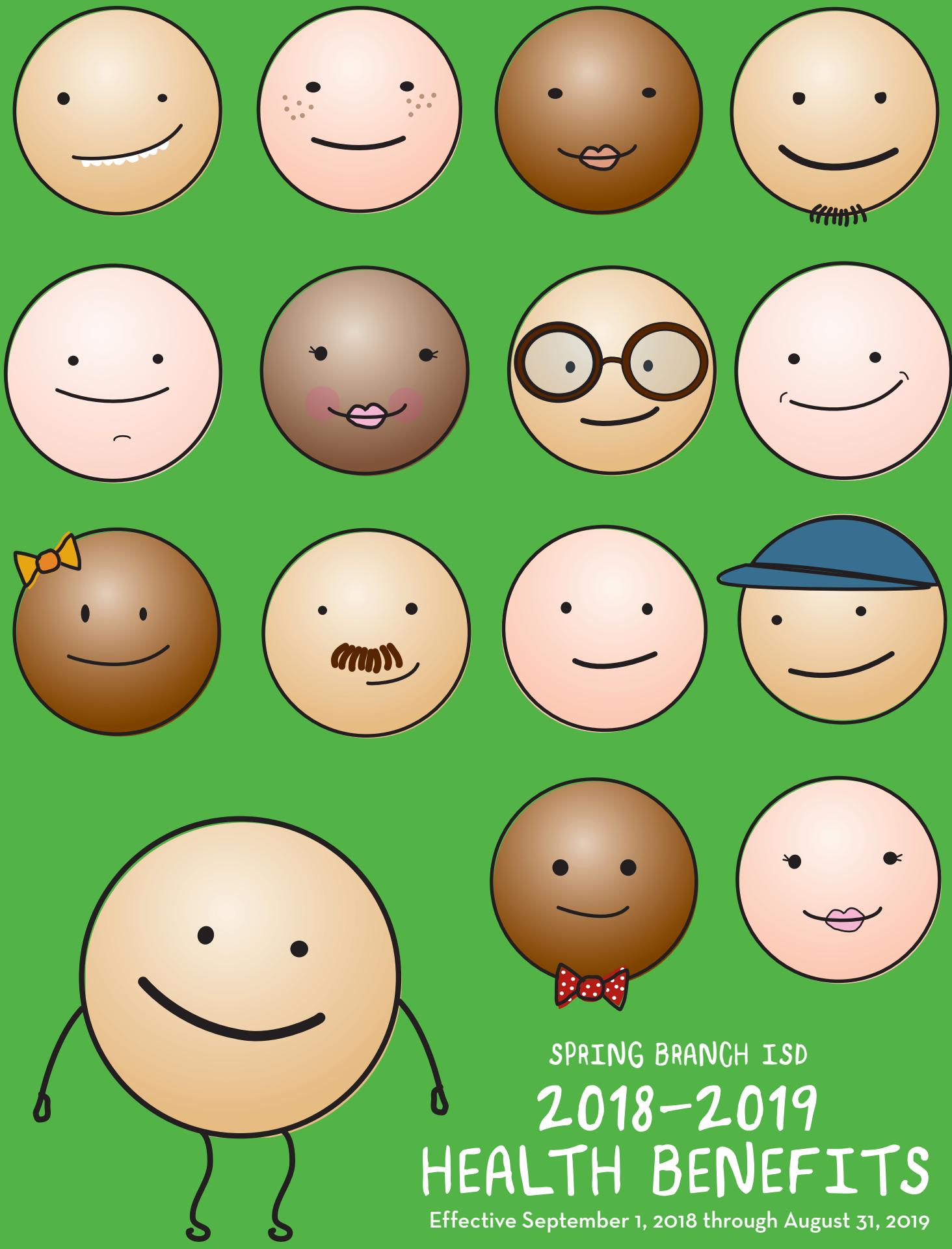


SPRING BRANCH ISD

2018–2019 HEALTH BENEFITS

Effective September 1, 2018 through August 31, 2019

CONTENTS:

Who to contact in the benefits department:

We are committed to providing you excellent customer service during open enrollment and year-round. If you have any questions about your benefits or need help enrolling, please feel free to contact the Benefits Department at one of the numbers below or email us at benefits@springbranchisd.com.

