60
$12,600	$1,050	$700	$25.13	$22.12	$18.76	$12.18	$10.50	$7.70
$14,400	$1,200	$800	$28.72	$25.28	$21.44	$13.92	$12.00	$8.80
$16,200	$1,350	$900	$32.31	$28.44	$24.12	$15.66	$13.50	$9.90
$18,000	$1,500	$1,000	$35.90	$31.60	$26.80	$17.40	$15.00	$11.00
$19,800	$1,650	$1,100	$39.49	$34.76	$29.48	$19.14	$16.50	$12.10
$21,600	$1,800	$1,200	$43.08	$37.92	$32.16	$20.88	$18.00	$13.20
$23,400	$1,950	$1,300	$46.67	$41.08	$34.84	$22.62	$19.50	$14.30
$25,200	$2,100	$1,400	$50.26	$44.24	$37.52	$24.36	$21.00	$15.40
$27,000	$2,250	$1,500	$53.85	$47.40	$40.20	$26.10	$22.50	$16.50
$28,800	$2,400	$1,600	$57.44	$50.56	$42.88	$27.84	$24.00	$17.60
$30,600	$2,550	$1,700	$61.03	$53.72	$45.56	$29.58	$25.50	$18.70
$32,400	$2,700	$1,800	$64.62	$56.88	$48.24	$31.32	$27.00	$19.80
$34,200	$2,850	$1,900	$68.21	$60.04	$50.92	$33.06	$28.50	$20.90
$36,000	$3,000	$2,000	$71.80	$63.20	$53.60	$34.80	$30.00	$22.00
$37,800	$3,150	$2,100	$75.39	$66.36	$56.28	$36.54	$31.50	$23.10
$39,600	$3,300	$2,200	$78.98	$69.52	$58.96	$38.28	$33.00	$24.20
$41,400	$3,450	$2,300	$82.57	$72.68	$61.64	$40.02	$34.50	$25.30
$43,200	$3,600	$2,400	$86.16	$75.84	$64.32	$41.76	$36.00	$26.40
$45,000	$3,750	$2,500	$89.75	$79.00	$67.00	$43.50	$37.50	$27.50
$46,800	$3,900	$2,600	$93.34	$82.16	$69.68	$45.24	$39.00	$28.60
$48,600	$4,050	$2,700	$96.93	$85.32	$72.36	$46.98	$40.50	$29.70
$50,400	$4,200	$2,800	$100.52	$88.48	$75.04	$48.72	$42.00	$30.80
$52,200	$4,350	$2,900	$104.11	$91.64	$77.72	$50.46	$43.50	$31.90
$54,000	$4,500	$3,000	$107.70	$94.80	$80.40	$52.20	$45.00	$33.00
$55,800	$4,650	$3,100	$111.29	$97.96	$83.08	$53.94	$46.50	$34.10
$57,600	$4,800	$3,200	$114.88	$101.12	$85.76	$55.68	$48.00	$35.20
$59,400	$4,950	$3,300	$118.47	$104.28	$88.44	$57.42	$49.50	$36.30
$61,200	$5,100	$3,400	$122.06	$107.44	$91.12	$59.16	$51.00	$37.40
$63,000	$5,250	$3,500	$125.65	$110.60	$93.80	$60.90	$52.50	$38.50
$64,800	$5,400	$3,600	$129.24	$113.76	$96.48	$62.64	$54.00	$39.60
$66,600	$5,550	$3,700	$132.83	$116.92	$99.16	$64.38	$55.50	$40.70
$68,400	$5,700	$3,800	$136.42	$120.08	$101.84	$66.12	$57.00	$41.80
$70,200	$5,850	$3,900	$140.01	$123.24	$104.52	$67.86	$58.50	$42.90
$72,000	$6,000	$4,000	$143.60	$126.40	$107.20	$69.60	$60.00	$44.00
$73,800	$6,150	$4,100	$147.19	$129.56	$109.88	$71.34	$61.50	$45.10
$75,600	$6,300	$4,200	$150.78	$132.72	$112.56	$73.08	$63.00	$46.20
$77,400	$6,450	$4,300	$154.37	$135.88	$115.24	$74.82	$64.50	$47.30
$79,200	$6,600	$4,400	$157.96	$139.04	$117.92	$76.56	$66.00	$48.40
$81,000	$6,750	$4,500	$161.55	$142.20	$120.60	$78.30	$67.50	$49.50
$82,800	$6,900	$4,600	$165.14	$145.36	$123.28	$80.04	$69.00	$50.60
$84,600	$7,050	$4,700	$168.73	$148.52	$125.96	$81.78	$70.50	$51.70
$86,400	$7,200	$4,800	$172.32	$151.68	$128.64	$83.52	$72.00	$52.80
$88,200	$7,350	$4,900	$175.91	$154.84	$131.32	$85.26	$73.50	$53.90
$90,000	$7,500	$5,000	$179.50	$158.00	$134.00	$87.00	$75.00	$55.00
$91,800	$7,650	$5,100	$183.09	$161.16	$136.68	$88.74	$76.50	$56.10
$93,600	$7,800	$5,200	$186.68	$164.32	$139.36	$90.48	$78.00	$57.20
$95,400	$7,950	$5,300	$190.27	$167.48	$142.04	$92.22	$79.50	$58.30
$97,200	$8,100	$5,400	$193.86	$170.64	$144.72	$93.96	$81.00	$59.40
$99,000	$8,250	$5,500	$197.45	$173.80	$147.40	$95.70	$82.50	$60.50
$100,800	$8,400	$5,600	$201.04	$176.96	$150.08	$97.44	$84.00	$61.60
$102,600	$8,550	$5,700	$204.63	$180.12	$152.76	$99.18	$85.50	$62.70
$104,400	$8,700	$5,800	$208.22	$183.28	$155.44	$100.92	$87.00	$63.80
$106,200	$8,850	$5,900	$211.81	$186.44	$158.12	$102.66	$88.50	$64.90
$108,000	$9,000	$6,000	$215.40	$189.60	$160.80	$104.40	$90.00	$66.00

