2020 Benefits Enrollment Guide

PAISD

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 31 for more details.

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Welcome to Your 2020-2021 Benefits Enrollment

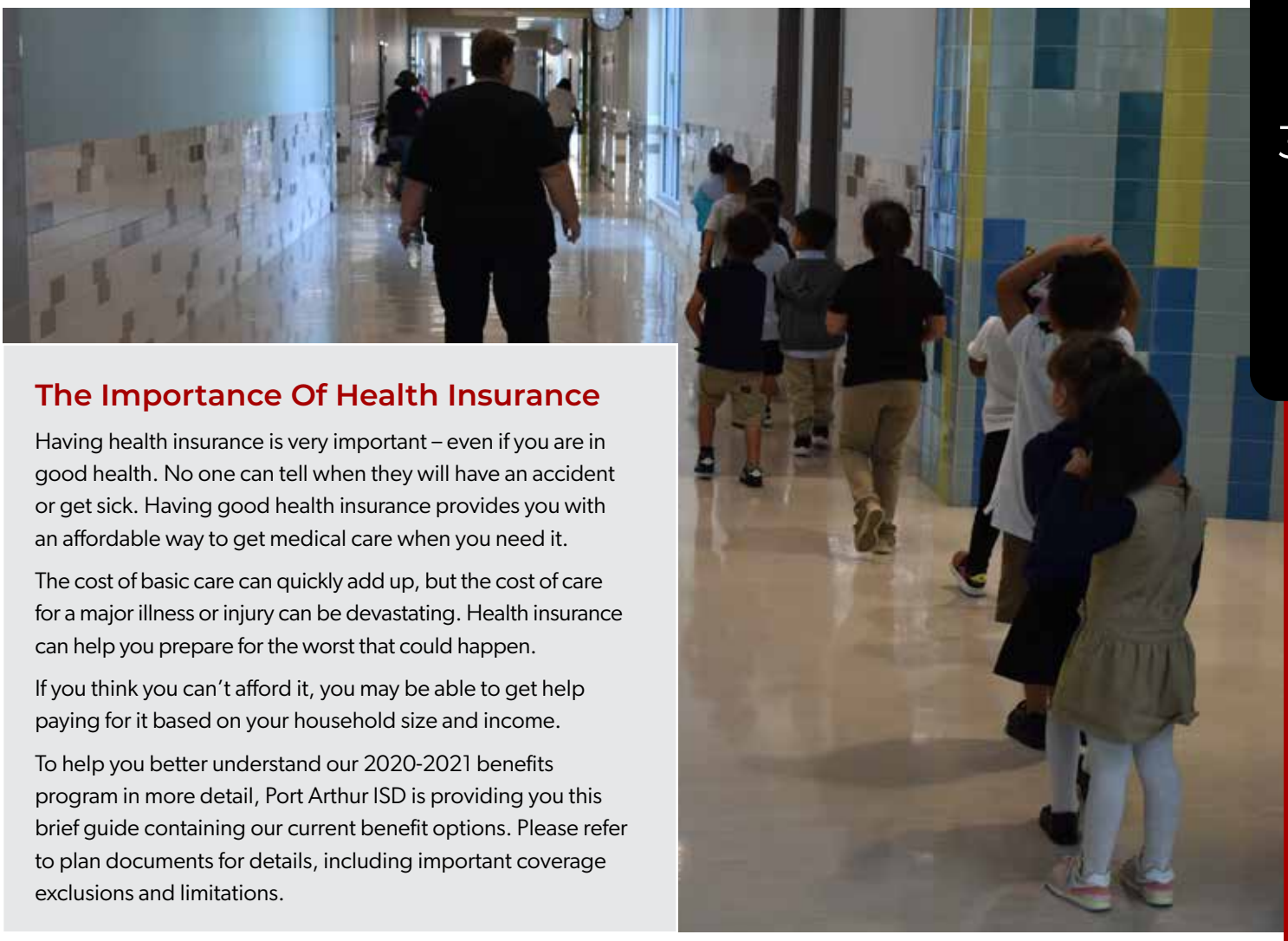
ATTENTION ALL EMPLOYEES! Annual enrollment for your Voluntary Benefits begins January 1, 2020 and ends on January 31, 2020. All changes are effective March 1, 2020.

Enroll online at: **mybenefitshub.com/portarthurisd**.

Annual enrollment for your Medical, Flexible Spending Accounts (FSAs) and Health Savings Account (HSA) will begin in July for a September 1, 2020 effective date.

Please review and print your summary of benefits for your records. It is very important that you verify your beneficiary, address and contact numbers.

The ACA and TRS are now requiring social security numbers for any of your dependents. This is not a PAISD rule, but a federal law. Therefore, you must provide valid social security numbers for your dependents during Annual Enrollment.



The Importance Of Health Insurance

Having health insurance is very important – even if you are in good health. No one can tell when they will have an accident or get sick. Having good health insurance provides you with an affordable way to get medical care when you need it.

The cost of basic care can quickly add up, but the cost of care for a major illness or injury can be devastating. Health insurance can help you prepare for the worst that could happen.

If you think you can't afford it, you may be able to get help paying for it based on your household size and income.

To help you better understand our 2020-2021 benefits program in more detail, Port Arthur ISD is providing you this brief guide containing our current benefit options. Please refer to plan documents for details, including important coverage exclusions and limitations.

Administration Eligibility

TRS ActiveCare Medical Plans

To be eligible for TRS ActiveCare, you must be an active, contributing TRS member or a regular part-time or substitute employee working a minimum of 10 hours a week. All employees contributing to TRS are eligible for the District medical contribution if medical is elected. All non-TRS members, including substitutes, are responsible for the full medical premium. Retirees eligible for TRS-Care are NOT eligible for TRS ActiveCare. Spouses and children up to age 26 are eligible to be enrolled as dependents. Retirees that are rehired and working more than 15 hours per week are considered full-time, and therefore, eligible for all benefits, except TRS ActiveCare medical coverage.

Your eligible dependents include your:

- Legally married spouse (same sex or opposite sex), or with whom you have proof of Common Law marriage
- Children up to the age of 26, regardless of student, marital status (medical only) or tax status, including stepchild(ren), adopted child(ren), child(ren) for whom you are the legal guardian, a grandchild who is your dependent for federal income tax purposes at the time of application
- Child over age 26, if medically incapacitated – forms required, please consult the Human Resource Department

