



Plano ISD Benefits Enrollment Guide for New Employees 2023 - 2024

Plano ISD
Benefits and Risk Management Department
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The language of the official plan documents and policies will prevail over the language of any communications vehicle.

Introduction

Welcome to the Plano ISD! The Benefits and Risk Management Department is here to assist you. This booklet provides an overview of the benefit options and can help you complete the enrollment process. Our web site www.pisd.edu/benefits provides full information regarding your benefits.

Health Plan

The District contributes \$330 per month (per full-time employee working at least 20 hours per week) towards the medical plan premiums only. Part-time employees (working between 10 and 19 hours per week) and substitutes (working at least 10 hours per week) may enroll in a medical plan only, by paying the total monthly premium without the district contribution. Other plans, such as dental and vision, are offered to employees working at least 25 hours per week.

When will my coverage start?

Coverage starts on the 1st of the month following your employment start date.

Special rule for medical plans: The effective date for your medical plan will automatically be set as the 1st of the next month. However, you can choose to begin medical coverage immediately on your employment start date. If you want to select the earlier start date, please contact the PISD benefits office for assistance.

- If you are **coming from another school district with TRS-ActiveCare**, be sure to coordinate the ending & starting dates of your coverage with each district. Overlapping coverage is not allowed.
- If you are **currently covered by your parent under TRS-ActiveCare**, you may remain covered by them until you reach age 26. At that time, you will be dropped from their plan, and you must enroll in coverage for yourself as an employee.

This booklet is only a summary of the benefits that are available. Visit our web site www.pisd.edu/benefits for complete plan descriptions, network provider search, policy booklets, life insurance application form, and much more.

For Questions or Assistance:

email benefits@pisd.edu call (469)752-8138

Monday to Friday
8 AM to 5 PM

Sockwell Center, 6301 Chapel Hill Blvd, Plano 75093

Employee Assistance Program (EAP)

All full-time employees and members of their household may use the EAP. This program is available even if you waive all other coverage. Each person is eligible to receive 6 free counseling sessions per problem, per plan year. The EAP is completely confidential and can help with a wide variety of situations such as stress, anxiety, marital or relationship issues, family problems, alcohol and/or drug abuse, balancing work and family, depression, grief, and financial or legal problems. The EAP can also assist you with finding community resources or services. Please take advantage of your EAP.

1-800-272-7255

www.GuidanceResources.com

Organization Web ID: PLANOISD

Employee Leave

District policies regarding the proper use of leave time are policies DEC, DECA, DECB, and DED. These are available online at www.pisd.edu linked under the Staff Section.

- Each employee receives 5 state personal days each year. Unused state personal leave will carry-over to the following year, with no maximum.
- Each full-time employee also receives local sick days from the District (5 days for 10-month employees, 6 days for 11-month employees, 7 days for 12-month employees). Unused local sick leave will carry-over to the following year, up to a maximum of 50 days.
- Each full-time 12-month employee also receives 10 days vacation leave (15 days after 5 years of continuous employment). Unused vacation leave will carry-over to the following year, up to a maximum of 40 days.

A “day” is an equivalent workday based on your assignment. Leave time is then granted to you in hours, based on your equivalent workday. Please read policies DEC(Local) and DED(Local) for complete explanations of the leave time for which you are eligible.

Additional extended leave may be available for personal illness, illness in the family, maternity, adoption, and military duty. These absences may or may not be paid, depending on the number of leave days you have accrued, your membership in the leave bank, the length of the absence, and other factors. Contact the benefits office for assistance.

Leave Bank

Any full-time employee may join the Leave Bank to receive additional paid time off for absences **at least 5 full consecutive workdays** due to personal illness or illness in the family. To join the Leave Bank, you donate one of your local sick days to the Leave Bank, and then have access to up to 25 Leave Bank days, which may be used once all of your accrued leave days are exhausted. You may change your Leave Bank membership selection during the annual enrollment period. Each year that you are a member, one of your local sick days will be donated, to ensure your membership. The Leave Bank is described in more detail in [Section 5](#) of this booklet.

When you complete your online enrollment, one of the screens will be for Leave Bank membership, and you must select Yes or No.

Wellness

A wide variety of wellness resources and services are available to all employees. In addition to the EAP and on-site flu shots, each of the medical plans includes a fitness program with discounted gym memberships, personal coaching programs to help you reach your nutrition or weight loss goals, self-paced lessons and challenges, support for a healthy pregnancy, mental health services, and much more. The District has also gathered informational and educational resources on topics that affect all aspects of overall well-being. You can access resources on our [wellness web pages](#). And check out the [Employee Perks & Discounts portal](#) for special offers.

Workers' Compensation

The District's workers' compensation program provides payment for health care reasonably required for an eligible work-related injury. Treatment must be obtained by a health care provider in the Coventry Workers' Compensation Network.

All incidents must be reported immediately, either [online](#) or by calling (469)752-6391. Workers' compensation benefits apply only if you timely report your incident. After 30 days, benefits may be denied if you have not reported your injury. Additional information is available on our [web site](#).

Employee Crisis Fund

This resource may provide a source of financial aid to employees who are facing an emergency situation and are unable to handle immediate financial obligations associated with the crisis. The fund is made available by the Plano ISD Education Foundation to provide short-term assistance to numerous Plano ISD employees each year. Examples of emergency situations may be related to a death in the family, a medical emergency, fire or other natural disaster. You can email crisisfund@pisd.edu if you have any questions, and you can also access the eligibility rules, application form, and other information online at www.pisd.edu/benefits.

Additional Programs

Although the following programs are not managed by the Benefits and Risk Management Department, we are mentioning them here for your information. Please contact the appropriate departments or organizations listed below for assistance and more information.

- Employees who work at least 50% will automatically become members of the Teacher Retirement System of Texas (TRS). Standard contributions from both the District and the employee are made to TRS. Employees also make standard monthly contributions to the TRS-Care retiree insurance plan, which is available upon your retirement through TRS. For more information, you may contact the payroll department at (469)752-8128, or TRS at 1-800-223-8778.
- You may choose to sign up for an optional 403(b) retirement savings account. Contributions are deducted from your paychecks and sent to the investments you select. The District does not contribute to 403(b) accounts. For more information, please contact the payroll department at (469)752-8128.

Section 1

Take Action!

How to Enroll

1 Ask some questions... Check the math... Decide which options are right for you

2 Login to [Employee Service Center](#) (use Google Chrome)

Go to My Benefits Information / Benefits Enrollment

Watch “how-to” videos on our [web site](#)

3 Enter your choices on each screen

Click Submit on the final review page - most important!

After you click Submit, you’ll be prompted to print a copy of your choices, which is another way to know you’ve enrolled successfully.

To make a change after you submit, contact the PISD benefits office.

Don’t miss your deadline:

31 calendar days after your employment start date

If you don’t click Submit by this deadline, you will have no coverage

For assistance, please email benefits@pisd.edu or call x28138.

Life Insurance

The [life insurance paper application form](#) is available online at www.pisd.edu/benefits.

If you are enrolling in \$250,000 or less, only the paper application form is needed if you return the completed application form to the benefits office within 31 calendar days after your hire date.

If you select more than \$250,000, you will also need to complete the Evidence of Insurability (EOI). Please return the completed application form to the benefits office, and we will email you the EOI link.

Section 2

Frequently Asked Questions

When will my coverage start?

Coverage starts on the 1st of the month following your employment start date.

Special rule for medical plans: The effective date for your medical plan will automatically be set as the 1st of the next month. However, you can choose to begin medical coverage immediately on your employment start date. If you want to select the earlier start date, please contact the PISD benefits office for assistance.

- If you are coming from another school district with TRS-ActiveCare, be sure to coordinate the ending & starting dates of your coverage with each district. Overlapping coverage is not allowed.
- If you are currently covered by your parent under TRS-ActiveCare, you may remain covered by them until you reach age 26. At that time, you will be dropped from their plan, and you must enroll in coverage for yourself as an employee.

Is there a deadline to enroll?

Yes! **You must complete your enrollment within 31 calendar days after your employment start date.** If you do not make your selections by this deadline, you may not enroll until the next open enrollment period. Once your benefits begin, they cannot be changed (except as explained on the next page).

What if I do not need any coverage?