Long Term Disability Insurance

65 YEAR SICKNESS—MONTHLY PREMIUM COST (based on 12 payments per year)								
			Accident / Sickness Elimination Period in Days					
Annual Earnings	Monthly Earnings	Monthly Benefit	0 / 7	14 / 14	30 / 30	60 / 60	90 / 90	180 / 180
$109,800	$9,150	$6,100	$218.99	$192.76	$163.48	$106.14	$91.50	$67.10
$111,600	$9,300	$6,200	$222.58	$195.92	$166.16	$107.88	$93.00	$68.20
$113,400	$9,450	$6,300	$226.17	$199.08	$168.84	$109.62	$94.50	$69.30
$115,200	$9,600	$6,400	$229.76	$202.24	$171.52	$111.36	$96.00	$70.40
$117,000	$9,750	$6,500	$233.35	$205.40	$174.20	$113.10	$97.50	$71.50
$118,800	$9,900	$6,600	$236.94	$208.56	$176.88	$114.84	$99.00	$72.60
$120,600	$10,050	$6,700	$240.53	$211.72	$179.56	$116.58	$100.50	$73.70
$122,400	$10,200	$6,800	$244.12	$214.88	$182.24	$118.32	$102.00	$74.80
$124,200	$10,350	$6,900	$247.71	$218.04	$184.92	$120.06	$103.50	$75.90
$126,000	$10,500	$7,000	$251.30	$221.20	$187.60	$121.80	$105.00	$77.00
$127,800	$10,650	$7,100	$254.89	$224.36	$190.28	$123.54	$106.50	$78.10
$129,600	$10,800	$7,200	$258.48	$227.52	$192.96	$125.28	$108.00	$79.20
$131,400	$10,950	$7,300	$262.07	$230.68	$195.64	$127.02	$109.50	$80.30
$133,200	$11,100	$7,400	$265.66	$233.84	$198.32	$128.76	$111.00	$81.40
$135,000	$11,250	$7,500	$269.25	$237.00	$201.00	$130.50	$112.50	$82.50
$136,800	$11,400	$7,600	$272.84	$240.16	$203.68	$132.24	$114.00	$83.60
$138,600	$11,550	$7,700	$276.43	$243.32	$206.36	$133.98	$115.50	$84.70
$140,400	$11,700	$7,800	$280.02	$246.48	$209.04	$135.72	$117.00	$85.80
$142,200	$11,850	$7,900	$283.61	$249.64	$211.72	$137.46	$118.50	$86.90
$144,000	$12,000	$8,000	$287.20	$252.80	$214.40	$139.20	$120.00	$88.00

Select Option

3 YEAR SICKNESS—MONTHLY PREMIUM COST (based on 12 payments per year)								
			Accident / Sickness Elimination Period in Days					
Annual Earnings	Monthly Earnings	Monthly Benefit	0 / 7	14 / 14	30 / 30	60 / 60	90 / 90	180 / 180
$3,600	$300	$200	$5.28	$4.32	$3.54	$2.90	$2.42	$1.82
$5,400	$450	$300	$7.92	$6.48	$5.31	$4.35	$3.63	$2.73
$7,200	$600	$400	$10.56	$8.64	$7.08	$5.80	$4.84	$3.64
$9,000	$750	$500	$13.20	$10.80	$8.85	$7.25	$6.05	$4.55
$10,800	$900	$600	$15.84	$12.96	$10.62	$8.70	$7.26	$5.46
$12,600	$1,050	$700	$18.48	$15.12	$12.39	$10.15	$8.47	$6.37
$14,400	$1,200	$800	$21.12	$17.28	$14.16	$11.60	$9.68	$7.28
$16,200	$1,350	$900	$23.76	$19.44	$15.93	$13.05	$10.89	$8.19
$18,000	$1,500	$1,000	$26.40	$21.60	$17.70	$14.50	$12.10	$9.10
$19,800	$1,650	$1,100	$29.04	$23.76	$19.47	$15.95	$13.31	$10.01
$21,600	$1,800	$1,200	$31.68	$25.92	$21.24	$17.40	$14.52	$10.92
$23,400	$1,950	$1,300	$34.32	$28.08	$23.01	$18.85	$15.73	$11.83
$25,200	$2,100	$1,400	$36.96	$30.24	$24.78	$20.30	$16.94	$12.74
$27,000	$2,250	$1,500	$39.60	$32.40	$26.55	$21.75	$18.15	$13.65
$28,800	$2,400	$1,600	$42.24	$34.56	$28.32	$23.20	$19.36	$14.56
$30,600	$2,550	$1,700	$44.88	$36.72	$30.09	$24.65	$20.57	$15.47
$32,400	$2,700	$1,800	$47.52	$38.88	$31.86	$26.10	$21.78	$16.38
$34,200	$2,850	$1,900	$50.16	$41.04	$33.63	$27.55	$22.99	$17.29
$36,000	$3,000	$2,000	$52.80	$43.20	$35.40	$29.00	$24.20	$18.20
$37,800	$3,150	$2,100	$55.44	$45.36	$37.17	$30.45	$25.41	$19.11
$39,600	$3,300	$2,200	$58.08	$47.52	$38.94	$31.90	$26.62	$20.02
$41,400	$3,450	$2,300	$60.72	$49.68	$40.71	$33.35	$27.83	$20.93
$43,200	$3,600	$2,400	$63.36	$51.84	$42.48	$34.80	$29.04	$21.84
$45,000	$3,750	$2,500	$66.00	$54.00	$44.25	$36.25	$30.25	$22.75
$46,800	$3,900	$2,600	$68.64	$56.16	$46.02	$37.70	$31.46	$23.66
$48,600	$4,050	$2,700	$71.28	$58.32	$47.79	$39.15	$32.67	$24.57