Important Notes on Eligibility

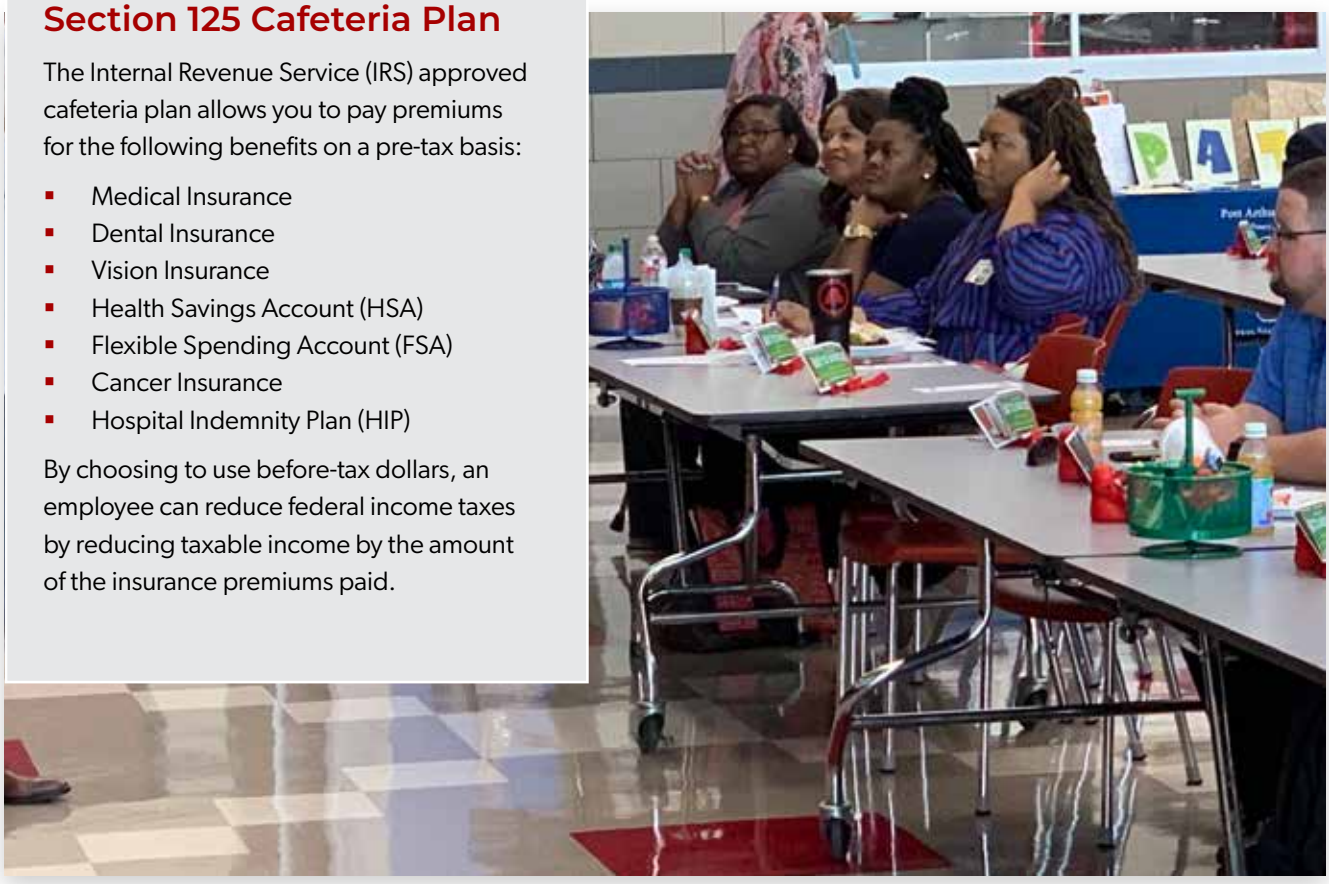
- Benefits for a dependent child will continue until the last day of the calendar month in which they turn 26
- If you are married to another employee, only one of you may cover any dependent children for a specific benefit

Section 125 Cafeteria Plan

The Internal Revenue Service (IRS) approved cafeteria plan allows you to pay premiums for the following benefits on a pre-tax basis:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Health Savings Account (HSA)
- Flexible Spending Account (FSA)
- Cancer Insurance
- Hospital Indemnity Plan (HIP)

By choosing to use before-tax dollars, an employee can reduce federal income taxes by reducing taxable income by the amount of the insurance premiums paid.



Qualifying Life Events

Generally, you may only change your benefit elections during the annual Open Enrollment period. However, you can change your benefit elections during the year if you experience a Qualifying Life Event. Qualifying Life Events include:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse or dependent child
- Adoption of/placement for adoption of your child
- Termination or commencement of your spouse's employment
- Involuntary loss of medical coverage
- Qualification by the Plan Administrator of a Medical Child Support Order
- Entitlement to Medicare or Medicaid
- Loss of COBRA coverage

If you experience a Qualifying Life Event, you must notify Port Arthur ISD and complete your benefit election form within 31 days of the effective date of change. Depending on the type of change, you may need to provide proof of the change. If you do not contact the Port Arthur ISD Benefits Department and make your benefit election within 31 days, you will have to wait until the next annual enrollment period to make changes, unless you have another Qualifying Life Event.

How To Enroll For Benefits

All employees must enroll online via the mybenefitsHUB. For a detailed explanation of how to enroll, please refer to the ThebenefitsHub Enrollment Instructions or download the instructions by visiting: **mybenefitshub.com/portarthurisd**. See page 27 for detailed enrollment instructions.

Once Benefits Are Elected

Once you have made your benefit elections, they will remain in effect until the end of the plan year:

Voluntary Benefits:

- Enroll for benefits: January 2020
- Plans effective: March 1, 2020

Medical, FSA and HSA:

- Enroll for benefits: July – August 2020
- Plans effective: September 1, 2020

Please remember, it's your responsibility to become educated about the benefits made available to you and to take an active role in your overall health care. Be certain to review all options before making your final elections.

Medical Coverage

Coverage provided by TRS ActiveCare Aetna

	ActiveCare 1-HD	ActiveCare Select [1,2]	ActiveCare 2 [3]
Deductible (per plan year)			
• In-Network	$2,750 Employee Only $5,500 Family	$1,200 Employee Only $3,600 Family	$1,000 Employee Only $3,000 Family
• Out-of-Network	$5,500 Employee Only $11,000 Family	N/A	$2,000 Employee Only $6,000 Family
Out-of-Pocket Maximum (per plan year) [4]			
• In-Network	$6,750 [5] Individual $13,500 Family	$7,900 Individual $15,800 Family	$7,900 Individual $15,800 Family
• Out-of-Network	$20,250 [5] Individual $40,500 Family	N/A	$23,700 Individual $47,400 Family
Coinsurance			
• In-Network Participant pays	20%*	20%*	20%*
• Out-of-Network Participant pays	40%* of allowed amount unless otherwise noted	N/A	40%* of allowed amount unless otherwise noted
Office Visit Participant pays	20%*	$30 copay (Primary) $70 copay (Specialist)	$30 copay (Primary) $70 copay (Specialist)
Diagnostic Lab Participant pays	20%*	20%*	20%*
Preventive Care See page 8 for more details	Plan pays 100%	Plan pays 100%	Plan pays 100%
Teladoc® Physician Services	$40 consultation fee (counts toward deductible and out-of-pocket maximum)	Plan pays 100%	Plan pays 100%
High-Tech Radiology (CT Scan, MRI, nuclear medicine) Participant pays	20%*	$100 copay plus 20%*	$100 copay plus 20%*
Inpatient Hospital Facility Charges Only (pre-authorization required)			
• In-Network	20%*	$150 copay per day plus 20%* ($750 maximum copay per admission)	$150 copay per day plus 20%* ($750 maximum copay per admission; $2,250 maximum copay per plan year)
• Out-of-Network	Plan pays up to $500 per day cap of covered charges*	N/A	Plan pays up to $500 per day cap of covered charges*
Urgent Care	20%*	$50 copay per visit	$50 copay per visit
Freestanding Emergency Room Participant pays	$500 copay per visit plus 20%*	$500 copay per visit plus 20%*	$500 copay per visit plus 20%*
Emergency Room (True Emergency Use) Participant pays	20%*	$250 copay per visit plus 20%* (copay waived if admitted)	$250 copay per visit plus 20%* (copay waived if admitted)
Outpatient Surgery Participant pays	20%*	$150 copay per visit plus 20%*	$150 copay per visit plus 20%*
Bariatric Surgery (only covered if performed at an IOQ facility) Physician charges; Participant pays	$5,000 copay (does apply to out-of-pocket maximum) plus 20%*	Not covered	$5,000 copay (does not apply to out-of-pocket maximum) plus 20%*

* After Deductible

1 Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance.