Please login to the online enrollment system to **officially decline coverage** and make your Leave Bank membership selection.

How do I get my ID cards?

Make sure the PISD human resources department has your most current address.

Medical and prescription ID cards will be mailed to you.

Dental ID cards will be mailed to you by Delta Dental.

If you enroll in a **VSP Vision plan**, you will not receive an ID card. Inform your provider that your coverage is with VSP. If you enroll in a **Davis Vision plan**, an ID card will be mailed to you by Davis Vision.

Although it can take up to 3 weeks for cards to arrive in the mail, you can access an [electronic ID card](#) earlier through the insurance company's mobile app or web site.

When can I change my benefit selections?

1. Open enrollment occurs every July/August. During the open enrollment period, you may change your benefit selections, and those changes will become effective September 1. Information is always sent out in advance, so you can review changes to the plans and premiums.
2. Some changes may be allowed at other times of the year if you experience a qualifying special enrollment event. This might include marriage, divorce, birth, adoption, or loss/gain of spouse's employment. In these situations, you must contact the benefits office and complete paperwork within 31 calendar days of the event.

Are orthodontics covered?

Yes, if 1) you enroll in the Premium Dental Plan; 2) the braces are for an eligible dependent child; 3) the treatment has not yet begun; and 4) it is an eligible orthodontic treatment program.

Can I cover my family on a dental plan but not a medical plan?

Yes, you can customize your benefit selections to fit your circumstances.

Do my children have to be full-time students?

No, an eligible dependent child may be covered until the end of the month in which he or she turns 26. Coverage past age 26 is only possible if the child is disabled. The plan documents contain further information regarding dependent eligibility.

Do I have to provide Social Security Numbers?

Yes. The Affordable Care Act requires all employers and insurance companies to report information to the IRS using Social Security Numbers for all covered members.

Can I have coverage through TRS-ActiveCare and also another plan?

In most cases, yes, but please review the rules of both plans before you enroll. If you enroll in a TRS-ActiveCare plan, it will likely be your primary coverage.

Where can I get more information about the benefits?

- Contact the PISD benefits office at (469)752-8138, email benefits@pisd.edu, schedule a virtual chat with us, or come personally to our offices at the Sockwell Center for answers to your benefit plan questions.
- Review our web site www.pisd.edu/benefits. You may also request printed copies of the plan documents from the benefits office.

Although your co-workers may share what has worked in their situations, please do not base your decision solely on their input. Each person's circumstances are different; what works for one may not work for another. The PISD benefits office staff are trained to assist you and answer questions regarding the benefit plans.

Section 3

How are Premiums Paid?

Bus Drivers, Bus Assistants, Bus Driver Mentors, Food Service Workers, Child Caregiver Aides, PASAR, and Substitutes

Premiums are deducted from almost every paycheck through June 6, 2024. Your deduction amount is calculated by estimating the total premium cost for the rest of the plan year (through August 2024), and then dividing by the number of paychecks during that time. On this schedule, your premiums for the summer months can be paid in full by the time you receive your last paycheck for the school year.

Example: ActiveCare Primary, employee only coverage starting September 1, monthly cost \$120

$$\text{Monthly cost } \$120 \times 12 = \$1,440 \div 17 = \$84.71 \text{ per check}$$

of months covered # of paychecks with deductions

Fill in your personal selections:

$$\text{Monthly cost } \$ \div \div = \$ \text{ per check}$$


Contact the benefits office for help calculating your deduction amount.

Other Employees Paid on a Biweekly Basis

The monthly premium is divided over two paychecks each month, so half of the monthly premium is deducted from each biweekly paycheck year-round. If a month contains a third paycheck, benefit premiums will still only be deducted from two of the three paychecks in that month. Premiums are paid in the current month (for example, premiums deducted from the September 15th and September 29th paychecks pay for the month of September).

Employees Paid on a Monthly Basis

The full monthly premium is deducted from your monthly paycheck year-round. Premiums are paid in arrears (for example, premiums deducted from the September 25th paycheck will pay for the month of September).

 **Note:** If premiums cannot be deducted from your paycheck for any reason, you will receive an invoice from the benefits office, which must be paid within 30 days. If the invoice is not paid and the premium cannot be deducted from a future paycheck, your coverage will be canceled retroactively.

Section 4

Plan Summaries & Costs

Who Can Enroll:	Eligible For:
❶ Employees/TRS Members working 25 or more hours per week (63-100%)	All plans, with District Contribution to medical premium
❷ Employees/TRS Members working between 20-24 hours per week (50-62%)	Medical plan only, with District Contribution to the premium
❸ Employees working between 10-19 hours per week (25-49%)	Medical plan only, no District Contribution
❹ Substitutes regularly working 10 or more hours per week	Medical plan only, no District Contribution

Visit
www.pisd.edu/benefits
 to view policy documents and search the provider networks

EAP

All full-time employees have access to the EAP for solutions and resources for living well at home and at work. It provides **confidential** support for a variety of concerns. Up to **6 free counseling visits** are available every year to each family member, even if not enrolled in a medical plan. The EAP can also provide legal and financial resources. Services are available 24 hours a day, 7 days a week.

Emotions <ul style="list-style-type: none"> • Stress, anxiety, overwhelmed • Depression, sadness • Grief, loss • Suicidal thoughts 	Relationships <ul style="list-style-type: none"> • Conflict resolution • Healthy relationships • Social development 	Day to Day <ul style="list-style-type: none"> • Money management, budgeting • Legal and financial guidance • Education planning • Pet care
Work <ul style="list-style-type: none"> • Work/life balance • Personal growth • Difficult conversations • Workplace relationships 	Family Care <ul style="list-style-type: none"> • Child/Elder care • Adoption • Caregiver resources • Healthy pregnancy • Parenting skills 	Healthy Living <ul style="list-style-type: none"> • Fitness • Nutrition • Weight management • Chronic illness • Addiction

MEDICAL

ActiveCare Primary	Total Monthly Cost (groups ③ & ④)	PISD Contribution	Reduced Monthly Cost (groups ① & ②)
Employee Only	\$450	\$330	\$120
Employee & Spouse	\$1,215	\$330	\$885
Employee & Child(ren)	\$765	\$330	\$435
Employee & Family	\$1,530	\$330	\$1,200

Plan At a Glance
Mid-range deductible Copays for doctor visits Statewide network PCP referrals required

ActiveCare HD	Total Monthly Cost (groups ③ & ④)	PISD Contribution	Reduced Monthly Cost (groups ① & ②)
Employee Only	\$462	\$330	\$132
Employee & Spouse	\$1,248	\$330	\$918
Employee & Child(ren)	\$786	\$330	\$456
Employee & Family	\$1,571	\$330	\$1,241

High deductible Nationwide network HSA-eligible

ActiveCare Primary +	Total Monthly Cost (groups ③ & ④)	PISD Contribution	Reduced Monthly Cost (groups ① & ②)
Employee Only	\$529	\$330	\$199
Employee & Spouse	\$1,376	\$330	\$1,046
Employee & Child(ren)	\$900	\$330	\$570
Employee & Family	\$1,746	\$330	\$1,416

Lower deductible Copays for doctor visits Statewide network PCP referrals required

Scott & White HMO	Total Monthly Cost (groups ③ & ④)	PISD Contribution	Reduced Monthly Cost (groups ① & ②)
Employee Only	\$569.76	\$330	\$239.76
Employee & Spouse	\$1,432.42	\$330	\$1,102.42
Employee & Child(ren)	\$916.49	\$330	\$586.49
Employee & Family	\$1,648.78	\$330	\$1,318.78

Mid-range deductible Copays for doctor visits Regional North Texas network – BSW Premier HMO

ActiveCare 2	Total Monthly Cost (groups ③ & ④)	PISD Contribution	Reduced Monthly Cost (groups ① & ②)
Employee Only	\$1,013	\$330	\$683
Employee & Spouse	\$2,402	\$330	\$2,072
Employee & Child(ren)	\$1,507	\$330	\$1,177
Employee & Family	\$2,841	\$330	\$2,511

Closed to new enrollees Lower deductible Nationwide network
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ActiveCare 2 remains available to current enrollees only. It is not available to new enrollees.