Long Term Disability Insurance

3 YEAR SICKNESS—MONTHLY PREMIUM COST (based on 12 payments per year)								
			Accident / Sickness Elimination Period in Days					
Annual Earnings	Monthly Earnings	Monthly Benefit	0 / 7	14 / 14	30 / 30	60 / 60	90 / 90	180 / 180
$50,400	$4,200	$2,800	$73.92	$60.48	$49.56	$40.60	$33.88	$25.48
$52,200	$4,350	$2,900	$76.56	$62.64	$51.33	$42.05	$35.09	$26.39
$54,000	$4,500	$3,000	$79.20	$64.80	$53.10	$43.50	$36.30	$27.30
$55,800	$4,650	$3,100	$81.84	$66.96	$54.87	$44.95	$37.51	$28.21
$57,600	$4,800	$3,200	$84.48	$69.12	$56.64	$46.40	$38.72	$29.12
$59,400	$4,950	$3,300	$87.12	$71.28	$58.41	$47.85	$39.93	$30.03
$61,200	$5,100	$3,400	$89.76	$73.44	$60.18	$49.30	$41.14	$30.94
$63,000	$5,250	$3,500	$92.40	$75.60	$61.95	$50.75	$42.35	$31.85
$64,800	$5,400	$3,600	$95.04	$77.76	$63.72	$52.20	$43.56	$32.76
$66,600	$5,550	$3,700	$97.68	$79.92	$65.49	$53.65	$44.77	$33.67
$68,400	$5,700	$3,800	$100.32	$82.08	$67.26	$55.10	$45.98	$34.58
$70,200	$5,850	$3,900	$102.96	$84.24	$69.03	$56.55	$47.19	$35.49
$72,000	$6,000	$4,000	$105.60	$86.40	$70.80	$58.00	$48.40	$36.40
$73,800	$6,150	$4,100	$108.24	$88.56	$72.57	$59.45	$49.61	$37.31
$75,600	$6,300	$4,200	$110.88	$90.72	$74.34	$60.90	$50.82	$38.22
$77,400	$6,450	$4,300	$113.52	$92.88	$76.11	$62.35	$52.03	$39.13
$79,200	$6,600	$4,400	$116.16	$95.04	$77.88	$63.80	$53.24	$40.04
$81,000	$6,750	$4,500	$118.80	$97.20	$79.65	$65.25	$54.45	$40.95
$82,800	$6,900	$4,600	$121.44	$99.36	$81.42	$66.70	$55.66	$41.86
$84,600	$7,050	$4,700	$124.08	$101.52	$83.19	$68.15	$56.87	$42.77
$86,400	$7,200	$4,800	$126.72	$103.68	$84.96	$69.60	$58.08	$43.68
$88,200	$7,350	$4,900	$129.36	$105.84	$86.73	$71.05	$59.29	$44.59
$90,000	$7,500	$5,000	$132.00	$108.00	$88.50	$72.50	$60.50	$45.50
$91,800	$7,650	$5,100	$134.64	$110.16	$90.27	$73.95	$61.71	$46.41
$93,600	$7,800	$5,200	$137.28	$112.32	$92.04	$75.40	$62.92	$47.32
$95,400	$7,950	$5,300	$139.92	$114.48	$93.81	$76.85	$64.13	$48.23
$97,200	$8,100	$5,400	$142.56	$116.64	$95.58	$78.30	$65.34	$49.14
$99,000	$8,250	$5,500	$145.20	$118.80	$97.35	$79.75	$66.55	$50.05
$100,800	$8,400	$5,600	$147.84	$120.96	$99.12	$81.20	$67.76	$50.96
$102,600	$8,550	$5,700	$150.48	$123.12	$100.89	$82.65	$68.97	$51.87
$104,400	$8,700	$5,800	$153.12	$125.28	$102.66	$84.10	$70.18	$52.78
$106,200	$8,850	$5,900	$155.76	$127.44	$104.43	$85.55	$71.39	$53.69
$108,000	$9,000	$6,000	$158.40	$129.60	$106.20	$87.00	$72.60	$54.60
$109,800	$9,150	$6,100	$161.04	$131.76	$107.97	$88.45	$73.81	$55.51
$111,600	$9,300	$6,200	$163.68	$133.92	$109.74	$89.90	$75.02	$56.42
$113,400	$9,450	$6,300	$166.32	$136.08	$111.51	$91.35	$76.23	$57.33
$115,200	$9,600	$6,400	$168.96	$138.24	$113.28	$92.80	$77.44	$58.24
$117,000	$9,750	$6,500	$171.60	$140.40	$115.05	$94.25	$78.65	$59.15
$118,800	$9,900	$6,600	$174.24	$142.56	$116.82	$95.70	$79.86	$60.06
$120,600	$10,050	$6,700	$176.88	$144.72	$118.59	$97.15	$81.07	$60.97
$122,400	$10,200	$6,800	$179.52	$146.88	$120.36	$98.60	$82.28	$61.88
$124,200	$10,350	$6,900	$182.16	$149.04	$122.13	$100.05	$83.49	$62.79
$126,000	$10,500	$7,000	$184.80	$151.20	$123.90	$101.50	$84.70	$63.70
$127,800	$10,650	$7,100	$187.44	$153.36	$125.67	$102.95	$85.91	$64.61
$129,600	$10,800	$7,200	$190.08	$155.52	$127.44	$104.40	$87.12	$65.52
$131,400	$10,950	$7,300	$192.72	$157.68	$129.21	$105.85	$88.33	$66.43
$133,200	$11,100	$7,400	$195.36	$159.84	$130.98	$107.30	$89.54	$67.34
$135,000	$11,250	$7,500	$198.00	$162.00	$132.75	$108.75	$90.75	$68.25
$136,800	$11,400	$7,600	$200.64	$164.16	$134.52	$110.20	$91.96	$69.16
$138,600	$11,550	$7,700	$203.28	$166.32	$136.29	$111.65	$93.17	$70.07
$140,400	$11,700	$7,800	$205.92	$168.48	$138.06	$113.10	$94.38	$70.98
$142,200	$11,850	$7,900	$208.56	$170.64	$139.83	$114.55	$95.59	$71.89
$144,000	$12,000	$8,000	$211.20	$172.80	$141.60	$116.00	$96.80	$72.80

Ability Assist® Counseling Services

Life presents complex challenges. Getting support should be easy.
If the unexpected happens, you want to know that you and your family have simple solutions to help you cope with the stress and life changes that may result. That's why the Hartford's Ability Assist Counseling Services, offered by ComPsych®,[1] can play such an important role. Our straightforward approach takes the complexity out of benefits when life throws you a curve.

COMPASSIONATE SOLUTIONS FOR COMMON CHALLENGES

From the everyday issues like job pressures, relationships, retirement planning or personal impact of grief, loss, or a disability, Ability Assist can be your resource for professional support. You and your family, including spouse and dependents, can access Ability Assist.

SERVICE FEATURES.

The service includes access to ComPsych HealthChampion℠[1] service and up to three face-to-face emotional or worklife counseling sessions per occurrence per year. This means you and your family members won't have to share visits. Each individual can get counseling help for his/ her own unique needs. Legal and financial counseling are also available by telephone during business hours. HealthChampion offers unlimited access to services.[2]

ABILITY ASSIST COUNSELING SERVICES	
Emotional or Work-Life Counseling	Helps address stress, relationship or other personal issues you or your family members may face. It's staffed by GuidanceExperts℠ – highly trained master's and doctoral level clinicians – who listen to concerns and quickly make referrals to in-person counseling or other valuable resources. Situations may include: • Job pressures. • Work/school disagreements. • Relationship/marital conflicts. • Substance abuse. • Stress, anxiety and depression. • Child and elder care referral services.
Financial Information and Resources	Provides support for the complicated financial decisions you or your family members may face. Speak by phone with a Certified Public Accountant and Certified Financial Planner ™ Professionals on a wide range of financial issues. Topics may include: • Managing a budget. • Tax questions. • Retirement. • Saving for college. • Getting out of debt.
Legal Support and Resources	Offers assistance if legal uncertainties arise. Talk to an attorney by phone about the issues that are important to you or your family members. If you require representation, you'll be referred to a qualified attorney in your area with a 25% reduction in customary legal fees thereafter. Topics may include: • Debt and bankruptcy. • Power of attorney. • Guardianship. • Divorce. • Buying a home.
Health Champion®	A service that supports you through all aspects of your health care issues by helping to ensure that you're fully supported with employee assistance programs and/or work-life services. HealthChampion is staffed by both administrative and clinical experts who understand the nuances of any given health care concern. Situations may include: • One-on-one review of your health concerns • Preparation for upcoming doctor's visits/lab work/tests/surgeries • Answers regarding diagnosis and treatment options • Coordination with appropriate health care plan provider(s) • An easy-to-understand explanation of your benefits–what's covered and what's not • Cost estimation for covered/non-covered treatment • Guidance on claims and billing issues • Fee/payment plan negotiation

Ability Assist® Counseling Services

A CASE IN POINT.[3]

"The initial counselor I spoke with was so comforting and easy to communicate with. She put me right at ease and empowered me to follow through with the program. She was wonderful."
– Hartford Customer, Ability Assist User

This award-winning resource provides trusted information, resources, referrals and answers to everyday questions right from your desktop or the privacy of your home.

It includes:

- Chat sessions with professional moderators.
- Access to hundreds of personal health topics and resources for child care, elder care, attorneys or financial planners.

Visit WWW.GUIDANCERESOURCES.COM to create your own personal username and password. If you're a first-time user, you'll be asked to provide the following information on the profile page:

1. In the **Company/Organization** field, use: HLF902
2. Then, create your own confidential user name and password.
3. Finally, in the Company Name field at the bottom of personalization page, use: ABILI

EXTRAS THAT SUPPORT AND ASSIST.

On the phone: Just one simple call.
For access over the phone, simply call toll-free 1-800-96-HELPS (1-800-964-3577).