2 The ActiveCare Select plan does not cover out-of-network services except for emergencies.

3 If you're currently enrolled in ActiveCare 2, you can remain in this plan. However, as of 9/1/18, the plan is closed to new enrollees.

4 Medical and prescription drug deductibles, copays and coinsurance count toward the out-of-pocket maximum.

5 The individual out-of-pocket maximum only includes covered expenses incurred by that individual.

	ActiveCare 1-HD	ActiveCare Select [1,2]	ActiveCare 2 [3]
Annual Vision Examination (one per plan year; performed by an ophthalmologist or optometrist using calibrated instruments) Participant pays	20%*	$70 copay (Specialist)	$70 copay (Specialist)
Annual Hearing Examination Participant pays	20%*	$30 copay (Primary) $70 copay (Specialist)	$30 copay (Primary) $70 copay (Specialist)
Prescription Drug Coverage [4]			
Drug Deductible (per person, per plan year)	Must meet plan-year deductible before plan pays.[5]	$0 (Generic) $200 (Brand)	$0 (Generic) $200 (Brand)
Retail Location (up to a 31-day supply)			
Tier 1 – Generic	20%* except for certain generic preventive drugs that are covered at 100% [5]	$15 copay	$20 copay
Tier 2 – Preferred Brand	25%* [6]	25% (min. $40 [7]; max. $80) [6]	25% (min. $40 [7]; max. $80) [6]
Tier 3 – Non-Preferred Brand	50%* [6]	50% [6]	50% (min. $100 [7]; max. $200) [6]
Specialty Medications	20%*	20%	20% (min. $200 [7]; max. $900)
Mail Order or Retail-Plus Location (60- to 90-day supply) [8]			
Tier 1 – Generic	20%*	$45 copay	$45 copay
Tier 2 – Preferred Brand	25%* [6]	25% (min. $105 [7]; max. $210) [6]	25% (min. $105 [7]; max. $210) [6]
Tier 3 – Non-Preferred Brand	50%* [6]	50% [6]	50% (min. $215 [7]; max. $430) [6]
Short-Term Supply of a Maintenance Medication at a Retail Location (up to a 31-day supply)			
The second time a participant fills a short-term supply of a maintenance medication at a retail pharmacy, they will pay a convenience fee. They will be charged the coinsurance and copays in the row below the second time they fill a short-term supply of a maintenance medication. Participants can avoid paying the convenience fee by filling a larger day supply of a maintenance medication through mail order or at a Retail-Plus Location.			
Tier 1 – Generic	20%*	$30 copay	$35 copay
Tier 2 – Preferred Brand	25%* [6]	25% (min. $60 [7]; max. $120) [6]	25% (min. $60 [7]; max. $120) [6]
Tier 3 – Non-Preferred Brand	50%* [6]	50% [6]	50% (min. $105 [7]; max. $210) [6]

* After Deductible

1 Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance.

2 The ActiveCare Select plan does not cover out-of-network services except for emergencies.

3 If you're currently enrolled in ActiveCare 2, you can remain in this plan. However, as of 9/1/18, the plan is closed to new enrollees.

4 Illustrates benefits when in-network providers are used. For some plans non-network benefits are also available; there is no coverage for non-network benefits under ActiveCare Select or ActiveCare Select Whole Health Plan; see Enrollment Guide for more information. Non-contracting providers may bill for amounts exceeding the allowable amount for covered services. Participants will be responsible for this balance bill amount, which may be considerable.

5 For ActiveCare 1-HD, certain generic preventive drugs are covered at 100%. Participants do not have to meet the deductible ($2,750 individual, $5,500 family) and they pay nothing out of pocket for these drugs. The list of drugs is on the TRA-ActiveCare website at **www.trsactivecareaetna.com**.

6 If a participant obtains a brand-name drug when a generic equivalent is available, they are responsible for the generic copay plus the cost difference between the brand-name drug and the generic drug.

7 If the cost of the drug is less than the minimum, you will pay the cost of the drug.

8 Participants can fill 32-day to 90-day supply through mail order.

Medical Plans	PAISD Monthly Contributions	Employee Semi-Monthly Contributions		
		ActiveCare 1-HD	ActiveCare Select	ActiveCare 2
Employee Only	$378.00	$0.00	$89.00	$237.00
Employee + Spouse	$378.00	$344.00	$494.50	$821.00
Employee + Child(ren)	$378.00	$172.00	$262.00	$444.50
Employee + Family	$378.00	$518.50	$670.00	$1,005.50

NOTE: Rates deducted equally between two paychecks each month. Rates reflect a semi-monthly cost for employees receiving 24 paychecks a year. For all other benefits, refer to other sections in this booklet or online at: **mybenefitshub.com/portarthurisd**.

Preventive Care

Some examples of preventive care frequency and services:

- **Routine physicals** – annually age 12 and over
- **Mammograms** – 1 every year age 35 and over
- **Smoking cessation counseling** – 8 visits per 12 months
- **Well-child care** – unlimited up to age 12
- **Colonoscopy** – 1 every 10 years age 50 and over
- **Healthy diet/obesity counseling** – unlimited to age 22; age 22 and over - 26 visits per 12 months
- **Well woman exam & pap smear** – annually age 18 and over
- **Prostate cancer screening** – 1 per year age 50 and over
- **Breastfeeding support** – 6 lactation counseling visits per 12 months

Note: Covered services under this benefit must be billed by the provider as "preventive care". Non-network preventive care is not paid at 100%. If you receive preventive services from a non-network provider, you will be responsible for any applicable deductible and coinsurance under the ActiveCare 1-HD and ActiveCare 2. There is no coverage for non-network services under the ActiveCare Select plan or ActiveCare Select Whole Health.

For a complete listing of preventive care services, please view the Benefits Booklet at **www.trsactivecareaetna.com** for the latest list of covered services.

TRS ActiveCare is administered by the Aetna Life Insurance Company. Aetna provides claims payment services only and does not assume any financial risk or obligation with respect to claims.

Prescription drug benefits are administered by Caremark.

Important Terms

Copay – amount participant must pay for medical services during an office visit at the time the services are provided or a prescription is filled.

Deductible – amount of covered medical expenses that you pay out-of-pocket each plan year before ActiveCare begins payment for eligible covered medical and pharmacy expenses.

Coinsurance – the percentage of the participant's share for covered expenses for services and supplies after the deductible has been met. For example, if the coinsurance amount is "80/20" that means the plan pays 80% and you pay 20% of the allowable amount for the eligible charges.

What is a maintenance medication?

Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

When does the convenience fee apply?

For example, if you are covered under TRS-ActiveCare Select, the first time you fill a 31-day supply of a generic maintenance drug at a retail pharmacy you will pay $20, then you will pay $35 each month that you fill a 31-day supply of that generic maintenance drug at a retail pharmacy. A 90-day supply of that same generic maintenance medication would cost $45, and you would save $225 over the year by filling a 90-day supply.

Health Savings Account (HSA)

Accounts administered by National Benefits Services

(Enroll for your HSA during the months of July and August 2020. Plans are effective September 1, 2020.)