See Plan Summaries on the following pages

MEDICAL

	ActiveCare Primary (Blue Cross Blue Shield)	ActiveCare HD (Blue Cross Blue Shield)	ActiveCare Primary + (Blue Cross Blue Shield)
Plan Summary	<ul style="list-style-type: none"> • Lowest premium • Copays for doctor visits • Statewide network¹ • PCP referrals required to see specialists • Not compatible with HSA • No out-of-network coverage 	<ul style="list-style-type: none"> • Lower premium • Compatible with HSA • Nationwide network with out-of-network coverage • No requirement for PCP referrals • Must meet deductible before plan pays for non-preventive care 	<ul style="list-style-type: none"> • Lower deductible than HD and Primary plan • Copays for doctor visits • Statewide network¹ • PCP referrals required to see specialists • Not compatible with HSA • No out-of-network coverage

Plan Features				
Type of Coverage	In-Network Coverage Only	In-Network	Out-of-Network	In-Network Coverage Only
Individual/Family Deductible	\$2,500 / \$5,000	\$3,000 / \$6,000	\$5,500 / \$11,000	\$1,200 / \$2,400
Coinsurance	You pay 30% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible
Individual/Family Max Out-of-Pocket	\$7,500 / \$15,000	\$7,500 / \$15,000	\$20,250 / \$40,500	\$6,900 / \$13,800
Network	Statewide Network ¹	Nationwide Network		Statewide Network ¹
Primary Care Provider (PCP) Required	Yes	No		Yes

Doctor Visits				
Primary Care	\$30 copay	You pay 30% after deductible	You pay 50% after deductible	\$15 copay
Specialist	\$70 copay	You pay 30% after deductible	You pay 50% after deductible	\$70 copay

Immediate Care				
Urgent Care	\$50 copay	You pay 30% after deductible	You pay 50% after deductible	\$50 copay
Emergency Care	You pay 30% after deductible	You pay 30% after deductible		You pay 20% after deductible
Virtual Health Programs	RediMD \$0 medical consultation Teladoc \$12 medical consultation	RediMD \$30 medical consultation Teladoc \$42 medical consultation		RediMD \$0 medical consultation Teladoc \$12 medical consultation

Prescription Drugs (avoid additional costs by filling 90-day supplies of long-term medications)			
Drug Deductible	Integrated with medical	Integrated with medical	\$200 brand deductible
Generics (30 day / 90 day supply)	\$15 / \$45 copay \$0 copay for certain generics	You pay 20% after deductible; \$0 copay for certain generics	\$15 / \$45 copay
Preferred Brand	You pay 30% after deductible	You pay 25% after deductible	You pay 25% after deductible
Non-preferred Brand	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Specialty (31 day max)	\$0 if SaveOnSP eligible; or You pay 30% after deductible	You pay 20% after deductible	\$0 if SaveOnSP eligible; or You pay 30% after deductible
Insulin Out-of-Pocket Costs	\$25 copay for 31-day supply \$75 copay for 61-90 day supply	You pay 25% after deductible	\$25 copay for 31-day supply \$75 copay for 61-90 day supply

MEDICAL

	Baylor Scott & White HMO (Baylor Scott & White)	ActiveCare 2 (Blue Cross Blue Shield)
Plan Summary	<ul style="list-style-type: none"> • Mid-range deductible • Copays for doctor visits • Regional BSW Premier HMO network • No requirement for PCP referrals • Not compatible with HSA • No out-of-network coverage 	<ul style="list-style-type: none"> • Closed to new enrollees • Current enrollees can choose to stay in plan • Copays for doctor visits • Nationwide network with out-of-network coverage • No requirement for PCP referrals • Not compatible with HSA

Plan Features			
Type of Coverage	In-Network Coverage Only	In-Network	Out-of-Network
Individual/Family Deductible	\$2,400 / \$4,800	\$1,000 / \$3,000	\$2,000 / \$6,000
Coinsurance	You pay 20% after deductible	You pay 20% after deductible	You pay 40% after deductible
Individual/Family Max Out-of-Pocket	\$8,150 / \$16,300	\$7,900 / \$15,800	\$23,700 / \$47,400
Network	BSW Premier HMO North/Central Texas	Nationwide Network	
Primary Care Provider (PCP) Required	No	No	

Doctor Visits			
Primary Care	\$20 copay ²	\$30 copay	You pay 40% after deductible
Specialist	\$70 copay	\$70 copay	You pay 40% after deductible

Immediate Care			
Urgent Care	\$45 copay	\$50 copay	You pay 40% after deductible
Emergency Care	\$500 copay after deductible	\$250 copay plus 20% after deductible	
Virtual Health Programs	\$0 per consultation	RediMD \$0 medical consultation Teladoc \$12 medical consultation	

Prescription Drugs (avoid additional costs by filling 90-day supplies of long-term medications)		
Drug Deductible	\$200 brand deductible	\$200 brand deductible
Generics (30 day / 90 day supply)	\$14 / \$35 copay	\$20 / \$45 copay
Preferred Brand	You pay 35% after deductible	You pay 25% after deductible (30-day \$40 min/\$80 max / 90-day \$105 min/\$210 max)
Non-preferred Brand	You pay 50% after deductible	You pay 50% after deductible (30-day \$100 min/\$200 max / 90-day \$215 min/\$430 max)
Specialty (31 day max)	You pay 35% after deductible	\$0 if SaveOnSP eligible; or You pay 30% after deductible (\$200 min/\$900 max)
Insulin Out-of-Pocket Costs	Covered under applicable category above	\$25 copay for 31-day supply \$75 copay for 61-90 day supply

Learn the Terms

Premium

The monthly amount you pay for coverage

Deductible

The annual amount for medical expenses you're responsible to pay before your plan begins to pay its portion

Copay

The set amount you pay for a covered service at the time you receive it

Coinsurance

The portion you're required to pay for services after you meet your deductible, often a specified percentage of the costs

Out-of-Pocket Maximum

The maximum amount you pay each year for medical costs. After reaching the out-of-pocket maximum, the plan pays 100% of allowable charges for covered services

¹ Call 1-866-355-5999 to expand network coverage on the Primary and Primary+ plans for kids at college out-of-state

² No PCP copay for first sick visit and no PCP copay for dependents under age 18 on the HMO plan

MEDICAL

Provider Search

[BCBS provider search](#)

or call 1-866-355-5999

[Baylor Scott & White HMO provider search](#)

or call 1-844-633-5325

Virtual Health Programs

BCBS plans:

Teladoc or RediMD

Baylor Scott & White HMO:

MyBSWHealth or MDLive

Choose a PCP

If you enroll in the **Primary** or **Primary +** plans, you must [select a PCP](#). Establishing care with a PCP is an important step in prioritizing your health and taking charge of your wellness. Your PCP will help you meet your health goals and will refer you to a specialist if needed.

[BCBS provider search](#)

Make note of the provider's **10-digit PCP ID**. You will need this to complete your online enrollment.

Extra Features

All plans have programs to support you through your **pregnancy**, or with your **fitness, nutrition, weight loss** goals, and much more.

After you receive your ID card, you can login to their web sites to learn more:

BCBS plans:

www.bcbstx.com/trsactivecare

Baylor Scott & White HMO:

myBSWhealth.com

\$0 Preventive Care

All plans have 100% coverage for in-network preventive care.

- Annual routine physicals (ages 12+)
- Annual mammogram (ages 35+)
- Annual OBGYN exam & pap smear (ages 18+)
- Annual prostate cancer screening (ages 45+)
- Well-child care
- Healthy diet/obesity counseling
- Smoking cessation counseling
- Breastfeeding support
- Colonoscopy (ages 45+ once every 10 years)

DENTAL

Offered to Employees/TRS Members working 25 or more hours per week (63%-100%)

Dental insurance is available through **Delta Dental**. Using a PPO dentist will provide the greatest savings. To search the network, visit deltadentalins.com or call 1-800-521-2651.

Delta will mail ID cards to your home address, but you can access an electronic ID card through Delta's mobile app. After your coverage begins, create an online account at deltadentalins.com to view your benefits, claims, and more.