Online: The point is simplicity.
You'll also have 24/7 access to GuidanceResources® Online (offered by ComPsych).[1]

Prepare. Protect. Prevail. ®
Visit us at TheHartford.com/employeebenefits

[1] Ability Assist®, GuidanceResources® and HealthChampionSM services are provided through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych. ComPsych and GuidanceResources are registered trademarks and HealthChampion is a service mark of ComPsych Corporation.

[2] HealthChampionSM specialists are only available during business hours. Inquiries outside of this timeframe can either request a call-back the next day or schedule an appointment.

[3] This case illustration is fictitious and for illustrative purposes only

APL

Cancer

YOUR BENEFITS PACKAGE

About this Benefit

Cancer insurance offers you and your family supplemental insurance protection in the event you or a covered family member is diagnosed with cancer. It pays a benefit directly to you to help with expenses associated with cancer treatment.

Breast Cancer is the most commonly diagnosed cancer in women.

If caught early, prostate cancer is one of the most treatable malignancies.

This is a general overview of your plan benefits. If the terms of this outline differ from your policy, the policy will govern. Additional plan details on covered expenses, limitations and exclusions are included in the summary plan description located on the Denton ISD Benefits Website: www.mybenefitshub.com/dentonisd

GC14
Limited Benefit Group Specified Disease Cancer Indemnity Insurance
Employees of Denton ISD

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Summary of Benefits	Plan 1	Plan 2
Cancer Treatment Policy Benefits	**Level 3**	**Level 4**
Radiation Therapy, Chemotherapy, Immunotherapy - Maximum per 12-month period	$15,000	$20,000
Hormone Therapy - Maximum of 12 treatments per calendar year	$50 per treatment	$50 per treatment
Experimental Treatment	paid in same manner and under the same maximums as any other benefit	
Cancer Screening Rider Benefits	**Level 1**	**Level 1**
Diagnostic Testing - 1 test per calendar year	$50 per test	$50 per test
Follow-Up Diagnostic Testing - 1 test per calendar year	$100 per test	$100 per test
Medical Imaging - per calendar year	$500 per test / 1 per calendar year	$500 per test / 1 per calendar year
Surgical Rider Benefits	**Level 1**	**Level 3**
Surgical	$30 unit dollar amount Max $3,000 per operation	$45 unit dollar amount Max $4,500 per operation
Anesthesia	25% of amount paid for covered surgery	
Bone Marrow Transplant - Maximum per lifetime	$6,000	$9,000
Stem Cell Transplant - Maximum per lifetime	$600	$900
Prosthesis - Surgical Implantation/Non-Surgical (not Hair Piece) 1 device per site, per lifetime	$1,000 / $100	$2,000 / $200
Internal Cancer First Occurrence Rider Benefits	**Level 2**	**Level 4**
Lump Sum Benefit - Maximum 1 per Covered Person per lifetime	$5,000	$10,000
Lump Sum for Eligible Dependent Children - Maximum 1 per Covered Person per lifetime	$7,500	$15,000
Heart Attack/Stroke First Occurrence Rider Benefits	**Level 2**	**Level 4**
Lump Sum Benefit - Maximum 1 per Covered Person per lifetime	$5,000	$10,000
Lump Sum for Eligible Dependent Children - Maximum 1 per Covered Person per lifetime	$7,500	$15,000
Hospital Intensive Care Unit Rider Benefits		
Intensive Care Unit	$600 per day	$600 per day
Step Down Unit - Maximum of 45 days per Confinement for any combination of Intensive Care Unit or Step Down Unit	$300 per day	$300 per day

Total Monthly Premiums by Plan**

Issue Ages	Individual		Individual & Spouse		1 Parent Family		2 Parent Family	
	Plan 1	Plan 2	Plan 1	Plan 2	Plan 1	Plan 2	Plan 1	Plan 2
18 +	$21.50	$33.48	$45.64	$71.64	$27.22	$41.32	$51.36	$79.50

**Total premium includes the Plan selected and any applicable rider premium. Premiums are subject to increase with notice.
The premium and amount of benefits vary dependent upon the Plan selected at time of application.

GC 14 Limited Benefit Group Specified Disease Cancer Indemnity Insurance

Benefits are only payable following a diagnosis of cancer for a loss incurred for the treatment of cancer while covered under the policy. A charge must be incurred for benefits to be payable. When coverage terminates for loss incurred after the coverage termination date, our obligation to pay benefits also terminates for a specified disease that manifested itself while the person was covered under the policy. All benefits are subject to the benefit maximums.

Cancer Treatment Benefits

Eligibility

You and your eligible dependents are eligible to be insured under this certificate if you and your eligible dependents meet our underwriting rules and you are actively at work with the policyholder and qualify for coverage as defined in the master application. A covered person is a person who is eligible for coverage under the certificate and for whom the coverage is in force. An eligible dependent means your lawful spouse; your natural, adopted or stepchild who is under the age of 26; and/or any child under the age of 26 who is under your charge, care and control, and who has been placed in your home for adoption, or for whom you are a party in a suit in which adoption of the child is sought; or any child under the age of 26 for whom you must provide medical support under an order issued under Chapter 154 of the Texas Family Code, or enforceable by a court in Texas; or grandchildren under the age of 26 if those grandchildren are your dependents for federal income tax purposes at the time application for coverage of the grandchild is made.

Limitations and Exclusions

No benefits will be paid for any of the following: treatment by any program engaged in research that does not meet the definition of experimental treatment; or losses or medical expenses incurred prior to the covered person's effective date regardless of when specified disease was diagnosed.

Only Loss for Cancer

The policy pays only for loss resulting from definitive cancer treatment including direct extension, metastatic spread or recurrence. Proof must be submitted to support each claim. The policy also covers other conditions or diseases directly caused by cancer or the treatment of cancer. The policy does not cover any other disease, sickness or incapacity which existed prior to the diagnosis of cancer, even though after contracting cancer it may have been complicated, aggravated or affected by cancer or the treatment of cancer.

Pre-Existing Condition Exclusion

No benefits are payable for any loss incurred during the pre-existing condition exclusion period, following the covered person's effective date as the result of a pre-existing condition. Pre-existing conditions specifically named or described as excluded in any part of the policy are never covered. If any change to coverage after the certificate effective date results in an increase or addition to coverage, incontestability and pre-existing condition exclusion for such increase will be based on the effective date of such increase.

Termination of Certificate

Insurance coverage under the certificate and any attached riders will end on the earliest of these dates: the date the policy terminates; the end of the grace period if the premium remains unpaid; the date insurance has ceased on all persons covered under this certificate; the end of the certificate month in which the policyholder requests to terminate this coverage; the date you no longer qualify as an insured; or the date of your death.

Termination of Coverage

Insurance coverage for a covered person under the certificate and any attached riders for a covered person will end as follows: the date the policy terminates; the date the certificate terminates; the end of the grace period if the premium remains unpaid; the end of the certificate month in which the policyholder requests to terminate the coverage for an eligible dependent; the date a covered person no longer qualifies as an insured or eligible dependent; or the date of the covered person's death.

We may end the coverage of any Covered Person who submits a fraudulent claim.

Cancer Screening Benefits

Limitations and Exclusions

No benefits will be paid for any of the following: treatment by any program engaged in research that does not meet the definition of experimental treatment; losses or medical expenses incurred prior to the covered person's effective date of this rider; or loss incurred during the pre-existing condition exclusion period following the covered person's effective date of this rider as a result of a pre-existing condition.