One of the key benefits of a High Deductible Health Plan (HDHP) is your ability to accumulate a balance in your Health Savings Account (HSA) over time. Like the majority of Americans, you may find you do not use your health care coverage often. PAISD's HSA is administered by National Benefit Services (NBS).

You can fund your HSA through pre-tax salary deferrals and/or after-tax contributions provided the total contribution does not exceed the IRS annual limit. For 2020, these limits are:

- **$3,550** for single coverage
- **$7,100** for family coverage

If you are age 55 or older, you may make a "catch-up" contribution each year. In 2020 the "catch-up" amount is $1,000. You may open and fund an HSA if you are not covered by any other non-HSA-eligible health plan (i.e., Choice Plan, spouse's medical plan), are not enrolled in Medicare, TRICARE, or TRICARE for Life, have not received Veterans Administration (VA) benefits within the past three months, are not eligible to be claimed as a dependent on someone else's tax return, and do not have a general purpose Health Care Flexible Spending Account (FSA) or Health Reimbursement Account (HRA).

By applying for and funding your HSA (other than as a rollover from another HSA), you confirm that you are:

- Covered under a HDHP
- Not also covered by any other health plan that is not a HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and coverage)
- Not enrolled in Medicare
- Not claimed as a dependent on another person's tax return
- Not enrolled in a general purpose FSA or HRA, or have a spouse enrolled in a general purpose FSA or HRA
- Not eligible to have qualified medical expenses reimbursed under another plan

Once you're enrolled, you will receive the disclosure upon the opening of your HSA account.

Ways you can save:

- Roll over your HSA balance from year to year (no "use it or lose it")
- Pre-tax contribution and tax-free reimbursement equal tax savings
- Tax-free interest or investment return earned on account balance

Flexible Spending Accounts (FSAs)

Accounts administered by National Benefits Services

(Enroll for your FSA during the months of July and August 2020. Plans are effective September 1, 2020.)

The Flexible Spending program is administered by **National Benefit Services, LLC (1-800-247-0503)**. Persons eligible to enroll in the Flexible Spending Accounts (FSAs) are employees eligible and contributing to the TRS and retirees that are considered full-time. There are three types of FSA accounts available: **Full-Purpose FSA**, **Dependent Care FSA** and **Limited-Purpose FSA**.

Important Note: Flexible Spending Accounts must be re-elected each year.

Once enrolled, your FSA contribution is loaded upfront and is deposited into your Health Care and/ or Dependent Care Spending Account. When you need money to cover an eligible health care expense, you make a pre-tax "withdrawal" by using your debit care or completing a claim form and providing proper documentation such as pharmacy receipts, detailed bills or explanation of benefit (EOB).

How Do I Receive Reimbursements?

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

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

NBS Flexcard – FSA Pre-Paid Mastercard

Port Arthur ISD uses of the NBS Flexcard, making access to your flex dollars easier than ever. You may use the card to pay merchants or service providers that accept credit cards, so there is no need to pay cash up front then wait for reimbursement.

FULL-PURPOSE FSA	DEPENDENT CARE FSA	LIMITED-PURPOSE FSA
• Maximum annual contribution: $2,750 • Used for most medical, dental, and vision care expenses that are not covered under the plans (like co- payments, deductibles, eyeglasses, and certain over-the-counter expenses)	• $5,000 annual tax year maximum (per tax filing household) • Used for Dependent Care or Elder Care expenses (i.e. daycare, after school programs, or elder care programs) so you and your spouse can work or attend school on a full-time basis	• Maximum annual contribution: $2,750 • Used alongside an HSA when an HSA is elected. The Limited FSA can only reimburse out-of-pocket dental and vision and some preventive expenses incurred during the plan year

Frequently Asked Questions

How does contributing to an FSA reduce my taxes? FSA contributions are deducted from your pay check before taxes are calculated. This means you do not pay federal income taxes or social security taxes on the portion of your pay check you contribute to the FSA.

If there's unused money in my FSA at the end of the plan year, do I get to keep it? If you do not use all the money in your FSA for expenses incurred during the plan year, any unused funds will be forfeited. This is known as the "use it or lose it" rule.

Can I request FSA reimbursement for services I received before the plan year begins if I am not billed until after the plan year starts? No. According to the IRS guidelines, a qualified expense is "incurred' at the time the service is provided, not when you are billed or when you actually pay for this service. Therefore, you can only file claims for eligible expenses incurred during the same plan year.

Health Care FSA Expenses

Below is a partial list of qualified approved expenses:

- Alcoholism Treatment
- Allergy Medicine/Shots
- Ambulance Charges
- Acupuncture
- Bandages
- Birth Control/Condoms
- Blood Pressure Devices
- Chiropractor
- Copayments / Coinsurance
- Contact Lenses/Solution
- Dental Expenses
- Doctor Fees
- Drug Addiction Treatment
- Emergency Room Visits
- Health Care Equipment
- Hospital Expenses
- Insulin
- Nursing Home Care
- Optometrist
- Orthodontia
- Oxygen
- Pain Medicine
- Physical Exams
- Psychologist Fees
- Psychotherapy
- Smoking Cessation
- Sterilization
- Therapy
- Vision Care
- X-Ray

As of January 1, 2011, over-the-counter (OTC) medicines are paid from the Flexible Spending Account (FSA) only if a physician provides a prescription for the medication; debit cards cannot be used. To receive reimbursement from the FSA account for an over-the-counter medication, you must submit an FSA claim form, the prescription for the OTC medication from the physician and the receipt.

Dental Coverage

Coverage provided by Unum – **NEW CARRIER**

(Enroll for Dental during the month of January 2020. Plans are effective March 1, 2020.)

See any dentist or maximize your benefits by utilizing our national network of more than 323,000+ dental access points with discounted fees for in-network services. Find an in-network provider at **unumdentalcare.com**. Manage your benefits online with **AlwaysAssist.com** and on-the-go with the AlwaysAssist mobile app.

For additional information about your dental benefit please contact customer service at **1-888-400-9304** or refer to your benefits summary for a schedule of benefits, limitations and exclusions.

PLAN BENEFITS	High Option		Low Option	
	IN-NETWORK	OUT-OF- NETWORK	IN-NETWORK	OUT-OF- NETWORK
Deductible (Single/Family)	$50/$150	$50/$150	$50/$150	$50/$150
Annual Maximum	$1,500	$1,500	$1,000	$1,000
Services (plan pays)				
Class A: Preventive (exams, cleanings, X-rays)	100% of PDP Fee*	100% of R&C Fee**	80% of PDP Fee*	80% of R&C Fee**
Class B: Basic (fillings, root canals, simple extractions)	80% of PDP Fee*	80% of R&C Fee**	80% of PDP Fee*	80% of R&C Fee**
Class C: Major (crowns, bridges, dentures)	50% of PDP Fee*	50% of R&C Fee**	50% of PDP Fee*	50% of R&C Fee**
Class D: Orthodontics	50% of PDP Fee*	50% of R&C Fee**	50% of PDP Fee*	50% of R&C Fee**
Orthodontic Lifetime Max. per person (Children up to age 19)	$1,000	$1,000	$1,000	$1,000

* PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any copayments deductibles, cost sharing and benefits maximums.

** R&C Fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

For a detailed dental summary of benefits, please refer to your summary plan documents.