Employees A–G:

MICHELLE MARTINEZ, BENEFITS SUPERVISOR — **713-251-2239**
michelle.martinez@springbranchisd.com

Employees H–O:

MILI FARRIS, BENEFITS SPECIALIST — **713-251-2457**
mili@highlanderfinancial.com

Employees P–Z:

JULIA LAMPART, BENEFITS SPECIALIST — **713-251-2409**
julianita.lampart@springbranchisd.com

Benefits Manager

PATTY REYES, BENEFITS MANAGER — **713-251-2459**
patricia.reyes@springbranchisd.com

Watch for these helpful icons:

This icon alerts you to a practical tip or good idea and other sources of information about a particular topic.

This is a caution to slow down and review what has changed for 2018.

Turn the page for details.

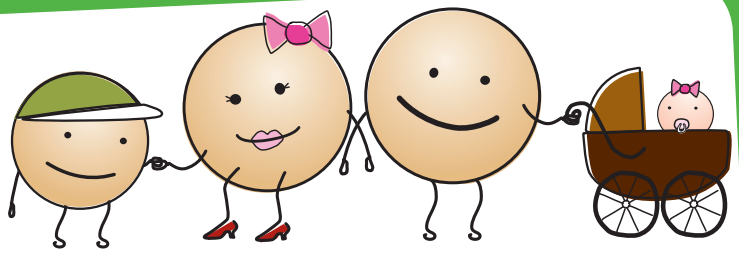
This benefits enrollment guide describes only the highlights of the Spring Branch ISD benefits program. For details and specific plan provisions, refer to the Spring Branch ISD Employee Benefits website. In the case of any discrepancy between this brochure and the plan documents, the plan documents will govern in all cases.

Spring Branch ISD feels it is very important to provide a competitive benefits package for its employees and intends to continue the benefits described in the enrollment guide. However, Spring Branch ISD reserves the right to amend, modify, or terminate any of the plans or benefits, in whole or in part, at any time and for any group of participants.

Participation in these plans does not create, imply or amend any contract of employment between you and Spring Branch ISD.

By participating in these benefit plans you authorize the necessary payroll deductions by Spring Branch ISD to cover the cost of your coverage. In the event that you do not receive a paycheck due to leave of absence or for any other reason, you are responsible for making payments for your benefit premiums. If payment is not made the outstanding premiums will be deducted from the first paycheck you receive upon your return to active duty. Continuing failure to make timely payments for benefit premiums owed may result in termination of benefits.

Who can enroll for benefits?



TRS-ActiveCare Health Plan (administered by Aetna)

To be eligible for TRS-ActiveCare, you must be either an active, contributing TRS member or employed 10 or more regularly scheduled hours each week. Please see the TRS-ActiveCare enrollment guide for details.

Employees who are contributing TRS members will receive the state and district contribution toward health insurance premiums.

Employees, substitutes and temporary workers who work at least 10 hours per week but are not paying members of TRS are eligible for TRS-ActiveCare, but are not eligible for the state and district contribution toward health insurance. These employees will pay the full monthly health premium. To find out the full monthly rate, see the TRS enrollment guide or contact the Benefits Department at 713-464-1511.

All other insurance products:

To be eligible for insurance products other than TRS-ActiveCare, you must be an active, contributing TRS member or a TRS retiree who works 50% or more of the time required of the standard workload for a full-time position.

When does my insurance become effective?

If you are employed with the District prior to the beginning of the plan year (September 1, 2018), your benefits will become effective **September 1, 2018.**

If you are hired after the beginning of the plan year, your benefits will become effective as follows:

TRS-ACTIVECARE HEALTH INSURANCE:
Your effective date of insurance is either your first day at work or the first of the month following your start date. If you elect for your insurance to become effective your first day of work, premium payment for the entire month is required.

ALL OTHER INSURANCE PRODUCTS:
Your effective date of coverage is the first of the month following your first day of work.

What if I want to change my benefits?

The elections you make during open enrollment will be effective for the full plan year (September 1, 2018 through August 31, 2019) unless you experience a change in status as defined by federal law. Once you experience a change in status, you have 31 days from the event date to change your benefit elections.

To find out if you qualify for a benefits status change: contact the Benefits Department at 713-464-1511.

What does my medical insurance cover?

2018/2019 TRS-ActiveCare Summary Plan Highlights

The chart below illustrates benefits when network providers are used. Non-network benefits are also available. See the TRS Enrollment Guide for more detail on your health benefits.