Surgical Benefits

Limitations and Exclusions

No benefits will be paid for any of the following: treatment by any program engaged in research that does not meet the definition of experimental treatment; losses or medical expenses incurred prior to the covered person's effective date of this rider regardless of when a specified disease was diagnosed; or loss incurred during the pre-existing condition exclusion period following the covered person's effective date of this rider as a result of a pre-existing condition.

Termination of Cancer Screening and Surgical Benefit Riders

The above listed rider(s) will terminate and coverage will end for all covered persons on the earliest of: the end of the grace period if the premium for the rider remains unpaid; the date the policy or certificate to which the rider is attached terminates; the end of the certificate month in which APL receives a request from the policyholder to terminate the rider; or the date of your death. Coverage on an eligible dependent terminates under the rider when such person ceases to meet the definition of eligible dependent.

Internal Cancer First Occurrence Benefits

Pays a lump sum benefit amount when a covered person receives a first diagnosis of internal cancer. Only one benefit per covered person, per lifetime is payable under this benefit and the lump sum benefit amount will reduce by 50% at age 70.

Limitations and Exclusions

We will not pay benefits for a diagnosis of internal cancer received outside the territorial limits of the United States or a metastasis to a new site of any cancer diagnosed prior to the covered person's effective date, as this is not considered a first diagnosis of an internal cancer.

Pre-Existing Condition Exclusion

No benefits are payable for any loss incurred during the pre-existing condition exclusion period following the covered person's effective date of this rider as the result of a pre-existing condition.

Termination

This rider will terminate and coverage will end for all covered persons on the earliest of any of the following: the end of the grace period if the premium for this rider remains unpaid; the date the policy or certificate to which this rider is attached terminates; the end of the certificate month in which we receive a request from the policyholder to terminate this rider; the date of covered person's death or the date the lump sum benefit amount for internal cancer has been paid for all covered persons under this rider. Coverage on an eligible dependent terminates under this rider when such person ceases to meet the definition of eligible dependent.

Heart Attack/Stroke First Occurrence Benefits

Pays a lump sum benefit amount when a covered person receives a first diagnosis of heart attack or stroke. Only one benefit per covered person per lifetime is payable under this benefit and the lump sum benefit amount will reduce by 50% at age 70.

Limitations and Exclusions
We will not pay benefits for any loss caused by or resulting from any of the following: intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane; alcoholism or drug addiction; any act of war, declared or undeclared, or any act related to war, or active service in the armed forces, or military service for any country at war (if coverage is suspended for any covered person during a period of military service, we will refund the pro-rata portion of any premium paid for any such covered person upon receipt of the policyholder's written request); participation in any activity or event while intoxicated or under the influence of any narcotic unless administered by a physician or taken according to the physician's instructions; or participation in, or attempting to participate in, a felony, riot or insurrection (a felony is defined by the law of the jurisdiction in which the activity takes place).

Pre-Existing Condition Exclusion
No benefits are payable for any loss incurred during the pre-existing condition exclusion period following the covered person's effective date of this rider as the result of a Pre-Existing Condition.

Termination
This rider will terminate and coverage will end for all covered persons on the earliest of any of the following: the end of the grace period if the premium for this rider remains unpaid; the date the policy or certificate to which this rider is attached terminates; the end of the certificate month in which we receive a request from the policyholder to terminate this rider; the date of a covered person's death or the date the lump sum benefit amount for heart attack or stroke has been paid for all covered persons under this rider. Coverage on an eligible dependent terminates under this rider when such person ceases to meet the definition of eligible dependent, as defined in the policy.

Hospital Intensive Care Unit Benefits
Pays a daily benefit amount, up to the maximum number of days for any combination of confinement, for each day charges are incurred for room and board in an intensive care unit (ICU) or step-down unit due to an accident or sickness. Benefits will be paid beginning on the first day a covered person is confined in an ICU or step-down unit due to an accident or sickness that begins after the effective date of this rider. This benefit will reduce by 50% at age 70.

Limitations and Exclusions
For a newborn child born within the 10-month period following the effective date, no benefits under this rider will be provided for confinements that begin within the first 30 days following the birth of such child. No benefits under this rider will be provided during the first two years following the effective date for confinements caused by any heart condition when any heart condition was diagnosed or treated prior to the end of the 30-day period following the covered person's effective date. The heart condition causing the confinement need not be the same condition diagnosed or treated prior to the effective date.

We will not pay benefits for any loss caused by or resulting from any of the following: intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane; alcoholism or drug addiction; any act of war, declared or undeclared, or any act related to war, or active service in the armed forces, or military service for any country at war (if coverage is suspended for any covered person during a period of military service, we will refund the pro-rata portion of any premium paid for any such covered person upon receipt of the policyholder's written request); participation in any activity or event while intoxicated or under the influence of any narcotic unless administered by a physician or taken according to the physician's instructions; participation in, or attempting to participate in, a felony, riot or insurrection (a felony is defined by the law of the jurisdiction in which the activity takes place).

Termination
This rider will terminate and coverage will end for all covered persons on the earliest of any of the following: the end of the grace period if the premium for this rider remains unpaid; the date the policy or certificate to which this rider is attached terminates; the end of the certificate month in which we receive a request from the policyholder to terminate this rider or the date of the covered person's death. Coverage on an eligible dependent terminates under this rider when such person ceases to meet the definition of eligible dependent.

Optionally Renewable
This policy/riders are optionally renewable. The policyholder or we have the right to terminate the policy/riders on any premium due date after the first anniversary following the policy/riders effective date. We must give at least 60 days written notice to the policyholder prior to cancellation.

Portability Rider
When the portability rider is in effect and coverage is not continued under COBRA, you have the option to port your coverage when the policy terminated for a reason other than non-payment of premium or cancelation or termination of the policy by APL. Evidence of insurability will not be required. You must make an election to port coverage and submit the first premium due within 31 days from the date APL notified the policyholder of your termination of coverage. All future premiums will be billed directly to you. Portability coverage will be effective on the day after coverage ends under the policy and any applicable exclusion periods or incontestability periods not yet met under the current policy, will only apply for the period of time that remains.

The benefits, terms and conditions of the ported coverage will be the same as those under the policy immediately prior to the date the portability option was elected, except as stated in this paragraph. Once ported coverage is in effect, the termination of ported coverage section, as shown in the portability rider, prevails all other termination provisions of the policy, certificate and any attached riders. Your coverage levels cannot be increased or decreased. Ported coverage may include any eligible dependent(s) who were covered under the policy at the time of termination. No eligible dependent may be added to the ported coverage except as provided in the newborn and adopted child provision set out in your certificate. An eligible dependent may be removed at any time. Premiums will be adjusted accordingly.

Termination of the policy will not terminate ported coverage. The benefits, terms and conditions of the ported coverage will be the same as if the group policy had remained in full force and effect, with no further obligation of the policyholder. Any premium collected beyond the termination date will be refunded promptly. This will not prejudice any claim that originated prior to the date termination took effect.

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NBS

FSA (Flexible Spending Account)

YOUR BENEFITS PACKAGE

About this Benefit

Healthcare FSA

A Cafeteria Plan is designed to take advantage of Section 125 of the Internal Revenue Code. It allows you to pay certain qualified expenses on a pre-tax basis, thereby reducing your taxable income. You can set aside a pre-established amount of money per plan year in a Healthcare Flexible Spending Account (FSA). Funds allocated to a healthcare FSA must be used during the plan year or are forfeited.