Dental Plans Semi-Monthly Rates		
Unum Dental	**High Option**	**Low Option**
Employee Only	$13.31	$9.82
Employee + Spouse	$26.61	$19.58
Employee + Child(ren)	$27.95	$20.56
Employee + Family	$39.93	$29.36

NOTE: Rates deducted equally between two paychecks each month. Rates reflect a semi-monthly cost for employees receiving 24 paychecks a year. For all other benefits, refer to other sections in this booklet or online at: **mybenefitshub.com/portarthurisd**.

Vision Coverage

Coverage provided by Unum – **NEW CARRIER**

(Enroll for Vision during the month of January 2020. Plans are effective March 1, 2020.)

Unum's vision network offers members access to convenient, quality care with more than 40,000 vision access points, including independent optometrists and retail stores like Walmart, Sam's Club, JCPenney, Sear's Optical, America's Best and many more! Find an in-network provider at **unumvisioncare.com**. Manage your benefits online with **AlwaysAssist.com** and on-the-go with the AlwaysAssist mobile app.

For more information visit the Unum website at **AlwaysAssist.com** or call Member Services at **1-888-400-9304**.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Copays		
Exams (Once every 12 months)	$10 copay	Up to $35
Materials	$15 copay	See below
Standard Plastic Lenses (Once every 12 months)		
Single Vision	Covered by copay	Up to $25
Bifocal	Covered by copay	Up to $40
Trifocal	Covered by copay	Up to $45
Lenticular	Covered by copay	Up to $80
Progressive	$70 allowance	Up to $45
Lens Options		
Scratch Resistant Coating	Covered at Walmart only	Not Covered
Polycarbonate Lenses for children to age 19	Covered	Not Covered
Frames (Once every 24 months)		
Members choose from any frame available at provider locations.	Up to $150 allowance	Up to $70 retail
Contact Lenses [1] (Once every 12 months) – Includes fit [2], follow-up and materials		
Elective	$0 copay Up to $150 allowance	Up to $100
Medically Necessary	Covered	Up to $150

1 Contact lenses are in lieu of eyeglass lenses and frames.

2 Some providers, such as Walmart, may charge for a contact lens fit and evaluation separately from your contact lens allowance, leaving the entire allowance for materials.

Note: Out-of-network services available on a reimbursement schedule only, please review your vision plan summary for a complete list of in- and out-of-network services. For a detailed vision summary of benefits please refer to your summary plan document.

Vision Plan Semi-Monthly Rates	
Unum Vision	
Employee Only	$3.06
Employee + Spouse	$5.22
Employee + Child(ren)	$5.53
Employee + Family	$8.29

NOTE: Rates deducted equally between two paychecks each month. Rates reflect a semi-monthly cost for employees receiving 24 paychecks a year. For all other benefits, refer to other sections in this booklet or online at: **mybenefitshub.com/portarthurisd**.

Term Life Insurance

Coverage provided by Unum – NEW CARRIER

(Enroll for this benefit during the month of January 2020. Plans are effective March 1, 2020.)

To help you ensure financial stability for your family, PAISD offers Life coverage through Unum. **This is an added benefit – at no cost to you.** PAISD provides you with Basic Term Life insurance coverage in the amount of **$25,000**.

For You	• Choose from $10,000 to $750,000 in $10,000 increments, up to 5 times your earnings. • You can get up to $250,000 with no health questions. This is your guaranteed issue amount.
For Your Spouse	• Get up to $500,000 of coverage in $10,000 increments. Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself. • Your spouse can get up to $50,000 with no health questions, if eligible (see delayed effective date). This is their guaranteed issue amount.
For Your Dependent Children	• Get up to $20,000 of coverage in $10,000 increments if eligible (see delayed effective date). One policy covers all of your children until their 26th birthday. • The maximum benefit for children live birth to 6 months is $500.

Delayed Effective Date: If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Voluntary Term Life Semi-Monthly Rates

	Employee & Spouse
Age	**Cost Per $10,000 of Coverage**
15-29	$0.27
30-34	$0.36
35-39	$0.41
40-44	$0.59
45-49	$0.86
50-54	$1.49
55-59	$2.66
60-64	$3.24
65-69	$6.12
70+	$9.90
Child(ren)	$0.50 per $10,000 coverage

PLEASE NOTE: This year only, for all employees, guaranteed issue is up to $250,000 for you, and up to $50,000 for your Spouse.

No evidence of insurability is required for amounts under these limits! Additionally, if you elect any amount of coverage during this Open Enrollment, you'll have the ability to increase coverage up to the guaranteed issue amount during future Open Enrollment periods.

It is important to name a beneficiary for all life insurance coverages. You can review/change your life insurance beneficiary at any time by visiting the PAISD website at: **mybenefitshub.com/portarthurisd**.

Accidental Death & Dismemberment Insurance

Coverage provided by Unum – NEW CARRIER

(Enroll for this benefit during the month of January 2020. Plans are effective March 1, 2020.)

AD&D insurance is also available, which pays a benefit if a covered accident results in your injury or death. All AD&D coverage is guaranteed issue. No evidence of insurability is required.

For You	• Get up to $750,000 of AD&D coverage for yourself in $10,000 increments to a maximum of 5 times your earnings.
For Your Spouse	• Get up to $500,000 of AD&D coverage for your spouse in $10,000 increments, if eligible (see delayed effective date).
For Your Dependent Children	• Get up to $20,000 of coverage for your children in $10,000 increments if eligible (see delayed effective date).

Delayed Effective Date: If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Employee Assistance Program (EAP)

Coverage provided by Unum – NEW CARRIER

Unum's EAP services are available to all eligible employees, their spouses or domestic partners, dependent children, parents and parents-in-law. Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor who can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Job stress, work conflicts
- Family and parenting problems
- Anger, grief and loss
- And more

Work/Life Balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our Work/Life Specialists can answer your questions and help you find resources in your community.

Ask our Work/Life Specialists about:

- Child care
- Elder care
- Legal questions
- Identity theft
- Financial services, debt management, credit report issues
- Even reducing your medical/dental bills!
- And more

Help Is Easy to Access

- **Online/phone support:** Unlimited, confidential, 24/7
- **In-person:** You can get up to 3 visits available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

Want to learn more?

Toll-free 24/7 access:

1-800-854-1446 (multi-lingual)

www.unum.com/lifebalance

Whole Life Insurance

Coverage provided by ManhattanLife

(Enroll for these benefits during the month of January 2020. Plans are effective March 1, 2020.)

This plan highlight is a summary provided to help you understand your insurance coverage from ManhattanLife. Please refer to your policy for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

General Information

- Guaranteed renewable for life
- Guaranteed death benefit
- Completely portable
- Loans available
- Issue ages: **Individual:** 18-70, **Dependent spouse:** 18-70, **Child(ren)/Grandchild(ren):** 14 days through 24 years

Employee Coverage

- Minimum $2,500, maximum $300,000
- This year there is an Open Enrollment guaranteed issue amount for all employees ages 18-50 of up to $150,000 and ages 51-70 of up to $60,000
- Tobacco/non-tobacco rates

Spouse Coverage

- Minimum $2,500, maximum $50,000
- This year there is an Open Enrollment guaranteed issue amount for all spouse whole life coverage up to and including $20,000
- Unisex/uni-tobacco rates

Child(ren) Coverage

- Minimum $2,500, maximum $25,000
- This year there is an Open Enrollment guaranteed issue amount for all child whole life coverage up to and including $15,000
- Unisex/uni-tobacco rates

Terminal Illness Benefit

- On primary insured, acceleration of up to 50% of the original death benefit (base/term rider) amount, including ABI amounts
- Physician certification of less than 12 months' life expectancy
- Illness must be diagnosed at least 12 months after date of policy
- Limit of one per lifetime

Please refer to your Benefit Summary for a full explanation of benefits.