MEDICAL COVERAGE	ActiveCare 1-HD	ActiveCare Select or ActiveCare Select Whole Health (Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance)	ActiveCare 2 **NOTE:** If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan. However, as of Sept. 1, 2018, TRS-ActiveCare 2 is closed to new enrollees.
Deductible (per plan year)			
In-Network	$2,750 employee only / $5,500 family	$1,200 individual / $3,600 family	$1,000 individual / $3,000 family
Out-of-Network	$5,500 employee only / $11,000 family	Not applicable. This plan does not cover out-of-network services except for emergencies.	$2,000 individual / $6,000 family
Out-of-Pocket Maximum (per plan year; medical & prescription drug deductibles, coinsurance & copays count toward the out-of-pocket maximum)	The individual out-of-pocket maximum only includes covered expenses incurred by that individual.		
In-Network	$6,650 individual / $13,300 family	$7,350 individual / $14,700 family	$7,350 individual / $14,700 family
Out-of-Network	$13,300 individual / $26,600 family	Not applicable. This plan does not cover out-of-network services except for emergencies.	$14,700 individual / $29,400 family
Coinsurance			
In-Network Participant pays (after deductible)	20%	20%	20%
Out-of-Network Participant pays (after deductible)	40% of allowed amount	Not applicable. This plan does not cover out-of-network services except for emergencies.	40% of allowed amount
Office Visit Copay Participant pays	20% after deductible	$30 copay primary; $70 copay specialist	$30 copay primary; $70 copay specialist
Diagnostic Lab Participant pays	20% after deductible	20% after deductible	20% after deductible
Preventive Care See page 3 for examples	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% after deductible	$100 copay plus 20% after deductible	$100 copay plus 20% after deductible
Inpatient Hospital (preauthorization required) (facility charges) Participant pays	20% after deductible	$150 copay per day plus 20% after deductible ($750 maximum copay per admission)	$150 copay per day plus 20% after deductible ($750 maximum copay per admission; $2,250 maximum copay per plan year)
Freestanding Emergency Room	$500 copay per visit plus 20% after deductible	$500 copay per visit plus 20% after deductible	$500 copay per visit plus 20% after deductible
Emergency Room (true emergency use) Participant pays	20% after deductible	$250 copay plus 20% after deductible (copay waived if admitted)	$250 copay plus 20% after deductible (copay waived if admitted)
Outpatient Surgery Participant pays	20% after deductible	$150 copay per visit plus 20% after deductible	$150 copay per visit plus 20% after deductible
Bariatric Surgery Physician charges (only covered if performed at an IOQ facility) Participant pays	$5,000 copay (does apply to out-of-pocket maximum) plus 20% after deductible	Not covered	$5,000 copay (does not apply to out-of-pocket maximum) plus 20% after deductible
Annual Vision Examination (one per plan year; performed by an ophthalmologist or optometrist using calibrated instruments) Participant pays	20% after deductible	$70 copay specialist	$70 copay specialist
Annual Hearing Examination Participant pays	20% after deductible	$30 copay primary; $70 copay specialist	$30 copay primary; $70 copay specialist
PRESCRIPTION COVERAGE			
Drug Deductible (per person, per plan year)	Must meet plan-year deductible before plan pays.[2]	$0 generic; $200 brand	$0 generic; $200 brand
Short-Term Supply at a Retail Location (up to a 31-day supply)			
Tier 1 – Generic	20% coinsurance after deductible (except for certain generic preventive drugs that are covered at 100%.[2])	$20 for a 1- to 31-day supply	$20 for a 1- to 31-day supply
Tier 2 – Preferred Brand	20% coinsurance after deductible	$40 for a 1- to 31-day supply[3]	$40 for a 1- to 31-day supply[3]
Tier 3 – Non-Preferred Brand	50% coinsurance after deductible	50% coinsurance for a 1- to 31-day supply[3]	50% coinsurance (Min. $65[4]; Max. $130)[3]
Extended-Day Supply at Mail Order or Retail-Plus Pharmacy Location (60- to 90-day supply)[5]			
Tier 1 – Generic	20% coinsurance after deductible	$45 for a 60- to 90-day supply	$45 for a 60- to 90-day supply
Tier 2 – Preferred Brand	20% coinsurance after deductible	$105 for a 60- to 90-day supply[3]	$105 for a 60- to 90-day supply[3]
Tier 3 – Non-Preferred Brand	50% coinsurance after deductible	50% coinsurance for a 60- to 90-day supply[3]	50% coinsurance (Min. $180[4]; Max. $360)[3]
Specialty Medications (up to a 31-day supply)	20% coinsurance after deductible	20% coinsurance	20% coinsurance (Min. $200[4]; Max. $900)
Short-Term Supply of a Maintenance Medication at 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% coinsurance after deductible	$35 for a 1- to 31-day supply	$35 for a 1- to 31-day supply
Tier 2 – Preferred Brand	20% coinsurance after deductible	$60 for a 1- to 31-day supply[3]	$60 for a 1- to 31-day supply[3]
Tier 3 – Non-Preferred Brand	50% coinsurance after deductible	50% coinsurance for a 1- to 31-day supply[3]	50% coinsurance (Min. $90[4]; Max. $180)[3]