Dependent Day Care FSA

Dependent Day Care FSA allows you to pay for day care expenses that enable you and your spouse to work or attend school full-time. Additionally, if you have an older dependent living with you that requires someone to come into the house to assist with day-to-day living, you can claim these expenses through your Dependent Day Care FSA. Funds allocated to a Dependent Day Care FSA must be used during the plan year or forfeited.

FSA (Flexible Spending Account)

Plan Highlights

Flexible Spending Plans

Congratulations!

Your employer has established a "flexible benefits plan" to help you pay for your out-of-pocket health and daycare expenses. One of the most important features of the plan is that the benefits being offered are paid for with a portion of your pay before federal income or social security taxes are withheld. This means that you will pay less tax and have more money to spend and save. However, if you receive a reimbursement for an expense under the plan, you cannot claim a federal income tax credit or deduction on your return.

Health Flexible spending account:

The health flexible spending account (FSA) enables you to pay for expenses allowed under Section 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan.

The most that you can contribute to your Health FSA each plan year is set by the IRS. This amount can be adjusted for increases in cost-of-living in accordance with Code Section 125(i)(2).

Premium expense plan:

A premium expense portion of the plan allows you to use pre-tax dollars to pay for specific premiums under various insurance programs we offer you.

Dependent care Flexible spending account:

The dependent care flexible spending account (DCFSA) enables you to pay for out-of-pocket, work-related dependent daycare costs. Please see the Summary Plan Description for the definition of an eligible dependent. The law places limits on the amount of money that can be paid to you in a calendar year. Generally, your reimbursement may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income.

Also, in order to have the reimbursements made to you and be excluded from your income, you must provide a statement from the service provider including the name, address and, in most cases, the taxpayer identification number of the service provider as well as the amount of such expense and proof that the expense has been incurred.

Determining contributions

Before each plan year begins, you will select the benefits you want and how much contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the plan year.

Generally, you cannot change the elections you have made after the beginning of the plan year. However, there are certain limited situations when you can change your elections if you have a "change in status". Please refer to your Summary Plan Description for a change in status listing.

How do I receive reimbursements?

During the course of the plan year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. You can get submit a claim online at: my.nbsbeneits.com

Please note: *Policies other than company sponsored policies (i.e. spouse's or dependents' individual policies) may not be paid through the flexible beneits plan. Furthermore, qualified long-term care insurance plans may not be paid through the flexible benefits plan.*

NBS Benefits Card

Your employer may sponsor the use of the NBS Benefits Card, making access to your flex dollars easier than ever. You may use the card to pay merchants or service providers that accept credit cards such as hospitals and pharmacies, so there is no need to pay cash up front then wait for reimbursement.

Orthodontic expenses that are paid fully up-front at the time of initial service are reimbursable in full after the initial service has been performed and payment has been made. Ongoing orthodontia payments are reimbursable only as they are paid.

Account Information

Participants may call NBS and talk to a representative during our regular business hours, Monday-Friday, 7 a.m. to 7 p.m. Central Time. Participants can also obtain account information using the Automated Voice Response Unit, 24 hours a day, 7 days a week at (385) 988-6423 or toll free at (800) 274-0503. For immediate access to your account information at any time, log on to our website at my.nbsbenefits.com or download the NBS Mobile App.

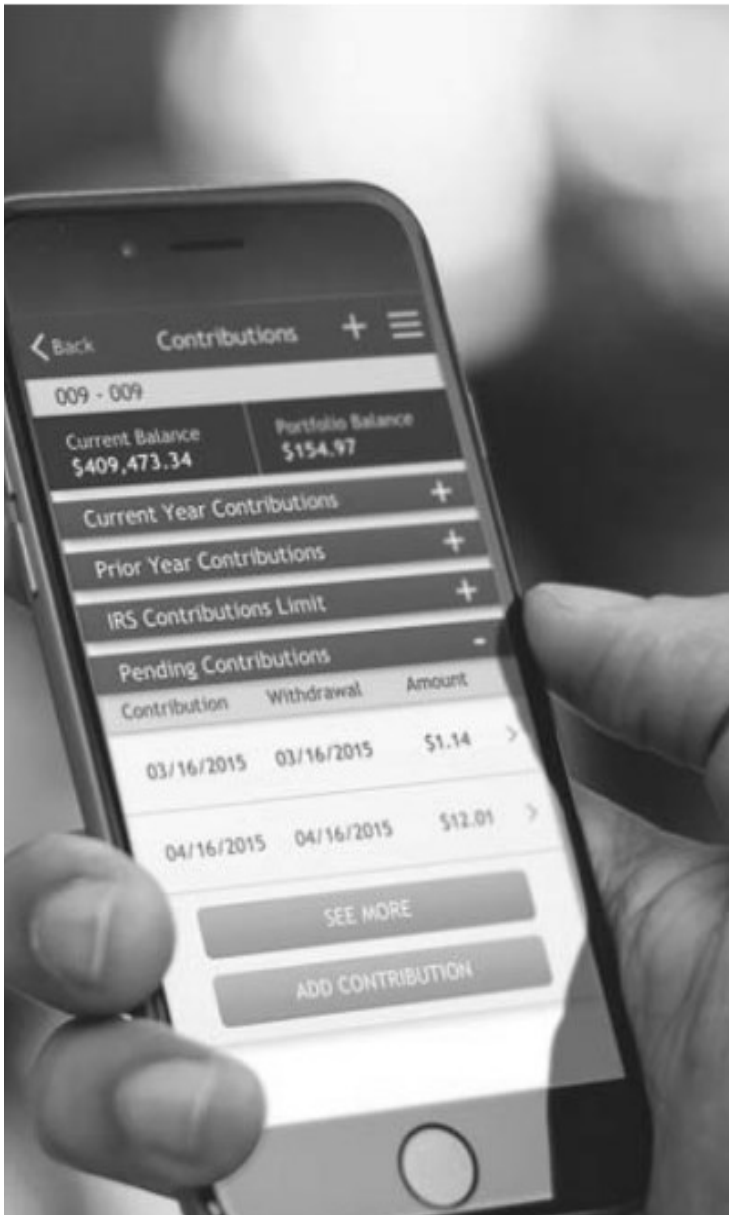
What can I save with an FSA?

	FSA	No FSA
Annual taxable income	$24,000	$24,000
Health FSA	$1,500	$0
Dependent care FSA	$1,500	$0
Total pre-tax contributions	-$3,000	$0
Taxable income after FSA	$21,000	$24,000
Income taxes	-$6,300	-$7,200
After-tax income	$14,700	$16,800
After-tax health and welfare expenses	$0	-$3,000
Take-home pay	$14,700	$13,800
You saved	**$900**	**$0**

FSA (Flexible Spending Account)

NBS Mobile App

When you're on the go, save time and hassle with the NBS Mobile App.
Submit claims, check your balances, view transactions, and submit documentation using your device's camera.



Easy and convenient

- Designed to work just as other iOS and Android apps which makes it easy to learn and use.
- Shares user authentication with the NBS portal. Registered users can download the app and log in immediately to gain access to their benefit accounts, with no need to register their phone or your account.

It's secure

- No sensitive account information is ever stored on your mobile device and secure encryption is used to protect all transmissions.