Disability Insurance

Coverage provided by Unum – NEW CARRIER

What Is Disability?

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

Benefit Amount

You may purchase a monthly benefit in $100 units, starting at a minimum of $200, up to 66 2/3% of your monthly earnings rounded to the nearest $100, but not to exceed a monthly maximum benefit of $8,000.

Elimination Period

The Elimination Period is the length of time of continuous disability, due to sickness or injury, which must be satisfied before you are eligible to receive benefits.

You may choose an Elimination Period (injury/sickness) of **14/14, 30/30, 60/60, 90/90** or **180/180** days.

Benefit Duration

Your duration of benefits is based on your age when the disability occurs.

You may choose one of the following duration options:

Plan A: ADEA II	
Age at Disability	**Maximum Duration of Benefits**
Less than age 60	To age 65, but not less than 5 years
Age 60 through 64	5 years
Age 65 through 69	To age 70, but not less than 1 year
Age 70 and over	1 year

Plan B: ADEA II/5 YR ADEA	
For disabilities due to injury:	
Age at Disability	**Maximum Duration of Benefits**
Less than age 60	To age 65, but not less than 5 years
Age 60 through 64	5 years
Age 65 through 69	To age 70, but not less than 1 year
Age 70 and over	1 year
For disabilities due to sickness:	
Age at Disability	**Maximum Duration of Benefits**
Less than age 65	5 years
Age 65 through 68	To age 70, but not less than 1 year
Age 69 and over	1 year

Rates below are per Monthly Benefit increments of $100. Choose from $200 to $8,000 up to a maximum of 66 2/3% of the employee's monthly earnings.

	Plan A					**Plan B**				
	ADEA II Duration of Benefits					Injury - ADEAII Duration of Benefits Sickness - 5YR Duration of Benefits				
	Elimination Period (Days)					**Elimination Period (Days)**				
Injury (Days)	14	30	60	90	180	14	30	60	90	180
Sickness (Days)	14	30	60	90	180	14	30	60	90	180
Employee Rate (Per $100 of monthly benefit)	$2.88	$2.20	$1.96	$1.60	$1.14	$2.82	$2.06	$1.46	$1.20	$0.86

For example: if you elect Plan A with a 30/30 elimination period and a $1,000 monthly benefit your monthly cost would be $2.20 x 10 = $22.00.

Cancer Insurance

Coverage provided by Allstate Benefits

(Enroll for these benefits during the month of January 2020. Plans are effective March 1, 2020.)
Guaranteed Issue – Health questions will not be required during annual enrollment for the 2020 plan year.

Allstate Benefits group voluntary cancer coverage provides cash benefits for cancer and 29 other specified diseases, and can help cover the costs of specific cancer and specified disease treatments and expenses as they happen.

In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer, for women, the risk is a little more than 1 in 3.[1] Allstate offers you and your family coverage in the event you are diagnosed with cancer or 29 other specified diseases. It protects you and your family 24 hours a day, seven days a week.

A cancer diagnosis can mean unforeseen expenses that may be difficult to pay, especially if you aren't working. Hospital stays, medical or surgical treatments, and transportation by ambulance can add up quickly and be very costly. Allstate helps offset some of the expenses your health insurance may not cover, so you can focus on getting well.

- Benefits will be paid directly to you unless otherwise specified.
- Coverage can be purchased for you and your entire family.
- Includes coverage for 29 other specified diseases such as: ALS, Muscular Dystrophy, Multiple Sclerosis, Sickle Cell Anemia and Lyme Disease.

Coverage Highlights[2]	High Plan	Low Plan
Cancer Radiation & Chemotherapy	$20,000 (every 12 months)	$10,000 (every 12 months)
Blood, Plasma and Platelets	$20,000 (every 12 months)	$10,000 (every 12 months)
Cancer Initial Diagnosis	$5,000	$5,000
Continuous Hospital Confinement	$200 (daily)	$100 (daily)
Wellness Benefit	$100	$100
ICU Benefit	$600 (daily)	$400 (daily)

1 Cancer Facts & Figures, American Cancer Society 2009.

2 Please see product brochure for full plan benefits and details.

Semi-Monthly Cost	High Plan	Low Plan
Employee	$20.17	$12.53
Employee & Spouse	$31.62	$19.95
Employee & Child(ren)	$28.78	$17.67
Family	$40.22	$25.09

Visit the PAISD intranet at: mybenefitshub.com/portarthurisd for a complete explanation of benefits.

Critical Illness Insurance

Coverage provided by Aetna

The Aetna Critical Illness plan pays benefits when you are diagnosed with a critical illness, including cancer and other conditions/illnesses. Rates are based on your current age but will increase as you move into a higher age-band. Eligible dependents' available benefits are based on 100% of your available benefits. Below are some of the available benefits. For more details, including exclusions and limitations that apply, review your benefit summary.

Employee, Spouse, Dependent Child(ren)	
Low Plan	$10,000
Medium Plan	$20,000
High Plan	$30,000

Get rewarded for taking better care of your health

Health screening benefit –The Aetna Critical Illness Plan pays a $50 annual benefit to each covered member who completes specific preventive health screening tests. See complete listing in your benefit summary.

Aetna Critical Illness Plan

	Low Plan $10,000	Medium Plan $20,000	High Plan $30,000	Benefit Paid
Heart Attack (Myocardial Infarction) or Stroke	$10,000	$20,000	$30,000	100% of face amount
Major Organ or End-Stage Renal Failure	$10,000	$20,000	$30,000	100% of face amount
Benign Brain Tumor	$10,000	$20,000	$30,000	100% of face amount
Third Degree Burns	$10,000	$20,000	$30,000	100% of face amount
Coma	$10,000	$20,000	$30,000	100% of face amount
Loss of Hearing/Sight/ Speech	$10,000	$20,000	$30,000	100% of face amount
Paralysis	$10,000	$20,000	$30,000	100% of face amount
Coronary Artery Condition Requiring Bypass Surgery	$2,500	$5,000	$7,500	25% of face amount
Alzheimer's Disease, Parkinson's Disease, Lupus	$2,500	$5,000	$7,500	25% of face amount
Muscular Dystrophy or Multiple Sclerosis (MS)	$2,500	$5,000	$7,500	25% of face amount
Subsequent* Critical Illness Diagnosis Benefit	$10,000	$20,000	$30,000	100% of face amount
Recurrence* Critical Illness Diagnosis Benefit	$10,000	$20,000	$30,000	100% of face amount

*All subsequent and recurrent critical illness and cancer diagnoses must occur after 180 treatment-free days in order for benefit to be paid.

Aetna Critical Illness Plan: Cancer Benefits

	Low Plan $10,000	Medium Plan $20,000	High Plan $30,000	Benefit Paid
Cancer (invasive)	$10,000	$20,000	$30,000	100% of face amount
Carcinoma in Situ (non-invasive)	$2,500	$5,000	$7,500	25% of face amount
Skin Cancer (paid once per lifetime)	$1,000	$1,000	$1,000	Lump sum paid once per lifetime
Recurrence Cancer* (invasive)	$10,000	$20,000	$30,000	100% of face amount
Recurrence Carcinoma in Situ Diagnosis**	$2,500	$5,000	$7,500	25% of face amount (100% of Carcinoma in Situ benefit)

* All recurrent critical illness and cancer diagnosis must occur after 180 treatment-free days in order for benefit to be paid.