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.

A specialist is any physician other than family practitioner, internist, OB/GYN or pediatrician.

[1] 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 the 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 maybe considerable.

[2] 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. Find the list of drugs at info.caremark.com/trsactivecare.

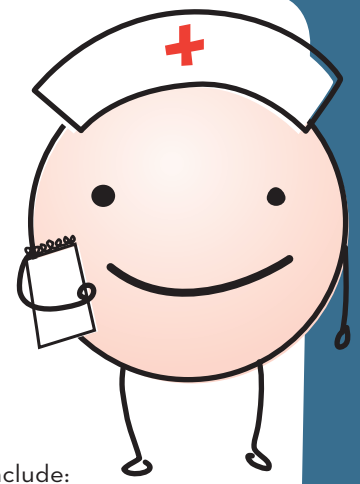
[3] If a participant obtains a brand-name drug when a generic equivalent is available, they are responsible for the generic copay plus the cost difference between the brand-name drug and the generic drug.

[4] If the cost of the drug is less than the minimum, you will pay the cost of the drug.

[5] Participants can fill 32-day to 90-day supply through mail order.

TRS-ActiveCare is administered by 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.

Before we get to the details, let's focus on the first decision you have to make: Do you need medical coverage?



Your first step in making this important decision should be to estimate what your medical expenses will be for the year, and what will influence those expenses. *Are you planning to add a child? Have you been putting off surgery or a procedure that you know you might face this year? Do you take good physical care of yourself?* The answers to these questions and more can have a big influence on your decision, and then there is always the unanswerable: *what is the probability of major illness or an accident in my family this year?*

After you've considered the questions and made your estimate, compare it with the employee medical contribution amounts below, taking into account deductibles, copays, and coinsurance on the previous page. That's how to make your decision.

The plan pays 100% for In-network Preventive Care Services. Some examples include:

- ROUTINE PHYSICALS – ANNUALLY AGE 12+
- MAMMOGRAMS – ONE EVERY YEAR AGE 35+
- SMOKING CESSATION COUNSELING – EIGHT VISITS PER 12 MONTHS
- WELL-CHILD CARE – UNLIMITED UP TO AGE 12
- COLONOSCOPY – ONE EVERY 10 YEARS AGE 50+
- HEALTHY DIET/OBESITY COUNSELING – UNLIMITED TO AGE 22; AGE 22+ – 26 VISITS PER 12 MONTHS
- WELL WOMAN EXAM AND PAP SMEAR – ANNUALLY AGE 18+
- PROSTATE CANCER SCREENING – ONE PER YEAR AGE 50+
- BREASTFEEDING SUPPORT – SIX 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 listing of preventive care services, please view the Benefits Booklet at trsactivecareaetna.com for the latest list of covered services,

Please note: The Affordable Care Act requires most U.S. citizens to have medical insurance as part of the "Individual Mandate" portion of the law or face penalties.

If you are declining TRS-ActiveCare coverage when you first become eligible, and later decide to enroll, you need to show proof of a change in status as defined by federal law which will allow for a mid-plan year change in coverage.

HOW MUCH IS IT?

PER PAYCHECK (24 Pay Periods)

TRS-ACTIVECARE 1-HD (HIGH DEDUCTIBLE)

Employee Only	$ 47.00
Employee + Spouse	$ 285.50
Employee + Child(ren)	$ 193.00
Employee + Family	$ 409.00
Employee + Family (both SBISD)	$ 319.50

TRS-ACTIVECARE 2

Employee Only	$ 209.00
Employee + Spouse	$ 663.50
Employee + Child(ren)	$ 434.50
Employee + Family	$ 861.50
Employee + Family (both SBISD)	$ 836.50

TRS-ACTIVECARE SELECT

Employee Only	$ 121.00
Employee + Spouse	$ 477.50
Employee + Child(ren)	$ 291.50
Employee + Family	$ 593.50
Employee + Family (both SBISD)	$ 518.50

Cigna Dental is our new dental provider!