Monthly Premiums

Premium Dental	Monthly Cost
Employee Only	\$33.51
Employee & Spouse	\$76.98
Employee & Child(ren)	\$70.81
Employee & Family	\$105.08

Basic Dental	Monthly Cost
Employee Only	\$18.93
Employee & Spouse	\$37.97
Employee & Child(ren)	\$30.45
Employee & Family	\$56.24

Coverage Comparisons

For details regarding covered, excluded, and limited services, please refer to the plan booklet available online at www.pisd.edu/benefits.

	Premium Dental	Basic Dental
Annual Deductible	\$50 indiv. / \$150 family	\$50 indiv. / \$150 family
Class 1 Services – Preventive & Diagnostic (cleanings, xrays, etc)	Plan pays 80% (no deductible)	Plan pays 50% (no deductible)
Class 2 Services – Basic (fillings, root canals, etc)	Plan pays 80%	Plan pays 50%
Class 3 Services – Major (crowns, bridges, etc)	Plan pays 50%	Plan pays 50%
Annual Maximum Benefit (Class 1, 2, 3 combined)	\$1,250 per person	\$1,000 per person
Class 4 Services – Orthodontics Only for children under age 26	Plan pays 50% Lifetime maximum \$1,250	Not Covered
Network of Dentists www.deltadentalins.com	Delta Dental PPO & Delta Dental Premier You can use dentists in either network. (If you use a non-network dentist, the dentist may bill you for an additional amount above Delta's allowable charge.)	

VISION

Offered to Employees/TRS Members working 25 or more hours per week (63%-100%)

Both **Vision Service Plan, Inc (VSP)** and **Davis Vision** offer low & high plan options, with different coverage levels. Each company has different strengths, so you have the flexibility to choose the best fit for you.

Monthly Premiums

VSP Standard	Monthly Cost
Employee Only	\$9.37
Employee & Spouse	\$20.10
Employee & Child(ren)	\$20.10
Employee & Family	\$20.10

Davis Designer	Monthly Cost
Employee Only	\$6.36
Employee & Spouse	\$13.64
Employee & Child(ren)	\$13.64
Employee & Family	\$13.64

VSP Buy Up	Monthly Cost
Employee Only	\$17.62
Employee & Spouse	\$37.80
Employee & Child(ren)	\$37.80
Employee & Family	\$37.80

Davis Premier	Monthly Cost
Employee Only	\$12.89
Employee & Spouse	\$27.63
Employee & Child(ren)	\$27.63
Employee & Family	\$27.63

ID cards:

- VSP does not issue ID cards, although you can print a membership card from their web site if needed. You'll tell your optometrist that your coverage is through VSP, and they will submit your claims.
- Davis Vision will mail you an ID card, which you can present to your optometrist.

Main considerations in choosing a plan:

- Compare the premium charts above
- Compare the coverage charts on the next page
- PPO networks – VSP has a unique network of independent optometrists that may not be in-network with Davis. The Davis network is a combination of both independent optometrists and retail options like Walmart, Costco, and Visionworks, etc. Check the network lists at www.vsp.com and www.davisvision.com.

Bottom line:

- VSP may be a good choice for you if your optometrist is only in the VSP network and you don't want to change. You would pay a higher premium, but you would be able to keep your optometrist in-network.
- Davis may be a good choice for you if you want lower premiums, are willing to change optometrists, or have access to retail service providers in-network.

Vision Plans (continued)

Coverage at In-Network Providers:

	VSP Standard	Davis Designer
Exam copay	\$25 total copay	\$10
Materials Copay		\$15
Frequency		
Exam	12 months	12 months
Lenses / Frames	12 months / 24 months	12 months / 24 months
Frame Allowance	\$130	100% covered – Davis Designer Collection \$170 – Visionworks stores \$120 – Other providers/frames
Covered Lens Options	Polycarbonate for children	Polycarbonate for children; Scratch Resistant
Contact Lenses	Every 12 months, in lieu of glasses	Every 12 months, in lieu of glasses
Fitting & Evaluation	\$60 allowance	\$15 copay or \$60 allowance for specialty contacts
Materials & Exam	\$150 allowance	100% covered – Davis Collection, max 4 boxes \$120 allowance – Other contacts
Additional Benefits & Discounts	20% off additional pairs of glasses Laser Vision Correction discount Diabetic EyeCare Plus Program	50% off 2 nd pair of glasses at Visionworks 20-30% off 2 nd pair of glasses at other in-network Laser Vision Correction discount 1 year breakage warranty on Davis Collection frames Hearing Aid discounts through Epic Hearing

	VSP Buy Up	Davis Premier
Exam copay	\$5	\$5
Materials Copay	\$10	\$10
Frequency		
Exam	12 months	12 months
Lenses / Frames	12 months / 12 months	12 months / 12 months
Frame Allowance	\$160	100% covered – Davis Designer & Premier Collection \$200 – Visionworks stores \$150 – Other providers/frames
Covered Lens Options	Polycarbonate for children & adults; Anti Reflective; Progressives	Polycarbonate for children & adults; Scratch Resistant; UV Coating; Anti Reflective; Progressives
Contact Lenses	Every 12 months, in lieu of glasses	Every 12 months, in lieu of glasses
Fitting & Evaluation	Up to \$60	\$10 copay or \$60 allowance for specialty contacts
Materials & Exam	\$150	100% covered – Davis Collection, max 8 boxes \$150 allowance – Other contacts
Additional Benefits & Discounts	20% off additional pairs of glasses 15% off Laser Vision Correction Diabetic EyeCare Plus Program Hearing Aid discounts through TruHearing	50% off 2 nd pair of glasses at Visionworks 20-30% off 2 nd pair of glasses at other in-network Laser Vision Correction discount 1 year breakage warranty on Davis Collection frames Hearing Aid discounts through Epic Hearing

LIFE INSURANCE

Offered to Employees/TRS Members working 25 or more hours per week (63%-100%)

Group term life insurance is available through **Dearborn Life Insurance** (owned by **Blue Cross Blue Shield**). The policy certificate is available on our web site, or you may also request a printed copy from the benefits office.

For Employees

You can enroll in up to \$250,000 life insurance by submitting a paper application form to the PISD benefits office within the first 31 calendar days of your employment. For amounts greater than \$250,000, you must also complete an Evidence of Insurability questionnaire and wait for underwriting approval. [Application forms are available on the benefits web site www.pisd.edu/benefits.](http://www.pisd.edu/benefits)

Monthly Premiums: (cannot be deducted pre-tax)

<u>Amount</u>	<u>Age 39 & Under</u>	<u>Age 40 & Over</u>
\$ 20,000	1.00	2.56
\$ 30,000	1.50	3.84
\$ 40,000	2.00	5.12
\$ 50,000	2.50	6.40
\$ 60,000	3.00	7.68
\$ 70,000	3.50	8.96
\$ 80,000	4.00	10.24
\$ 90,000	4.50	11.52
\$100,000	5.00	12.80
\$110,000	5.50	14.08
\$120,000	6.00	15.36
\$130,000	6.50	16.64
\$140,000	7.00	17.92
\$150,000	7.50	19.20
\$160,000	8.00	20.48
\$170,000	8.50	21.76
\$180,000	9.00	23.04
\$190,000	9.50	24.32
\$200,000	10.00	25.60

<u>Amount</u>	<u>Age 39 & Under</u>	<u>Age 40 & Over</u>
\$210,000	10.50	26.88
\$220,000	11.00	28.16
\$230,000	11.50	29.44
\$240,000	12.00	30.72
\$250,000	12.50	32.00
\$260,000	13.00	33.28
\$270,000	13.50	34.56
\$280,000	14.00	35.84
\$290,000	14.50	37.12
\$300,000	15.00	38.40
\$310,000	15.50	39.68
\$320,000	16.00	40.96
\$330,000	16.50	42.24
\$340,000	17.00	43.52
\$350,000	17.50	44.80
\$360,000	18.00	46.08
\$370,000	18.50	47.36
\$380,000	19.00	48.64
\$390,000	19.50	49.92
\$400,000	20.00	51.20

Automatic reduction of value: When you reach age 70, the value of the life insurance becomes half the original value. For example, if you are enrolled in \$150,000, the coverage will reduce to \$75,000 on the September 1 after you turn 70.

Life Insurance (continued)

Although you may purchase high life insurance amounts through the district, we encourage you to have other life insurance that is not tied to your employment. If you resign, you can convert this group insurance to a personal policy, but the cost usually increases significantly.