** If an insured person is initially diagnosed with and received a benefit for carcinoma in situ (non-invasive) under this plan, and is then diagnosed with any kind of carcinoma in situ (non-invasive) again at least 180 days later, Aetna will pay the stated percentage of the carcinoma in situ (non-invasive) as shown on the Schedule of Benefits for the carcinoma in situ (non-invasive) diagnosed.

Aetna Critical Illness Plan Semi-Monthly Rates*

Attained Age	Low Plan – $10,000		Medium Plan – $20,000		High Plan – $30,000	
	Employee	Family	Employee	Family	Employee	Family
<20	$1.36	$3.02	$2.10	$4.75	$2.84	$6.48
20-24	$1.63	$3.61	$2.62	$5.85	$3.61	$8.10
25-29	$1.97	$4.41	$3.26	$7.38	$4.55	$10.36
30-34	$2.38	$5.24	$4.07	$9.05	$5.77	$12.85
35-39	$2.93	$6.54	$5.18	$11.65	$7.43	$16.75
40-44	$3.91	$8.87	$7.15	$16.30	$10.38	$23.73
45-49	$5.67	$12.70	$10.65	$23.96	$15.64	$35.23
50-54	$8.33	$19.05	$15.97	$36.66	$23.62	$54.27
55-59	$12.44	$28.11	$24.21	$54.79	$35.97	$81.47
60-64	$17.73	$39.81	$34.78	$78.18	$51.83	$116.56
65-69	$23.70	$54.41	$46.72	$107.39	$69.74	$160.37
70+	$31.19	$68.43	$62.60	$135.44	$93.57	$202.44

* Dependent children to age 26 are automatically included with the employee at no additional cost.

Hospital Indemnity Plan

Coverage provided by Aetna

The Aetna Hospital Indemnity Plan pays benefits related to an inpatient hospital stay. Below are some of the benefits available. Benefits are payable once per member during a plan year unless otherwise specified. For more details, including exclusions and limitations that apply, review your benefit summary.

Hospital Admission

Surgical Care

Hospital Confinement

Medical Diagnostic and Imaging

Hospital Intensive Care

Transportation and Lodging

Aetna Hospital Indemnity Plan	Low Plan	High Plan
Hospital admission*	$500	$1,000
Daily Hospital Stay – non-ICU / ICU**	$50 / $100	$100 / $200
Newborn routine care	$100	$100
Observation unit (Max. 1 day per plan year)	$100	$100
Daily Substance Abuse Stay**	$50	$100
Daily Mental Disorder Stay**	$50	$100
Daily Rehabilitation Unit Stay**	$25	$50

* Hospital admission benefit paid once per plan year on the first day of an inpatient hospital stay.

** All daily inpatient stay benefits begin on day two and count toward the combined 30-day plan year maximum.

Coverage	Low Plan	High Plan
Employee	$4.19	$8.16
Employee & Spouse	$8.44	$16.56
Employee & Child(ren)	$6.78	$13.17
Employee, Spouse & Child	$10.66	$20.80

We Make It Simple

If you're eligible to enroll and apply for coverage, your acceptance is guaranteed. We don't ask you any questions about your health. Cash benefits are paid directly to you and are not reduced by other insurance benefits you may have. And there's more:

- You get access to negotiated group rates.
- You'll enjoy the convenience of payroll deduction to pay premiums.
- If you leave your company, you can take your plan with you.

Filing a Claim Couldn't Be Easier

After you become a member, you can review our benefits and file claims on our portal at **myaetnasupplemental.com**. Or download the My Aetna Supplemental app to your smartphone or tablet, create an account and you can access your benefits and file claims right in the palm of your hand.

Group Accident Insurance Plan

Coverage provided by Unum – NEW CARRIER

Group Accident insurance is designed to help covered employees meet the out-of-pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. Indemnity lump sum benefits are paid directly to the employee based on the amount of coverage listed in the schedule of benefits. The accident base plan is guaranteed issue, so no health questions are required.

Coverage Highlights[1]	Benefit Amount
Hospital Admission	$1,000
ER Treatment or Doctor/ Urgent Care	$150/$75
Dislocations/Fractures	Up to $6,000/$7,500
Medical Imaging (MRI, MR, CT, CAT, EEG)	$200
Surgery	Up to $1,500
Ambulance (ground/air)	$400/$1,500
Physician Follow-up Visit	$75
Accidental Death/ Dismemberment	See Table in Brochure

Coverage	Semi-Monthly Cost
Employee	$8.89
Employee & Spouse	$14.65
Employee & Child(ren)	$16.04
Employee, Spouse & Child	$21.81

[1] Please see product brochure for full plan benefits and details.

Visit the PAISD intranet at: **mybenefitshub.com/ portarthurisd** for a complete explanation of benefits.

Legal Services and ID Shield

Coverage provided by Legal Shield

Legal Plan

A pre-paid legal plan membership gives you access to quality legal advice when you need it. (With Legal Shield, you know who to call when you have a legal need.)

You are empowered by knowing your legal rights. If you don't know your rights, you don't have any.

- Legal Consultation and Advice
- Court Representation
- Dedicated Law Firm
- Legal Document Preparation and Review
- Letters and Phone Calls Made on Your Behalf
- Speeding Ticket Assistance
- Will Preparation
- 24/7 Emergency Legal Access
- Mobile App

Identity Theft Protection Benefit

You also have the option to buy Identity Theft Protection. Identity Theft Shield will cover you, your spouse and your dependent children under age 18 by continuously monitoring your credit. If your identity is stolen, the experts will take the necessary steps to restore your good name and credit for you.

- Identity Consultation and Advice
- Dedicated Licensed Private Investigators
- Identity and Credit Monitoring
- Social Media Monitoring
- Child Monitoring (family plan only)
- Comprehensive IdentityRestoration
- Identity and Credit Threat Alerts
- 24/7 EmergencyAccess
- Mobile App

Coverage	Semi-Monthly Cost
Legal Plan Only	$7.00
Identity Theft Protection Only	$6.25
Both Legal and Identity Theft Protection	$12.30

Visit the PAISD intranet at: mybenefitshub.com/portarthurisd for a complete explanation of benefits.

Retirement Investment Programs

Coverage provided by TCG

You can start, stop, or change your contributions at any time. Each plan has an administrator who handles enrollment, changes and signature authorization. The law allows you to participate in one or both.