Mobile app features

The NBS mobile app supports a wide variety of features, empowering you to proactively manage your account.

- View account balances
- View claims
- View reimbursement history
- Submit claims
- Submit documentation using your device's camera
- Pay providers
- Setup a variety of SMS alerts
- Edit your personal information
- View contribution details
- View plan information
- View calendar deadlines
- Contact a service representative
- View Benefits Card information

FSA (Flexible Spending Account)

Sample Expenses

Medical expenses

- Acupuncture
- Addiction programs
- Adoption (medical expenses for baby birth)
- Alternative healer fees
- Ambulance
- Body scans
- Breast pumps
- Care for mentally handicapped
- Chiropractor
- Copayments
- Crutches
- Diabetes (insulin, glucose monitor)
- Eye patches
- Fertility treatment
- First aid (i.e. bandages, gauze)
- Hearing aids & batteries
- Hypnosis (for treatment of illness)
- Incontinence products (i.e. Depends, Serene)
- Joint support bandages and hosiery
- Lab fees
- Monitoring device (blood pressure, cholesterol)
- Physical exams
- Pregnancy tests
- Prescription drugs
- Psychiatrist/psychologist (for mental illness)
- Physical therapy
- Speech therapy
- Vaccinations
- Vaporizers or humidifiers
- Weight loss program fees (if prescribed by physician)
- Wheelchair

Dental expenses

- Artificial teeth
- Copayments
- Deductible
- Dental work
- Dentures
- Orthodontia expenses
- Preventative care at dentist office
- Bridges, crowns, etc.

Vision expenses

- Braille - books & magazines
- Contact lenses
- Contact lens solutions
- Eye exams
- Eye glasses
- Laser surgery
- Office fees
- Guide dog and upkeep/other animal aid

Items that generally do not qualify for reimbursement

- Personal hygiene (deodorant, soap, body powder, sanitary products)
- Addiction products
- Allergy relief (oral meds, nasal spray)
- Antacids and heartburn relief
- Anti-itch and hydrocortisone creams
- Athlete's foot treatment
- Arthritis pain relieving creams
- Cold medicines (i.e. syrups, drops, tablets)
- Cosmetic surgery
- Cosmetics (i.e. makeup, lipstick, cotton swabs, cotton balls, baby oil)
- Counseling (i.e. marriage/family)
- Dental care - routine (i.e. toothpaste, toothbrushes, dental floss, anti-bacterial mouthwashes, fluoride rinses, teeth whitening/ bleaching)
- Exercise equipment
- Fever & pain reducers (i.e. Aspirin, Tylenol)
- Hair care (i.e. hair color, shampoo, conditioner, brushes, hair loss products)
- Health club or fitness program fees
- Homeopathic supplement or herbs
- Household or domestic help
- Laser hair removal
- Laxatives
- Massage therapy
- Motion sickness medication
- Nutritional and dietary supplements (i.e. bars, milkshakes, power drinks, Pedialyte)
- Skin care (i.e. sun block, moisturizing lotion, lip balm)
- Sleep aids (i.e. oral meds, snoring strips)
- Smoking cessation relief (i.e. patches, gum)
- Stomach & digestive relief (i.e. Pepto- Bismol, Imodium)
- Tooth and mouth pain relief (Orajel, Anbesol)
- Vitamins
- Wart removal medication
- Weight reduction aids (i.e. Slimfast, appetite suppressant

These expenses may be eligible if they are prescribed by a physician (if medically necessary for a specific condition).

nbs national benefit services

FSA (Flexible Spending Account)

FLEXIBLE BENEFITS PLAN

Denton Independent School District
Employer ID NBS563887

PLAN HIGHLIGHTS

Login at: my.nbsbenefits.com

Congratulations! Denton Independent School District has established a "Flexible Benefits Plan" to help you pay for your out-of-pocket medical expenses. One of the most important features of the Plan is that the benefits being offered are paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return.

DETERMINING CONTRIBUTIONS

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year.

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections if you have a "change in status". Please refer to your Summary Plan Description for a change in status listing.

GENERAL PLAN INFORMATION

Plan Year End:.....August 31st
Run-out Period:.....90 Days
Maximum Medical Limit.....Current IRS limit $2,750
...See Code Section 125(i)(2) or current enrollment information
Maximum Dependent Care Limit:.....$5,000

Deadlines to File Claims

Health FSA.....,November 29 following Plan Year End
DCAP.....November 29 following Plan Year End
FSA Mid-year termination..... 90 days following termination date
DCAP Mid-year termination....90 days following termination date

Deadlines to Use Funds

Health FSA Grace Period.....75 days
Dependent Care Grace Period:.....75 days

WHEN AM I ELIGIBLE TO PARTICIPATE

If you work 20 hours or more each week for the company, you will be eligible to join the Plan when you have met the eligibility requirements for our group medical plan.

You will enter the Plan on the same day that you join our group medical plan.

WHAT TYPE OF BENEFITS ARE AVAILABLE

Under our Plan, you can choose the following benefits. Each benefit allows you to save taxes at the same time because the amount you elect is set aside on a pre-tax basis.

Health Flexible Spending Account:
The Health Flexible Spending Account (FSA) enables you to pay for expenses allowed under Section 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan. The most that you can contribute to your Health FSA each Plan Year is $2,750. Please note: If you contribute to this benefit you **cannot** elect a Health Savings Account (HSA) Benefit.

Health Savings Account:
A Health Savings Account allows participants insured by a Qualified High Deductible Insurance Plan to save for deductibles and other expenses not covered under the Plan. If you participate in this benefit you **cannot** participate in the Health Flexible Spending Account benefit.

Dependent Care Flexible Spending Account:
The Dependent Care Flexible Spending Account (DCAP) enables you to pay for out-of-pocket, work-related dependent day-care cost. Please see the Summary Plan Description for the definition of eligible dependent. The law places limits on the amount of money that can be paid to you in a calendar year. Generally, your reimbursement may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns; (b) your taxable compensation; (c) your spouse's actual or deemed earned income. Also, in order to have the reimbursements made to you and be excluded from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider, as well as the amount of such expense and proof that the expense has been incurred.

Premium Expense Plan:
A Premium Expense portion of the Plan allows you to use pre-tax dollars to pay for specific premiums under various insurance programs that we offer you.
Please note: Policies other than company sponsored policies (i.e. spouse's or dependents' individual policies etc.) may not be paid through the Flexible Benefits Plan. Furthermore, qualified long-term care insurance plans may not be paid through the Flexible Benefits Plan.

HOW DO I RECEIVE REIMBURSEMENTS

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. You can get a claim form at www.NBSbenefits.com.

FSA (Flexible Spending Account)

Claim forms must be submitted no later than 90 days after the end of the Plan Year for the Health Flexible Spending Account and the Dependent Care Flexible Spending Account. Any contributions remaining at the end of the Plan Year will be forfeited.

NBS Flexcard – FSA Pre-paid MasterCard

Your employer may sponsor the use of the NBS Flexcard, making access to your flex dollars easier than ever. You may use the card to pay merchants or service providers that accept credit cards, so there is no need to pay cash up front then wait for reimbursement.
Terminated Employees have 90 Days after their date of termination to submit receipts for services prior to their termination date.