Why buy dental?

- THE HEALTH OF OUR TEETH AND MOUTH ARE LINKED TO OVERALL HEALTH AND WELL-BEING.
- YOUR WELLNESS ROUTINE SHOULD INCLUDE REGULAR DENTAL CHECK-UPS WITH PROPER CARE.
- YOU CAN PREVENT UNNECESSARY DISEASE.

Spring Branch ISD offers 3 dental plan options for you to choose FrOM: DHMO, LOW PPO, and HIGH PPO.

What does a dental plan cover?

All three options cover four main types of dental expenses:

1. Preventive and diagnostic care
   routine exams and cleanings, fluoride treatments, sealants, x-rays
2. Basic treatment
   pulling teeth, fillings, root canal therapy and some oral surgeries
3. Major treatment
   dentures, bridges and crowns, and some oral surgeries
4. Orthodontic braces
   including installation, removal and follow-up care

- BOTH DPPO DENTAL PLANS HAVE A **PLAN YEAR DEDUCTIBLE**.

Any time a deductible is referred to as plan year, this indicates that the **deductible begins on September 1st and ends on August 31st.**

The plan year deductible tells you how much you will be responsible for paying toward your covered dental expenses before the insurance company begins paying their share.

How to find a participating provider:

For the most current information, please contact your selected provider or Cigna Dental Member Services at 800-244-6224, or visit mycigna.com for a list of dentists in the Cigna Dental network. Click the "Find a Dentist" tab on the web page. Select the dental plan network which applies to you and begin your search.

When you don't use the network:

DHMO Option – Dental services must be provided by your primary care dentist. In some cases, your dentist will refer you to a specialist. You will need to choose a dentist in the DHMO network.

DPPO Options – If you go to a provider who is not in the network, you may pay additional charges over and above your normal portion of the cost.

For more information, please refer to
https://www.springbranchisd.com/about/departments/talent-operations/benefits/dental

2018/2019 Dental Summary Plan Highlights

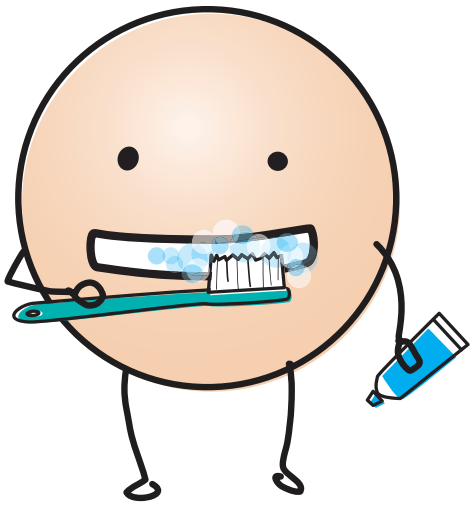
	DHMO OPTION **	LOW DPPO OPTION ***	HIGH DPPO OPTION ***
DEDUCTIBLE PER PLAN YEAR Amount you must pay	$0 Employee Only $0 Employee + Family	You pay $50 per individual You pay $150 per family	You pay $25 per individual You pay $75 per family
PREVENTIVE AND DIAGNOSTIC TREATMENT	Plan pays 100% after copay*	Plan pays 100%	Plan pays 80%
BASIC TREATMENT	Plan pays 100% after copay*	Plan pays 80% after deductible	Plan pays 80% after deductible
MAJOR TREATMENT	Plan pays 100% after copay*	Plan pays 50% after deductible	Plan pays 80% after deductible
ORTHODONTIC TREATMENT	Plan pays 100% after copay*	Plan pays 50%	Plan pays 50%
ANNUAL BENEFIT MAXIMUM PER COVERED PERSON PER PLAN YEAR	N/A	Plan pays up to $1,500	Plan pays up to $1,500
ORTHODONTIA LIFETIME MAXIMUM	N/A	Plan pays up to $750	Plan pays up to $750
OUT-OF-NETWORK BENEFIT	NO	YES	YES

* Please see the DHMO Dental Benefit Summary for covered services and copays.

