Benefits

Open Enrollment Guidebook

2024-2025

Deadline
Friday, August 16

INSIDE SCOOP

Learn More

in our

Online Video Library

- How to Enroll
- About Our Plans
- Insurance 101

GET THE DETAILS

Visit www.pisd.edu/benefits for:

- Complete plan descriptions
- Provider search tools
- Policy booklets
- TRS-ActiveCare presentation
- Enrollment “how-to” videos

WHEN TO ENROLL

Anytime between

Thursday, July 25, 2024

and the **deadline**

Friday, August 16, 2024

Don’t miss out!

WE CAN HELP

Benefits Department

Email benefits@pisd.edu

Call (469)752-8138

8am-5pm, Mon-Fri

Expecting a new ID card?

Is your address up-to-date with the PISD HR Department?

Address Change Form

New Plan Year

Starts

Sept. 1, 2024

TABLE OF CONTENTS

The language of the official plan documents and policies will prevail over the language of any communications vehicle.

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

If your District login has expired, contact the help desk at x28767

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 the deadline
Friday, August 16, 2024

Who? All employees who work at least 20 hours a week

Why? Coverage does not carry forward. Take action to re-enroll, change, or waive coverage.

What about Life Insurance?

It's the only plan that does carry forward. Your current life insurance will automatically continue for next year.

To add or change life insurance, go to www.pisd.edu/benefits | Health Plan | Forms to print the life insurance application. Complete the form and email it to the PISD benefits office.

Tip: Do I have to provide Social Security Numbers?
Yes. The Affordable Care Act requires us to report the SS# for every person covered by the health plan.

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 from September 13, 2024, through June 5, 2025. Your deduction amount is calculated by estimating the total premium cost for the entire year, and then dividing by the number of paychecks. 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, monthly cost $171

Monthly cost [$ 171] x 12 = [$ 2,052] ÷ 17 = [$ 120.71] per check

months in the year (Sept-Aug) — # paychecks with deductions

Fill in your personal selections:

Monthly cost [$] x 12 = [$] ÷ 17 = [$] 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 13th and September 27th 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 (premiums deducted from the September 25th paycheck will pay for the month of September).

Tip: 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.

Plan Summaries

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 10-19.9 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 **5 free counseling visits** are available every year to each family member, even if not enrolled in a medical plan. Services are available 24 hours a day, 7 days a week.

Emotions • Stress, anxiety, overwhelmed • Depression, sadness • Grief, loss • Suicidal thoughts	**Relationships** • Conflict resolution • Healthy relationships • Social development	**Day to Day** • Money management, budgeting • Legal and financial guidance • Education planning • Pet care
Work • Work/life balance • Personal growth • Difficult conversations • Workplace relationships	**Family Care** • Child/Elder care • Adoption • Caregiver resources • Healthy pregnancy • Parenting skills	**Healthy Living** • Fitness • Nutrition • Weight management • Chronic illness • Addiction

MEDICAL

ActiveCare Primary	Total Monthly Cost (groups ❸ & ❹)	PISD Contribution	Reduced Monthly Cost (groups ❶ & ❷)
Employee Only	$501	$330	$171
Employee & Spouse	$1,353	$330	$1,023
Employee & Child(ren)	$852	$330	$522
Employee & Family	$1,704	$330	$1,374

Plan At a Glance

Mid-range deductible
Copays for doctor visits
Statewide network
PCP referrals required

ActiveCare HD			
Employee Only	$513	$330	$183
Employee & Spouse	$1,386	$330	$1,056
Employee & Child(ren)	$873	$330	$543
Employee & Family	$1,745	$330	$1,415

High deductible
Nationwide network
HSA-eligible

ActiveCare Primary +			
Employee Only	$588	$330	$258
Employee & Spouse	$1,529	$330	$1,199
Employee & Child(ren)	$1,000	$330	$670
Employee & Family	$1,941	$330	$1,611

Lower deductible
Copays for doctor visits
Statewide network
PCP referrals required

ActiveCare 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

ActiveCare 2 remains available to current enrollees only. It is not available to new enrollees.