For Dependents

You may purchase life insurance on your spouse and/or children; however, you must be enrolled in employee life insurance in order to request dependent life insurance. Spouses are eligible until age 70, and children are eligible until age 26. You may enroll by submitting a paper application form to the PISD benefits office within the first 31 calendar days of your employment. Any life insurance applications for your spouse made after this initial enrollment period will require Evidence of Insurability subject to underwriting approval. You may add, change, or cancel life insurance at any time during the year.

Monthly Premiums: (cannot be deducted pre-tax)

Plan A: \$5,000 for spouse, \$2,000 for each child = total monthly premium \$2.12

Plan B: \$10,000 for spouse, \$4,000 for each child = total monthly premium \$5.10

DISABILITY INSURANCE

Offered to Employees/TRS Members working 25 or more hours per week (63%-100%)

Disability insurance is available through **Cigna (New York Life)**. The [policy document](#) and [premium charts](#) are available online, or you may request a printed copy from the benefits office. Premiums are based on your elimination period, benefit level, and your age. Premiums cannot be deducted pre-tax.

Disability insurance can replace a portion of your income if you are unable to work due to illness or injury. When accidents or long-term illness arise, most people see their expenses go up, and their income go down. Disability income protection can be very beneficial, and is most appreciated when the unexpected happens.

You may choose from 4 elimination periods (7 days, 14 days, 30 days, or 90 days), which is the length of time you must be off work before benefit payments can begin. The 7, 14, and 30 day plans also include a first-day hospital benefit, which begins benefit payments immediately following a 24-hour inpatient hospital admission with room & board charges. Benefits are paid directly to you, and are not subject to taxes.

- Enrollment in disability insurance is automatically approved within the first 31 calendar days of employment. If you do not enroll as a new employee, the next time you may enroll will be the annual enrollment period. Proof of good health is not required, but pre-existing condition limitations will apply.
- **Pregnancy:** The disability plan will cover pregnancy claims if the coverage took effect prior to conception. Benefits will be based on the lower of the coverage you had at the time you became pregnant or the time your claim begins.
- **Other income offsets:** If you also receive certain types of other income (such as social security, retirement, or workers compensation), any benefit payments from the disability plan will be offset by the amount of other income.
- Our enrollment system will show you the maximum coverage you can select. If your coverage is not at the maximum, any increase you make in future years will be subject to pre-existing condition limitations.

FSA & HSA

Offered to Employees/TRS Members working 25 or more hours per week (63%-100%)

The District offers **Flexible Spending Accounts (FSA)** and a **Health Savings Account (HSA)** for you to set aside money on a pre-tax basis to pay for eligible expenses. While all of these accounts help with pre-tax expenses, there are significant differences. If you choose to enroll, be sure to choose the account that is right for your circumstances. A detailed list of eligible expenses is available on our web site www.pisd.edu/benefits.

Questions?
Call Flexible
Benefit Admin
1-800-437-3539

HEALTH SAVINGS ACCOUNT (HSA)

- Can be chosen only if you are enrolled in a High Deductible Health Plan (HDHP), such as ActiveCare HD
- Cannot be chosen if you are enrolled in Medicare or Tricare, or if anyone else claims you as a dependent on their tax return
- Cannot be chosen if either you or your spouse is enrolled in a traditional/general FSA
- For medical, dental, and vision expenses
- For you, your spouse, and dependent children, even if not covered on insurance
- No minimum contribution
- Maximum \$3,850 annually if HDHP medical plan enrollment is for employee only, or \$7,750 annually if HDHP medical plan enrollment includes any family members
- Maximum contributions are combined if both you and your spouse each have an HSA
- Money is not available up front
- Account balance rolls over from year to year, earns interest along the way, and stays with you even if you leave PISD
- Contribution amount can be changed during the year
- Monthly fee \$2.00 (plus \$1.25 unless you choose paperless statements)

HEALTH CARE FSA

General Health FSA

- Cannot be chosen if you enroll in a Health Savings Account
- For medical, dental, and vision expenses
- For you, your spouse, and dependent children, even if not covered on insurance
- Minimum \$25 per month
- Maximum \$251 per month
- Full annual amount is available up front
- Use it or lose it – only contribute what you know you will spend within the plan year
- Enrollment is irrevocable for the rest of the plan year, except in limited circumstances
- Monthly fee \$3.00

Limited Purpose FSA

- Can be chosen if you enroll in a Health Savings Account, but is not required
- For dental and vision expenses **only**
- For you, your spouse, and dependent children, even if not covered on insurance
- Minimum \$25 per month
- Maximum \$251 per month
- Full annual amount is available up front
- Use it or lose it – only contribute what you know you will spend within the plan year
- Enrollment is irrevocable for the rest of the plan year, except in limited circumstances
- Monthly fee \$3.00

FSA & HSA (continued)

You cannot enroll in both an HSA and the General Health FSA – [see comparison chart below](#).

However, you can enroll in an HSA and the Limited Purpose FSA.

Enrollment in an HSA or FSA is optional.

	Health Savings Account HSA	General Health FSA
Can only be paired with a High Deductible Health Plan	Yes – cannot be covered by any other type of plan	No – medical plan choice is irrelevant
Employees on Medicare or Tricare can participate	No	Yes
Money can only be used for medical, dental, and vision expenses	Yes ¹	Yes
Full election amount available right away	No	Yes
Money rolls over from year to year	Yes	No – unused funds are forfeited at end of plan year
You keep the money in your account if you resign	Yes	No
Debit card can be used to pay eligible expenses	Yes – up to amount currently in the account	Yes – full annual election available up front
Employer is responsible for verifying expenses are eligible	No – you are responsible for keeping receipts in case of audit	Yes – you must provide receipts to FSA administrator
Account fee	\$2.00 per month (+\$1.25 if not paperless)	\$3.00 per month
Annual Maximum Contribution	\$3,850 - employee HDHP coverage \$7,750 - family HDHP coverage	\$3,050 annually
Additional catch-up contributions if age 55+	\$1,000 annually	None
You can change your election during the year	Yes	No – only limited circumstances may allow a change
Contributions are pre-tax	Yes	Yes
Money in the account earns interest	Yes	No
Money in the account can be invested in mutual funds	Yes – if account balance is greater than \$1,000, additional fee applies	No
Employee must file form 8889 with Federal Income Tax Return	Yes	No

¹ Money withdrawn before age 65 for non-medical expenses is subject to additional 20% tax penalty.

DEPENDENT CARE FSA

- For dependent care expenses such as day care for children under age 13 or a disabled spouse
- Minimum \$25 per month
- Maximum \$413 per month (or \$205 if married filing separate tax returns)
- Take summer months into consideration when calculating contributions – payroll deductions continue in the summer
- Electing this account may affect your eligibility for the Federal Income Tax Credit
- Use it or lose it – only contribute what you know you will spend within the plan year
- Enrollment is irrevocable for the rest of the plan year, except in limited circumstances
- Monthly fee \$3.00

IRS regulations state that dependent care services must already have been performed in order to be eligible for reimbursement. For example, it is common to pay for childcare at the first of the month for the entire month. This is not permitted for flex accounts under IRS guidance. The childcare must already have been performed in order to claim reimbursement.

Therefore, if you select this flex account, it is extremely important that you carefully consider the amount you set aside. For example, you may choose to reduce the amount of your flex account to allow for days that your child is sick and does not attend childcare as planned. While you may still be required to pay your childcare provider for those days, those charges are not eligible for reimbursement according to IRS rules.

FLEX CARD

The flex card can provide added convenience for paying eligible expenses on your FSA or HSA, although you still have the option to submit paper claims. The card allows immediate access to the funds in your account at the time you need them. The card will work only at specific merchants based on the type of account you are enrolled in.

Use of the flex card does not remove your responsibility to keep all receipts and documentation to prove the eligibility of an expense. For FSA, the IRS requires the administrator to audit every transaction so they may request copies of your documentation to validate a transaction. For HSA, you are responsible for using the account appropriately within IRS regulations.

The Flexible Benefit Plan document contains complete details regarding use of the flex card, including:

- how the card works
- how to use it properly
- your obligations when using the card
- the Plan's rights to deny access to your card
- the Plan's rights to recover ineligible expenses

Section 5

Leave Bank

When you complete your online enrollment, you will be asked to answer Yes or No regarding Leave Bank membership for the current year. If you do not complete the online enrollment, you will not be enrolled in the Leave Bank.