** If you elect the DHMO, you must select a primary care dentist before you can use your dental benefits. You can select one by calling the Cigna Dental number at 800-244-6224 or visiting mycigna.com, then clicking "Find a Dentist".

If you do not choose a dentist when you enroll, Cigna Dental will automatically choose one for you. You can change your dentist at any time by contacting Cigna Dental at 800-244-6224.

*** If you are searching for a DPPO dentist, you will be prompted to choose a network. Choose Cigna Dental PPO network.



HOW MUCH IS IT?

PER PAYCHECK (24 Pay Periods)

DHMO OPTION

Employee Only	$6.22
Employee + Spouse	$11.00
Employee + Child(ren)	$11.92
Employee + Family	$17.62

LOW DPPO OPTION

Employee Only	$19.64
Employee + Spouse	$38.41
Employee + Child(ren)	$36.87
Employee + Family	$53.06

HIGH DPPO OPTION

Employee Only	$23.35
Employee + Spouse	$45.63
Employee + Child(ren)	$43.79
Employee + Family	$63.05

United HealthCare is our vision provider!

Might be time to visit the eye doctor

The eye is the second most complex organ after the brain. If that's not reason enough for you to get an eye exam you should also know that annual eye exams are key to healthy eyes and provide the following benefits:

- CORRECTING NEARSIGHTEDNESS, FARSIGHTEDNESS AND ASTIGMATISM WITH PRESCRIPTION LENSES AS NEEDED.
- CHECKING FOR THE PRESENCE OF EYE DISEASES AND CONDITIONS SUCH AS GLAUCOMA, MACULAR DEGENERATION, CATARACTS AND DIABETIC RETINOPATHY.
- MAKING SURE YOUR EYES ARE WORKING WELL TOGETHER, WHILE ALSO EVALUATING YOUR EYES AS PART OF YOUR OVERALL HEALTH.

SBISD has partnered with UnitedHealthcare Vision Plan (UHC) for our vision insurance. This benefit is designed to provide a basic level of coverage, subject to exclusions and limitations, for eye examinations, lenses, frames, or contacts.

Please note: individual insurance cards are not provided, and are not necessary for office visits. Services must be obtained from a participating provider in order to receive In-Network benefits.

Plan will cover an exam, frames and lenses or contact lenses (in lieu of glasses) once per plan year (9/1 to 8/31).

2018/2019 Vision Summary Plan Highlights

	IN-NETWORK	OUT-OF-NETWORK
EXAMINATION	$10 copay	Up to $40
LENSES*		
SINGLE VISION	$10 copay, then 100% covered	Up to $40
BIFOCAL	$10 copay, then 100% covered	Up to $60
TRIFOCAL	$10 copay, then 100% covered	Up to $80
LENTICULAR	$10 copay, then 100% covered	Up to $80
RETAIL FRAME ALLOWANCE	UP to $130 allowance	Up to $45
CONTACT LENSES**	SELECTION: copay, then 100% covered, + evaluation/fitting fees + 2 follow-up visits NON-SELECTION: copay, then $150 allowance	Up to $150 Elective Up to $210 Medically Necessary

* Standard scratch-resistant coating, polycarbonate lenses, and standard/premium anti-reflective coating are covered in full.

** The contact lens allowance is $150 for in-network and out-of-network, up to 6 boxes (if a network provider is used).

Sample Illustration of Savings

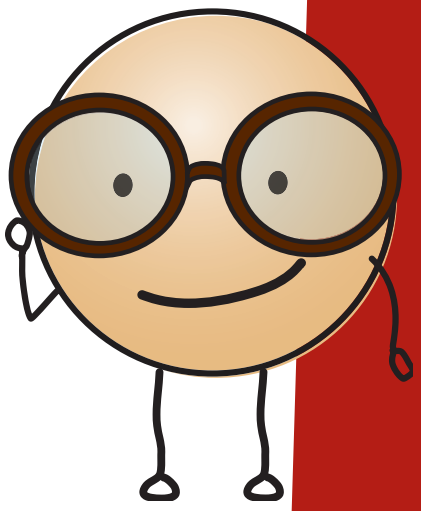
Exam and Materials Covered by UnitedHealthcare Vision Plan (Exam, Single Vision & Covered-in-Full Frames)	Estimated Cost Without a Vision Plan[1]	Less Employee Cost (Premium + in-network copays)	Total Savings with UnitedHealthcare Vision
Employee Only	$275.00	$112.88	$162.12
Employee + Spouse	$550.00	$238.24	$311.76
Employee + Child(ren)[2]	$825.00	$218.88	$606.12
Employee + Family[3]	$1,100.00	$383.89	$716.16

[1] Approximate retail value illustrated: Exam & Refraction ($65), Single Vision Lenses ($80), and Frames ($130). Average retail costs may vary by provider.
[2] For purposes of this calculation, Employee + Child(ren) is calculated with three (3) members.
[3] For purposes of this calculation, Employee + Family is calculated with four (4) members.