See Plan Summaries on the following pages

Learn the Terms

Deductible
The annual amount of 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

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

MEDICAL

	ActiveCare Primary *(Blue Cross Blue Shield)*	ActiveCare HD *(Blue Cross Blue Shield)*	ActiveCare Primary + *(Blue Cross Blue Shield)*
Plan Summary	• Lowest premium • Copays for doctor visits • Statewide network[1] • PCP referrals required to see specialists • Not compatible with HSA • No out-of-network coverage	• 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	• Lower deductible than HD and Primary plans • Copays for doctor visits • Statewide network[1] • 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	$3,200 / $6,400	$6,400 / $12,800	$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	$8,050 / $16,100	$8,050 / $16,100	$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 (per person)
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

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

MEDICAL

	ActiveCare 2 *(Blue Cross Blue Shield)*
Plan Summary	• 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	Out-of-Network
Individual/Family Deductible	$1,000 / $3,000	$2,000 / $6,000
Coinsurance	You pay 20% after deductible	You pay 40% after deductible
Individual/Family Max Out-of-Pocket	$7,900 / $15,800	$23,700 / $47,400
Network	Nationwide Network	
Primary Care Provider (PCP) Required	No	

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

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

Prescription Drugs	
Drug Deductible	$200 brand deductible (per person)
Generics (30 day / 90 day supply)	$20 / $45 copay
Preferred Brand	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 (30-day $100 min/$200 max / 90-day $215 min/$430 max)
Specialty (31 day max)	$0 if SaveOnSP eligible; or You pay 30% after deductible ($200 min/$900 max)
Insulin Out-of-Pocket Costs	$25 copay for 31-day supply $75 copay for 61-90 day supply

Important Notes

ID Cards

Everyone will receive a new BCBS medical ID card. **Continue using your old card until the new one arrives mid-September.** You can access your digital ID card online as of Sept 1: www.bcbstx.com/trsactivecare

You will not receive a new card for Express Scripts prescriptions.

Provider Network Search

Review each plan's list of in-network providers. Even for Blue Cross Blue Shield, a doctor may be in-network for one plan but not another.

The Primary and Primary + plans use a specially curated network that some doctors refer to as an HMO network. If you select either of these plans, it will only cover doctors within this network. Do some extra checking if you have specific doctors that you need to see.

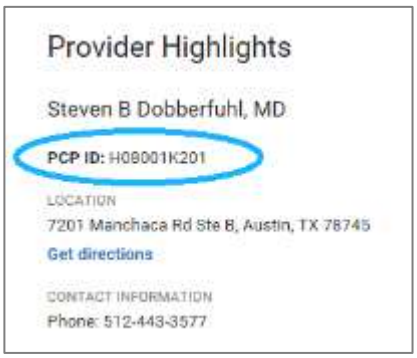
www.bcbstx.com/trsactivecare/doctors-and-hospitals

Choose a PCP

If you enroll in the Primary or Primary + plans, you must select a PCP. Your PCP will help you manage your health care journey and must provide referrals to specialists.

www.bcbstx.com/trsactivecare/doctors-and-hospitals

Make note of the provider's 10-digit PCP ID shown in their profile, which you will need to complete your online enrollment.



MEDICAL

Included on All Medical Plans

Learn more at www.bcbstx.com/trsactivecare

$0 Preventive Care

100% coverage for in-network preventive care:

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

Pregnancy Support

Ovia Health apps for health trackers, videos, tips, coaching, and more

Coverage for **breast pump** purchase or rental

Lactation specialist covered 100% (6 visits per year)

Digital self-guided courses through **Well onTarget**

Virtual Options

Teladoc – virtual doctor visits for cold and flu, allergies, acute illnesses, asthma, mental health, and more

RediMD – virtual doctor visits for skin issues, muscle strains, respiratory infections, digestive problems, and more

Well onTarget & Fitness Program

Well onTarget – digital self-guided courses, or one-on-one support from a wellness coach, on a wide variety of topics

Fitness Program – affordable, no-contract memberships at gyms nationwide. There's also a virtual-only option.