General Information about Leave Bank

Eligible full-time employees may join the Leave Bank by donating one local sick leave day for each year they are Leave Bank members. The days donated to the Leave Bank are not refundable. Leave Bank membership will carry-over from year to year, until the employee chooses to decline.

What type of absences qualify for Leave Bank?

Absences of **5 or more** full consecutive work days for the following reasons:

- Employee's illness (including up to 6-week period after delivery of baby)
- Family member's illness (family member is defined in policy DEC(Local))
- All requests are subject to the annual (25 days) and lifetime (75 days) maximums

What does not qualify for Leave Bank?

- Bereavement/funerals
- Personal business
- Family emergency
- Workers' compensation
- Paternity
- Adoption
- Absences shorter than 5 full consecutive work days
- Absences already docked on your paycheck
- Requests for which complete documentation is not provided
- Any maternity leave taken beyond duration limit in administrative guidelines
- Any absence in excess of the annual (25 days) or lifetime (75 days) maximums

How do I request days from the Leave Bank?

Turn in the "Request for Leave Bank Days" form and supporting medical documentation to the benefits office before your paycheck is docked for the absences.

Leave Bank Administrative Guidelines

1. An employee must be absent, or expect to be absent five or more consecutive full work days for the same reason, in order to apply for leave bank days. Appropriate medical certification showing the qualifying reason for the employee's absence must accompany the request.
2. It is the employee's responsibility to request leave bank days for qualifying absences and to submit all required documentation in a timely manner. If the employee has not requested leave bank days from the Benefits and Risk Management Department before the paycheck is docked for those absences, leave bank days will not be granted.
3. All accrued leave, including vacation leave, must be exhausted or expect to be exhausted through medical certification in order to receive leave bank days.
4. Family as defined in Plano ISD Board Policy DEC(LOCAL), shall include:
 - Spouse
 - Son or daughter, including a biological, adopted, or foster child, a son- or daughter-in-law, a stepchild, a legal ward, or a child for whom the employee stands *in loco parentis*.
 - Parent, stepparent, parent-in-law, or other individual who stands *in loco parentis* to the employee.
 - Sibling, stepsibling, sibling-in-law.
 - Grandparent and grandchild.
 - Any person who may be residing in the employee's household at the time of illness.
5. Intermittent absences (anything shorter than five consecutive full work days), bereavement, workers' compensation, adoption, and family emergency do not qualify for leave bank.
6. Upon notice from medical certification that an employee is eligible for or receiving hospice care, the lifetime maximum of 75 days may be granted.
7. Any accrued local leave left by employees resigning or retiring is donated to the leave bank.
8. Employees who end employment before the end of their work year, and who have used more local leave than they earned, are docked to re-coupe these days. Leave bank will not be used to cover this docked pay.
9. Should the leave bank balance fall below 1/6 of the annual contribution by April 1, the district may need to reduce the number of leave bank days available to leave bank members.
10. All full time employees are required to submit a leave bank selection, either accepting or declining participation. Leave bank enrollment selections are required by the end of the annual open enrollment period (date to be determined each fiscal year and published in enrollment materials). If an employee has never made a leave bank selection, and does not submit a selection by the date specified in the enrollment materials, he or she will not be allowed to participate in the leave bank for the upcoming fiscal year. He or she will be required to submit a leave bank selection at the next open enrollment period for the following fiscal year.
11. New employees are required to submit a leave bank selection when they make their other health benefit plan selections. New employees will be allowed to submit a leave bank selection within the first 31 calendar days of employment. If a leave bank selection is not received by the deadline, the employee will not be allowed to participate in the leave bank until the next fiscal year. During the next open enrollment period, the employee must submit a leave bank selection, either accepting or declining participation.
12. Leave bank days during maternity leave may only be granted during medically necessary bed rest or during the first 6 calendar weeks after delivery. Requests for leave bank days beyond the 6-week period may be considered with additional documentation from the physician regarding medical necessity.

Section 6

Required Notices

ACA Health Insurance Marketplace

PART A: General Information

Key parts of the Affordable Care Act created a new way to buy health insurance: the Health Insurance Marketplace. To assist as you evaluate options for you and your family, this notice provides some basic information about the Marketplace as well as employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than approximately 9.6% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.*

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Plano ISD Benefits and Risk Management Department at (469)752-8138 or email benefits@pisd.edu.

The Marketplace can help you evaluate coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Plano Independent School District	4. Employer Identification Number (EIN) 75-6002252	
5. Employer address 2700 West 15 th Street	6. Employer phone number (469)752-8138	
7. City Plano	8. State TX	9. Zip Code 75075
10. Who can we contact about employee health coverage at this job? Nikki James, Coordinator for Employee Benefits		
11. Phone number (if different from above)	12. Email address Benefits@pisd.edu	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to most employees. Eligible employees are:
 - Employees and substitutes who are regularly scheduled to work 10 or more hours per week. Permanent full-time employees regularly scheduled to work 20 or more hours per week may also qualify for the employer contribution.
- With respect to dependents, we do offer coverage. Eligible dependents are:
 - A spouse (including a common law spouse)
 - A child under age 26 who is either a natural child, 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
 - A grandchild under age 26 whose primary residence is the employee's household 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
 - Any other child (other than those listed above) under the age of 26 (unmarried) in a regular parent-child relationship with the employee, meeting all four of the following requirements: 1) the child's primary residence is the household of the employee; 2) the employee provides at least 50% of the child's support; 3) neither of the child's natural parents resides in that household; and 4) the employee has the legal right to make decisions regarding the child's medical care
 - An unmarried child, age 26 or over, may be eligible for dependent coverage, provided that the child is either mentally or physically incapacitated to such an extent to be dependent on the employee on a regular basis as determined by TRS, and meets other requirements as determined by TRS.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

14. Does the employer offer a health plan that meets the minimum value standard*?

☒ Yes

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):

a. How much would the employee have to pay in premiums for this plan?

☒ If eligible for the employer contribution \$120.00

☒ If not eligible for the employer contribution \$450.00

b. How often?

☒ Monthly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Future Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you recently became eligible for coverage under the Plano ISD Employee Benefit Plan (the Plan). This notice has important information about your right to COBRA continuation coverage (a temporary extension of coverage under the Plan), which can become available to you and your covered family members in the future if you would otherwise lose your group health coverage as a result of a qualifying event. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

This notice is only a summary of your COBRA continuation coverage rights and how to protect them. For more information about your rights and obligations under the Plan and under federal law, please review the Plan Document online at www.pisd.edu/benefits, or contact the Plano ISD Benefits and Risk Management Department, 6301 Chapel Hill Blvd, Plano TX 75093, phone (469)752-8138, email benefits@pisd.edu.

In addition to COBRA, you may have other options available to you if you lose group health coverage in the future, and these other coverage options may cost less than COBRA. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace, which may offer lower premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the Plan when it would otherwise end because of a "qualifying event". Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, you, your spouse, and your dependent children may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must continue to pay for coverage.

Employee: If you are an employee, you will be offered COBRA if you lose your coverage under the Plan because of the following qualifying events:

- your hours of employment are reduced, or
- your employment ends for any reason other than your gross misconduct.

Spouse: If you are the spouse of an employee, you will be offered COBRA if you lose your coverage under the Plan because of the following qualifying events:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- you become divorced or legally separated from your spouse.

Children: Your dependent children will be offered COBRA if they lose coverage under the Plan because of the following qualifying events:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the Plan as a "dependent child".

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Benefits and Risk Management Department has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction in hours of employment, or death of the employee, the HR Department will notify the Benefits and Risk Management Department of the qualifying event.

You Must Give Notice of Some Qualifying Events

For all other qualifying events (divorce or legal separation of the employee and spouse, a dependent child's losing eligibility for coverage as a dependent child, or Medicare entitlement), you must notify the Benefits and Risk Management Department within 60 days after the qualifying event occurs. You must provide this notice to the Benefits and Risk Management Department in writing, in person, or by telephone. The Benefits and Risk Management Department will provide a form for your signature and will inform you of the documentation required to process the qualifying event.