Port Arthur 457(b) Plan: Administered by TCG Services

- On-Line paperless enrollment and changes **www.tcgservices.com**
- Low cost, self-directed investment options range from no-risk to high-risk
- No 10% federal tax penalty for early withdrawal prior to age 59 ½
- Toll Free Help Line – Trained Retirement Specialist **1-800-943-9179**

Port Arthur ISD 403(b) 403(b)(7) Plan: Administered by TCG

- Due to a new Federal 403(b) law, all starts, stops and changes will be done on-line through TCG at **www.tcgservices.com**
- Federal Tax penalty of 10% for early withdrawal prior to age 59 ½
- Toll Free Help Line **1-800-943-9179**

Port Arthur ISD Retirement Plans Comparison Chart

	457 (b)	403 (b)
Third Party Administrator	Administered by TCG	Administered by TCG
Customer Service Number	1-800-943-9179	1-800-943-9179
Enrollment Process	Call TCG or visit them at **www.tcgservices.com**	Visit them online at: **www.tcgservices.com**
When Can I Enroll?	Start, stop, or change your contributions at any time	Start, stop, or change your contributions at any time
2019 Contribution Limit	$19,000	$19,000
2019 Age 50+ Catch-Up Limit	$6,000	$6,000
Contribution Pre-Taxed	YES	YES
Tax-Deferred Earnings	YES	YES
Hardship Withdrawals	YES	YES
10% IRS Penalty Fee For Early Fund Withdrawal	NO	YES
Types Of Investment Products	No load and load-waived mutual funds	Qualified investments approved by TRS including fixed annuity, variable annuity, and mutual fund
Fees	No administration fees - Only fund management fees	Due to the wide variety of 403 (b) products there are many variations of fees being charged

Important Contact Information

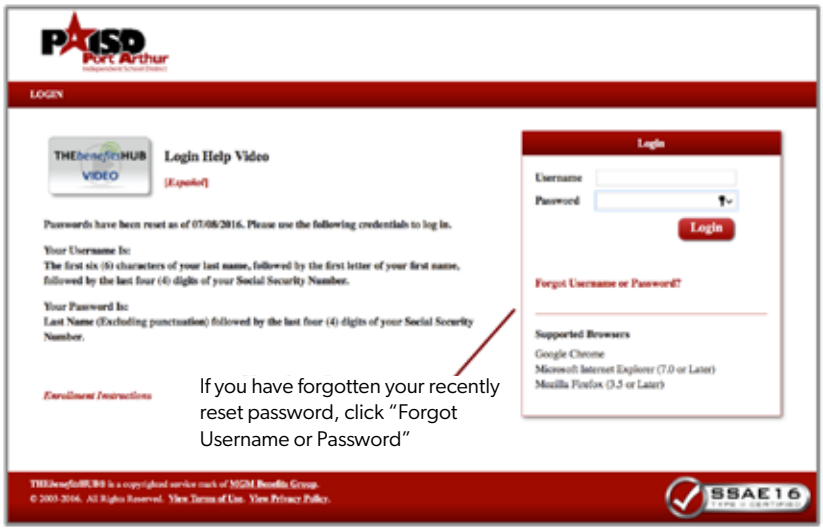
Benefit	Carrier	Telephone Number / Website
TRS ActiveCare Medical Plans	Aetna	1-800-222-9205 **www.trsactivecareaetna.com**
Prescription/Pharmacy Plan	Caremark	1-800-222-9205 **www.trsactivecareaetna.com**
Dental Plan DPPO (Policy # 913319)	Unum	1-888-400-9304 **www.unumdentalcare.com**
Vision Plan (Policy # 913319)	Unum	1-888-400-9304 **www.unumvisioncare.com**
Flexible Spending Account (FSA)	National Benefit Services	1-801-532-4000 or 1-800-247-0503
Basic Life, AD&D and Supplemental Insurance (Policy # 913316)	Unum	1-800-445-0402
Whole Life Insurance (Group #898106)	ManhattanLife	1-800-992-9642 Contact Highlander Financial
Disability Insurance (Policy # 913317)	Unum	1-800-858-6843/Fax 1-800-447-2498 **www.unum.com**
Employee Assistance Program (EAP)	Unum	1-800-854-1446 **www.unum.com/lifebalance**
Accident Insurance (Policy #R0535633)	Unum	1-800-635-5597 **www.unum.com**
Cancer Insurance (Policy #09536)	Allstate	1-800-348-4489
Hospital Indemnity Insurance (Group # 802585)	Aetna	1-800-607-3366 Visit **myaetnasupplemental.com** or download the My Aetna Supplemental mobile app
Critical Illness Insurance (Group # 802585)	Aetna	1-800-607-3366 Visit **myaetnasupplemental.com** or download the My Aetna Supplemental mobile app
Group Legal Services w/Legal Shield	Legal Shield	1-888-807-0407 **www.benefits.legalshield.com/paisd**
Port Arthur ISD 403(b) (7) Plans	TCG Administrators	1-800-943-9179 **www.tcgservices.com**
Port Arthur 457 Plan	TCG Administrators	1-800-943-9179 **www.tcgservices.com**
Port Arthur ISD Benefit Office		
Jackie Berry		409-989-6252 **jackie.berry@paisd.org**
Servicing Agent		
Voluntary Enrollment and Benefit Questions	Highlander Financial Services, LLC	1-800-992-9642

How To Enroll for Benefits

Step 1: Go to: **mybenefitshub.com/portarthurisd**.

Click on the "Login" Button

Step 2: Enter your user name and password, then click "login"



If you have forgotten your recently reset password, click "Forgot Username or Password"

Required Health Notices

Company Name (the "Company")

PORT ARTHUR ISD (PAISD)

Effective Date

January 1, 2020

Creditable Plan Name(s)

Aetna

Plan Administrator:

Port Arthur ISD
4801 9th Avenue
Port Arthur, Texas 77642

Telephone: 409-989-6100

HIPAA Privacy Official

Director of Human Resources
Telephone: 409-989-6100

HIPAA Special Enrollment Deadline

30 days

Members of Organized Health Care Arrangement

Aetna, ManhattanLife, National Benefit Services, Legal Shield, Unum, Allstate Benefits and Willis Towers Watson

Women's Health and Cancer Rights Notice

The Company is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Company's plan(s) provide medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description/Policy booklet or contact the Plan Administrator.

Newborn and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Notice of Privacy Policy and Procedures

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is provided to you on behalf of the Company about the Plan. It pertains only to health care coverage provided under the Plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected

Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources Department, or contact the Plan's HIPAA Privacy Official).

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations

- Treatment: Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
- Payment: Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- Health care operations: The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

Other Uses and Disclosures of Your PHI Not Requiring Authorization

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- To the Plan Sponsor: The Plan may disclose PHI to the employers (such as the Company) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.
- To the Plan's Service Providers: The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
- Required by law: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- For public health activities: The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- For health oversight activities: The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- Relating to descendants: The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

- For research purposes: In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- To avert threat to health or safety: In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- For specific government functions: The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

Uses and Disclosures Requiring Authorization

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to Have an Opportunity to Object

The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

To request restrictions on uses and disclosures: You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

- To choose how the Plan contacts you: You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- To request amendment of your PHI: If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed on the first page of these notices. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach. If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see first page). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

Organized Health Care Arrangement Designation

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment by the HIPAA Special Enrollment Deadline after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment by the HIPAA Special Enrollment Deadline, after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator. Note: Additional information may be required if the plan requires that persons declining coverage under the plan state, in writing, the reason(s) for declining coverage.

Important Notice from the Company About Your Prescription Drug Coverage and Medicare under the Creditable Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Company has determined that the prescription drug coverage offered by the Creditable Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15th through December 7th. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period, you go 63 continuous days or longer without "creditable" prescription drug coverage (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed at the beginning of the Required Notices section of this guide.

Coordinating Other Coverage with Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Company Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Company Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or Web address listed at the end of this notice.

If you do decide to join a Medicare drug plan and drop your prescription drug coverage with Aetna, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For more information about this notice or your current prescription drug coverage...

Contact the Plan Administrator for further information. Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Company changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

Notes

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While information in this Benefit Booklet is believed to be correct at the time of printing, this information is for education and reference purposes only. This material is in summary form. The provisions in each plan are governed by the Summary Plan Description, or the Certificate of Coverage, or the Group/ Individual contract of that plan.

PAISD