WHO ARE HIGHLY COMPENSATED & KEY EMPLOYEES

Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid.
If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Please refer to your Summary Plan Description for more information. You will be notified of these limitations if you are affected.

Updated: 6/29/2020

NBS Welfare Benefit Service Center
8523 S. Redwood Road
West Jordan, UT 84088
801-532-4000 or 1-800- 274-0503
Fax: 1-800-478-1528

Denton School District Flexible Benefits Plan
Plan Contact Person:
Maria Ortiz
1849 Central Drive
Bedford, Texas 76022
(817) 399-2056

MASA

Medical Transport

YOUR BENEFITS PACKAGE

About this Benefit

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

A ground ambulance can cost up to **$2,400** and a helicopter transportation fee can cost **over $30,000**

This is a general overview of your plan benefits. If the terms of this outline differ from your policy, the policy will govern. Additional plan details on covered expenses, limitations and exclusions are included in the summary plan description located on the Denton ISD Benefits Website: www.mybenefitshub.com/dentonisd

Emergent Plus Plan

Coverage against unplanned medical emergencies is surprisingly affordable.

Facts You Should Know

- Emergent Ground Ambulance transports can easily surpass $2,000 and can reach as high as $5,000.
- Emergent Air Ambulance transports frequently cost more than $40,000, reaching as high as $70,000.
- If you are in need of specialized care and can be transported on an non-emergent basis, it is common for a medically equipped plane to cost more than $20,000.
- Most people assume that their health insurance will cover most, if not all, of the costs for these transports. Usually, the opposite is true, leaving you with financially crippling bills.

MASA MTS protects you when your insurance falls short.

- One low fee for peace of mind for emergent transport costs
- No deductibles
- Easy claim process
- No health questions
- Anyone can join

MASA MTS provides peace of mind.

Be prepared for the unexpected with a MASA membership. No matter where you live, you could have access to vital emergency medical transportation for a minimal monthly fee. That membership could one day save your life, and, every day, it will give you peace of mind like nothing else.

When is your next medical emergency planned?
Are you prepared?

Our Benefits

Benefit	Emergent Plus $14/mo
Emergent Ground Transportation	U.S./Canada
Emergency Air Transportation	U.S./Canada
Repatriation	U.S./Canada

*Basic Coverage Area (BCA) includes U.S., Canada, Mexico, and Caribbean (excluding Cuba)
Coverage available for spouses/domestic partners and dependents up to age 26.

Platinum Plan

Coverage against unplanned medical emergencies is surprisingly affordable.

Facts You Should Know

- Emergent Ground Ambulance transports can easily surpass $2,000 and can reach as high as $5,000.
- Emergent Air Ambulance transports frequently cost more than $40,000, reaching as high as $70,000.
- If you are in need of specialized care and can be transported on an non-emergent basis, it is common for a medically equipped plane to cost more than $20,000.
- Most people assume that their health insurance will cover most, if not all, of the costs for these transports. Usually, the opposite is true, leaving you with financially crippling bills.

MASA MTS protects you when your insurance falls short.

- One low fee for peace of mind for emergent transport costs
- No deductibles
- Easy claim process
- No health questions
- Anyone can join

MASA MTS provides peace of mind.

Be prepared for the unexpected with a MASA membership. No matter where you live, you could have access to vital emergency medical transportation for a minimal monthly fee. That membership could one day save your life, and, every day, it will give you peace of mind like nothing else.

When is your next medical emergency planned?
Are you prepared?

Our Benefits

Benefit	Platinum $39/mo
Ground Transportation	U.S./Canada
Emergency Air Transportation	U.S./Canada
Repatriation	Worldwide
Non-Emergent Air Transportation	Worldwide
Escort Transportation	Worldwide
Mortal Remains Transportation	Worldwide
Visitor Transportation	BCA*
Minor Children/Grandchildren Return	BCA*
Vehicle Return	BCA*
Pet Return	BCA*
Organ Retrieval	U.S. Only
Organ Recipient Transportation	U.S. Only

Medical Transport

PLATINUM MEMBERSHIP BENEFITS	
Emergency Air Medical Transportation	Should a member suffer serious life or limb threatening emergency that requires immediate transport by fixed wing or helicopter air ambulance of that member to the nearest most appropriate medical facility capable of providing required emergency medical treatments, also referred to as “golden hour transports”, MASA MTS will cover the out-of-pocket expenses resulting from that transport. (U.S. and Canada only)
Emergency Ground Transportation	Should a member suffer a life or limb emergency requiring emergent ground transport from the site of serious illness or injury, or from a transferring medical facility that is unable to provide services required, to the nearest most appropriate medical facility capable of attending to the member’s medical needs MASA MTS will cover the out-of-pocket expenses resulting from that transport. (U.S. and Canada only)
Air Transportation – Hospital to Hospital	Should a member suffer a serious illness or injury resulting in hospitalization and if the member is in need of specialized treatment not available locally, then MASA MTS will fly him/her to the nearest appropriate medical facility capable of providing such specialized treatment (Worldwide coverage)
Organ Retrieval**	MASA MTS will provide air transportation of an organ to be used in an organ transplant. (U.S. only)
Organ Recipient Transportation**	MASA MTS will fly a member to the commercial airport nearest the medical facility where an organ transplant is scheduled to happen. (U.S. only)
Recuperation / Repatriation	If a member is hospitalized while away from home, MASA MTS will fly them home to recuperate in familiar surroundings. (Worldwide coverage)
Escort Transportation	If a member requires emergency air transport, MASA MTS will fly the member's spouse, family member or friend to accompany them in the air. (Worldwide coverage)
Non-injury Transportation	If a member is hospitalized while away from his/her home for more than 7 days, the member may select a family member to visit them during confinement. MASA MTS will provide round trip, common carrier air transportation for the person selected. (Basic coverage area only*)
Minor Children / Grandchildren Return	When minor children or grandchildren are left unattended as a result of a member using MASA MTS air ambulance service, MASA MTS will provide one-way common carrier air transport for return of the children to the commercial airport nearest the place of residence of the children. (Basic coverage only*)

*Basic Coverage Area includes U.S., Canada, Mexico, and Caribbean (excluding Cuba).
**One (1) year waiting period if pre-existing condition requiring transplant.

There is a 90 day waiting period on pre-existing conditions. This clause is WAIVED for emergent ground and air transports.

Medical Transport

PLATINUM MEMBERSHIP BENEFITS	
Vehicle Return	MASA MTS will return vehicles such as cars, vans, RVs or trucks owned or rented by the member when illness, injury or death requires use of the air ambulance services provided by MASA MTS. The vehicle will be carried to the member's place of residence or rental vehicles will be returned to the nearest rental company office or agent. (Basic coverage area only*)
Mortal Remains Transport	In the event a member dies while away from his/her place of residence, MASA Assist will return his/her remains to the commercial airport nearest his/her residence. (Worldwide coverage)
Pet Return	MASA MTS will return the Member's dog, cat or smaller animal, should the Member be flown to a hospital near their residence on an air ambulance arranged by the MASA MTS. (Basic coverage area only*)

*Basic Coverage Area includes U.S., Canada, Mexico, and Caribbean (excluding Cuba).

There is a 90 day waiting period on pre-existing conditions. This clause is WAIVED for emergent ground and air transports.

NOTES

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WWW.MYBENEFITSHUB.COM/DENTONISD