How is COBRA Continuation Coverage Provided?

Once the Benefits and Risk Management Department receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA on behalf of their spouses, and parents may elect COBRA on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA will begin on the date that Plan coverage would otherwise have been lost.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events (death of the employee, divorce, or dependent child losing eligibility for coverage), or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which the 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage: If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled, and you notify the Benefits and Risk Management Department in a timely fashion, you and your family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of COBRA continuation coverage: If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits, gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must notify the Benefits and Risk Management Department of the second qualifying event within 60 days of the second qualifying event.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or another group health plan (such as your spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If You Have Questions

For questions about your Plan or your COBRA continuation coverage rights, **please contact the Plano ISD Benefits and Risk Management Department at (469)752-8138 or email benefits@pisd.edu**. For more information about your rights under various laws affecting group health plans, you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa. For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, keep the Plan informed of any changes in the addresses of family members. While employed, please notify the Plano ISD Human Resources Division of any address changes. You should also keep a copy, for your records, of any notices you send to or receive from the Plan.

For more information, please contact the Plano ISD Benefits and Risk Management Department at (469)752-8138 or benefits@pisd.edu.

HIPAA Exemption

Under a Federal law known as the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended (HIPAA), group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than insured through a health insurance policy.

The benefits subject to this election are:

- Medical Reimbursement Plan
- Employee Assistance Program

The Plano ISD has elected to exempt the above benefits from the following requirements:

- Standards relating to benefits for mothers and newborns

The exemption from these Federal requirements will be in effect for the plan year beginning September 1, 2023, and ending August 31, 2024. The election may be renewed for subsequent years.

Even though the Plan is exempt from the above requirements, the Plan has been voluntarily amended to provide protections similar to some, but not all, of these requirements.

If you have questions or need assistance, please contact the benefits office at (469)752-8138 or email benefits@pisd.edu.

Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you may obtain access to this information. Please review it carefully.

Effective Date and Scope of Notice

This Notice applies to all health plans maintained by Plano Independent School District (the "Employer"). All such plans are referred to in this Notice as the "Plans."

The Health Insurance Portability and Accountability Act ("HIPAA") regulates the use and disclosure of protected health information by the Plans. This Notice summarizes some of the requirements of HIPAA. It is not a contract or guarantee and does not provide any additional or other rights not expressly provided under and required by HIPAA.

This Notice does not apply to health information that does not identify an individual. Such "de-identified" information is not protected health information.

Purpose of Notice

The Plans are required by law to take reasonable steps to maintain the privacy of protected health information and to inform you about:

- the practices of the Plans regarding use and disclosure of your protected health information;
- your privacy rights with respect to your protected health information;
- the Plan's duties with respect to your protected health information;
- your right to file a complaint with the Plans and the Secretary of the U.S. Department of Health and Human Services ("HHS"); and
- the person or office to contact for further information about the privacy practices of the Plans.

Use and Disclosure of Protected Health Information

Disclosure to You

The Plans may disclose your protected health information to you or your personal representative.

Disclosure to HHS

The Secretary of HHS may require use and disclosure of your protected health information to investigate or determine the Plans' compliance with the privacy regulations under HIPAA.

Use and Disclosure for Treatment, Payment, and Health Care Operations and Plan Administration

The Plans and their business associates will use and disclose protected health information to carry out treatment, payment, and health care operations without your consent, authorization, or opportunity to agree or object. The Plans may also use and disclose protected health information to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. As an organized health care arrangement, the Plans may share protected health information with each other to carry out treatment, payment, or health care operations relating to the Plans.

- **Treatment** is the provision, coordination, or management of health care and related services, including consultations and referrals between one or more of your providers. For example, the Plans may disclose to a treating specialist the name of your treating provider, so that the specialist may ask for relevant medical information from your provider.
- **Payment** includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, and utilization review and preauthorization). For example, a Plan may tell a doctor whether you are eligible for coverage under the Plan. A Plan may also disclose claim information relating to a covered family member (including the participating employee and the employee's spouse) to the employee or the employee's spouse. In addition to the employee and any other authorized representatives the employee designates, an employee's spouse will be considered the employee's authorized claim representative with respect to all claims the employee may have under the Plans, including claims relating to the employee and other covered family members.
- **Health Care Operations** include, but are not limited to, quality assessment and improvement; reviewing competence or qualifications of health care professionals; underwriting, premium rating, and other activities relating to insurance contracts; disease management; case management; conducting or arranging for medical review; legal services and auditing functions, including fraud and abuse compliance programs; business planning and development; business management (including business acquisition activities); and general administrative activities. For example, the Plans may use or disclose your claim information to refer you to a disease management program, project future benefit costs, or audit the accuracy of the claims processing functions of the Plans.
- **Disclosures to and Use by the Plan Sponsor.** The Plans may disclose whether you are participating in one or more of the Plans, or are enrolled in or have disenrolled from a health insurance issuer or HMO offered by the Plans. The Plans and any health insurers or HMOs with respect to the Plans may also disclose protected health information to the Employer as plan sponsor of the Plans for underwriting and for plan administration functions, carried out by the Employer. For example, if the Employer sponsors a health reimbursement arrangement that is administered by the Employer through payroll, the Plans may disclose protected health information to the Employer so that it can properly review claims for reimbursement and make appropriate payment. To permit such disclosure, the Employer has amended the governing documents for the Plans as required by HIPAA. The Plans may not, however, disclose protected health information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the plan sponsor that is not a group health plan sponsored by the Employer. Additionally, federal law prohibits the Plans and the Employer from using or disclosing for underwriting purposes protected health information that is genetic information.

Use and Disclosure of Summary Health Information

The Plans may use and disclose "summary health information" to the Employer for purposes of obtaining premium bids or modifying, amending, or terminating the Plans. Summary health information is information that summarizes the claims history, claims expenses, or type of claims experienced by employees and covered family members and that does not include certain identifying information. However, neither the Plans nor the Employer may use or disclose summary health information for underwriting purposes to the extent the information is genetic information.

Use and Disclosure with Your Authorization

Except as otherwise provided in this Notice, uses and disclosures of your protected health information will be made only with your written authorization. For example, the Plans generally will not disclose your protected health information to the Employer for employment purposes or other non-health plan purposes without your authorization. You may revoke an authorization in writing unless action has been taken in reliance on such authorization. The revocation of an authorization does not apply to any disclosures already made with authorization. The Plans cannot take back, and have no obligation to remedy, any such prior disclosures.

Except as otherwise permitted by applicable law, the Plans must have your authorization to obtain, use or disclose any psychotherapy notes. Additionally, the Plans must also have your authorization to disclose your protected health information for purposes of

marketing, except for face-to-face communications with you or your personal representative, providing promotional gifts of nominal value, and except to the extent such marketing activities constitute “treatment” or “healthcare operations,” as explained above, but only if the Plans and the Employer do not receive financial remuneration for such treatment or healthcare operations marketing activities. Also, the Plans must have your authorization for any disclosure of protected health information that constitutes a “sale” of protected health information under applicable law.

Use and Disclosure Subject to Your Right to Object

The Plans may disclose your protected health information to family members, other relatives, and your close personal friends if the information is directly relevant to the family member’s relative’s or friend’s involvement with your care or payment for that care and if you are present at or prior to the disclosure and have either agreed to the disclosure or have been given an opportunity to object and not objected.