Additional Mental Health Support

Teladoc – speak with a licensed mental health provider online or over the phone ($0 on Primary and Primary + plans)

Learn to Live – free online program to get help with stress, anxiety, depression, substance abuse, and more

Headway – search for and schedule an appointment with an in-network licensed therapist or psychiatrist

Member Rewards

When you choose to use a cost-effective, trusted provider for services like MRI, CT scan, mammogram, and colonoscopy, you can **earn rewards** to apply towards the cost of future medical expenses

Earn up to $599 per person per year to reduce future copays or coinsurance

Airrosti Muscoloskeletal Care

Virtual and in-person options to help provide **pain relief** in the back, knee, arm, foot, wrist, and more

Blue Points & Blue365

Blue Points – earn and redeem points for participating in healthy activities

Blue365 – save money on health and wellness products from top retailers

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.

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.

	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 (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 would be able to keep your optometrist in-network.
- Davis may be a good choice for you if you want lower premiums or access to retail service providers in-network.

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 2nd pair of glasses at Visionworks 20-30% off 2nd pair of glasses at other in-network Laser Vision Correction discount 1 year breakage warranty on Davis Collection frames

	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	50% off 2nd pair of glasses at Visionworks 20-30% off 2nd pair of glasses at other in-network Laser Vision Correction discount 1 year breakage warranty on Davis Collection frames

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. **Life insurance currently in effect will continue with no action required**.

When was the last time you updated your beneficiary?

For Employees - ***Application form is online*** -

New applications will require a health questionnaire. However, if you are currently enrolled in life insurance of $240,000 or less, and are only requesting an increase of $10,000 (for example, from $50,000 to $60,000), a health questionnaire is not required, as long as you turn in the form by August 16.

Monthly Premiums: (cannot be deducted pre-tax)

Amount	Age 39 & Under	Age 40 & Over
$ 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

Amount	Age 39 & Under	Age 40 & Over
$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 September 1 after you turn 70.

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.

Monthly Premiums: (cannot be deducted pre-tax)

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

Plan B: $10,000 spouse, $4,000 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 **New York Life**. The policy certificate 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 as of September 1, 2024. 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.

Reminders

- You may add or change the disability plan during open enrollment only. 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, so you can see if you need to adjust your coverage due to salary changes. 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.

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

A detailed list of eligible expenses is available on our web site.

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 has 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 $4,150 annually if HDHP medical plan enrollment is for employee only, or $8,300 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 $263 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 $263 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

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 – you 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	$4,150 - employee HDHP coverage $8,300 - family HDHP coverage	$3,156 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

Leave Bank

General Information

Eligible full-time employees may join the Leave Bank by donating one local sick day for each year they are Leave Bank members. The days donated to the Leave Bank are not refundable.

When you complete your online enrollment, you will be asked to answer Yes or No regarding Leave Bank membership for the coming year.

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.

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. 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.

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 15th 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 will guide you through the process. Here's the employer information you'll enter when you visit 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 $171.00
        ☒ If not eligible for the employer contribution $501.00
    b. How often?
        ☒ Monthly

HIPAA Exemption

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996, 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, 2024, and ending August 31, 2025. 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 and Risk Management Department at (469)752-8138 or e-mail benefits@pisd.edu.

Privacy Practices

PLANO INDEPENDENT SCHOOL DISTRICT BENEFIT PLANS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET 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 Plans' 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 related 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 and 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, e-mail. 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.

This page intentionally left blank.

Insurance Company	Contact Info
Blue Cross Blue Shield (medical)	1-866-355-5999 www.bcbstx.com/trsactivecare
Express Scripts (prescriptions)	1-844-367-6108 www.esrx.trsactivecare
Delta Dental	1-800-521-2651 www.deltadentalins.com
Vision Service Plan	1-800-877-7195 www.vsp.com
Davis Vision	1-800-999-5431 www.davisvision.com
EAP ComPsych (until Aug 31) Magellan (starting Sept 1)	1-800-272-7255 www.guidanceresources.com Organization ID: PLANOISD Magellan info coming soon
New York Life (disability plan)	1-888-842-4462 www.myNYLGBS.com
Flexible Benefit Administrators (FSA & HSA)	1-800-437-3539 www.flex-admin.com flexdivision@flex-admin.com Employer ID: FBAPISD

PISD Benefits Department

benefits@pisd.edu (469)752-8138
www.pisd.edu/benefits

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