Other Permissible Uses and Disclosures

The Plans may use and disclose your protected health information without your consent, authorization, or request under the following circumstances:

- When required by federal, state, or local law.
- When permitted for purposes of public health activities. For example, protected health information may be disclosed (1) to a public health authority for the purpose of preventing or controlling disease or injury or to report child abuse or neglect, and (2) to report product defects, to permit product recalls, and to conduct post-marketing surveillance.
- When required or authorized by law to report information about abuse, neglect, or domestic violence to public authorities if a reasonable belief exists that the individual may be a victim of abuse, neglect, or domestic violence.
- For health oversight activities authorized by law. This includes uses or disclosures in civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required in the course of any judicial or administrative proceeding. For example, the Plans may disclose protected health information in response to a court order. The Plans may also disclose such information in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that the Plans be provided satisfactory assurances that the requesting party has made a good faith attempt to provide written notice to you, the notice provided sufficient information about the proceeding to permit you to raise an objection, and no objections were raised or were resolved in favor of disclosure by the court or administrative tribunal.
- For law enforcement purposes. For example, if required by law the Plans may disclose protected health information to report certain types of wounds. The Plans may also disclose certain protected health information in response to a law enforcement request for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or for certain purposes relating to the victim of a crime.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. Also, disclosure is permitted to a funeral director, consistent with applicable law, as necessary to carry out the duties of the director with respect to the decedent.
- For the purpose of facilitating organ, eye, or tissue donation and transplantation.
- For research purposes, subject to certain conditions.
- When consistent with applicable law if the Plans, in good faith, believe the use or disclosure is necessary (1) to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, or (2) is necessary for law enforcement authorities to identify or apprehend an individual. The Plans may also disclose protected health information to federal, state, or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.
- For purposes of certain specialized government functions, including military and veteran’s activities, national security and intelligence activities, certain protective services, and activities of correctional institutions.
- When authorized by and to the extent necessary to comply with workers’ compensation or other similar programs established by law.
- With respect to psychotherapy notes, to defend the Plan or the Employer in its capacity as plan sponsor in a legal action or other proceeding brought by you or your personal representative.

Privacy Rights

Right to Request Restriction on Protected Health Information Use and Disclosure

You may request that the Plans restrict use and disclosure of your protected health information to carry out treatment, payment, or health care operations or restrict use and disclosure to family members, relatives, or friends identified by you who are involved in your care or payment for your care. **The Plans are not required to agree to your requests.** The Plans may accommodate your request to receive communications of protected health information by alternative means or at alternative locations if you notify the Plans that

communication in another manner may endanger you.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your protected health information or alternative communications of your protected health information. Such requests must be submitted to the attention of "Protected Health Information Restriction Request" c/o the Privacy Officer (see the contact information at the end of this section).

Right to Inspect and Copy Your Protected Health Information

You have the right to inspect and obtain a copy of your protected health information contained in a "designated record set" for as long as the Plans maintain such protected health information. A "designated record set" includes enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for the Plans and used to make decisions about individuals. However, certain types of protected health information will not be made available for inspection and copying, including psychotherapy notes and protected health information collected by the Plans in connection with, or in reasonable anticipation of, any claim or legal proceeding. The requested information will be provided within 30 days, if the information is maintained on-site, or within 60 days if the information is maintained off-site. A single 30-day extension is allowed if the Plans are unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to your protected health information in a designated record set. Such requests must be submitted to the attention of "Protected Health Information Inspection Request" c/o the Privacy Officer (see the contact information at the end of this section). If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights, and a description of how you may complain to the Secretary of the HHS.

Right to Amend Your Protected Health Information

You have the right to request that the Plans amend your protected health information or a record about you contained in a designated record set for as long as the information is maintained in the designated record set. The Plans may deny your request if it is not in writing or does not include a reason that supports the request. In addition, the Plans may deny your request if you request to amend protected health information that is accurate and complete; was not created by the Plans, unless the person or entity that created the protected health information is no longer available to make the amendment; is not part of a designated record set kept by or for the Plans; or is not part of the protected health information which you would be permitted to inspect and copy. The Plans have 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plans are unable to comply with such deadline.

You or your personal representative will be required to complete a form to request an amendment of your records or protected health information in a designated record set. Such requests must be submitted to the attention of "Protected Health Information Amendment Request" c/o the Privacy Officer (see the contact information at the end of this section). If the request is denied in whole or in part, the Plans must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of such protected health information.

Right to an Accounting of Protected Health Information Disclosures

The Plans will provide you with an accounting of the Plans' disclosures of your protected health information during the six-year period prior to the date of your request (or the time specified by your request, if less). However, such accounting need not and will not include disclosures made: (1) to carry out treatment, payment, or health care operations; (2) to individuals about their own protected health information; (3) prior to April 14, 2003; (4) for national security purposes or certain law enforcement purposes; (5) as part of a limited data set; or (6) pursuant to your written authorization.

You or your personal representative will be required to complete a form to request an accounting of disclosures of your protected health information. Such requests must be submitted to the attention of "Protected Health Information Accounting" c/o the Privacy Officer (see the contact information at the end of this section). If the accounting cannot be provided within 60 days after your request, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each additional accounting beyond the first.

Right to a Paper Copy of this Notice

To obtain a paper copy of this Notice, submit a request to the attention of "Privacy Notice Request" c/o the Privacy Officer (see the contact information at the end of this section).

Your Personal Representatives

You may exercise your rights under this Notice through a personal representative. Your personal representative may be required to produce evidence of authority to act on your behalf before the representative will be given access to your protected health information or allowed to take any action for you. Proof of such authority may include a parental relationship, a duly notarized power of attorney

for health care purposes, or a court order of appointment of the representative as the conservator or guardian of the individual. The Plans retain the discretion to deny access to your protected health information to a personal representative, to the extent permitted by applicable regulations.

Duties of the Plans

The Plans are required by HIPAA to maintain the privacy of protected health information, to provide covered employees and covered family members with this Notice of the privacy practices of the Plans, and to notify affected individuals following a breach of unsecured protected health information. The Plans will comply with mandatory requirements of applicable state laws regarding the use and disclosure of health information to the extent such laws are more restrictive than and are not preempted by applicable federal laws.

Each Plan is required to abide by the terms of the Notice currently in effect. However, the Plans reserve the right to change their privacy practices at any time and to apply the changes to any protected health information received or maintained by the Plans prior to the date such change is adopted. If a privacy practice is changed, a revised version of this Notice will be provided to all past and present covered employees and covered family members for whom the Plan still maintains protected health information. Such revised Notice will be provided via hand delivery, mail, or, to the extent permissible, email. The exact method of delivery will be determined by the Plans and may be different for different individuals. Any revised version of this Notice will be distributed within 60 days after the effective date of any material change to the permissible uses or disclosures, an individual's rights, the duties of the Plans, or other privacy practices set forth in this Notice.

When using or disclosing protected health information or when requesting protected health information from another covered entity, the Plans will make reasonable efforts not to use, disclose, or request more than the minimum amount of protected health information reasonably necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. However, this "minimum necessary" standard will not apply in the following situations: (1) disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the individual or a personal representative; (3) disclosures made to HHS; (4) uses or disclosures that are required by law; (5) uses or disclosures made pursuant to an authorization; and (6) uses or disclosures that are required for compliance with HIPAA regulations.

Complaints

If you believe that your privacy rights have been violated, you may complain to the Plans in care of the Privacy Officer: Benefits and Risk Management Department, Plano Independent School District, 6301 Chapel Hill Blvd, Plano, TX 75093, benefits@pisd.edu. You may also file a complaint with the Secretary of HHS, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint. An individual cannot sue or bring a claim or other action against any of the Plans or any other person to enforce any of the requirements of HIPAA.

Contact Information

If you have any questions regarding this Notice or the subjects described in it, you may contact the Privacy Officer listed above.

Benefits and Risk Management Department

benefits@pisd.edu **(469)752-8138**

Let us help you with:

Enrollment issues
General coverage questions
Life insurance
Mid-year changes

Get information anytime

www.pisd.edu/benefits

Employee Service Center

<http://esc.pisd.edu>

View your leave balances, absences, benefits, & paychecks

Benefit Plan	Company	Phone	Web Site
Medical			
ActiveCare Primary ActiveCare HD ActiveCare Primary + ActiveCare 2	Blue Cross Blue Shield	1-866-355-5999	<u>www.bcbstx.com/trsactivecare</u>
Scott & White HMO	Baylor Scott & White	1-844-633-5325	<u>trs.swhp.org</u>
Dental	Delta Dental	1-800-521-2651	<u>www.deltadentalins.com</u>
Vision	VSP	1-800-877-7195	<u>www.vsp.com</u>
	Davis	1-800-999-5431	<u>www.davisvision.com</u>
EAP (free counseling)	ComPsych	1-800-272-7255	<u>www.guidanceresources.com</u> Web ID: PLANOISD
Disability Insurance	Cigna / New York Life	1-800-362-4462	<u>www.mycigna.com</u>
FSA & HSA	FBA	1-800-437-3539	<u>www.flex-admin.com</u> Employer ID: FBAPISD