For more information, please refer to
https://www.springbranchisd.com/about/departments/talent-operations/benefits/vision

HOW MUCH IS IT?

	PER PAYCHECK (24 Pay Periods)
Employee Only	$3.87
Employee + Spouse	$8.26
Employee + Child(ren)	$6.62
Employee + Family	$12.66



FSA & HSA. They're not so scary ... really!

Discovery Benefits is our FSA & HSA provider!

If you're interested in reducing your income taxes, you should consider contributing to a Flexible Spending Account (FSA). FSAs offer a convenient way to reimburse yourself for certain healthcare and dependent care expenses with pre-tax dollars.

There are two types of FSAs:

1. **Healthcare FSA** used to reimburse out-of-pocket medical expenses incurred by you and your dependents. Use your healthcare FSA for:
   - MAJOR DENTAL WORK OR ORTHODONTIA
   - DEDUCTIBLES AND COPAYS FOR MEDICAL, RX, DENTAL AND VISION
   - QUALIFIED OUT-OF-POCKET HEALTHCARE EXPENSES NOT REIMBURSED BY A MEDICAL PLAN
2. **Dependent care FSA** used to reimburse expenses related to the care of your eligible dependents while you and your spouse work. Use your dependent care account for:
   - CARE OR SERVICES FOR CHILDREN UNDER 13 YEARS, INCLUDING BEFORE OR AFTER SCHOOL CARE
   - ELDER CARE

Eligible and Ineligible Expenses

The IRS determines what expenses are eligible and ineligible, and be aware they may from time to time change these lists. You can view eligible and ineligible expenses, for both healthcare and dependent care accounts on the SBISD benefits website. If you are unsure about whether an expense is eligible or not, contact Discovery Benefits at 866-451-3399 (FSA).

Knowing how much to set aside for your FSA is an important decision you have to make. You may want to consider:

- LAST YEAR'S MEDICAL AND/OR DEPENDENT CARE EXPENSES.
- ANY MEDICAL, DENTAL, OR VISION CARE COSTS YOU FORESEE THAT MIGHT NOT BE COVERED UNDER YOUR HEALTHCARE PLAN.
- ANY CHANGES IN YOUR FAMILY STATUS THAT MIGHT HAVE AN IMPACT ON YOUR MEDICAL, DENTAL/VISION OR DEPENDENT CARE EXPENSES. LIKE, HAVING A BABY.

Tax-Free Basis & Pre-Tax Dollars = Less taxes you have to pay

When you contribute to an FSA account ($2,650 maximum for healthcare/$5,000 maximum for dependent care), deductions are taken out of your paycheck prior to having any taxes withheld. This means that you don't pay federal income tax, TRS, and (in most cases) state and local income taxes on the portion of your paycheck you contribute to your FSA. Depending on your individual income and tax filing status, you could save as much as 20 to 50 percent on eligible healthcare services by utilizing an FSA.

(*EXAMPLE BASED ON EFFECTIVE FEDERAL INCOME RATE OF 15% AND MEDICARE OF 1.45%)

	WITHOUT FSA	WITH FSA
GROSS PAY	$25,000	$25,000
FSA HEALTHCARE CONTRIBUTIONS	$ 0	– $ 2,000
FSA DEP. CARE CONTRIBUTIONS	$ 0	– $ 5,000
SALARY YOU'RE TAXED ON	$25,000	$ 18,000
LESS FEDERAL INCOME TAXES	– $ 3,750	– $ 2,700
LESS MEDICARE	– $ 363	– $ 261
LESS AFTER-TAX HEALTHCARE EXPENSES	– $ 2,000	$ 0
LESS AFTER-TAX DEP. CARE EXPENSES	– $ 5,000	$ 0
YOUR TAKE-HOME PAY	$ 13,887	$ 15,039

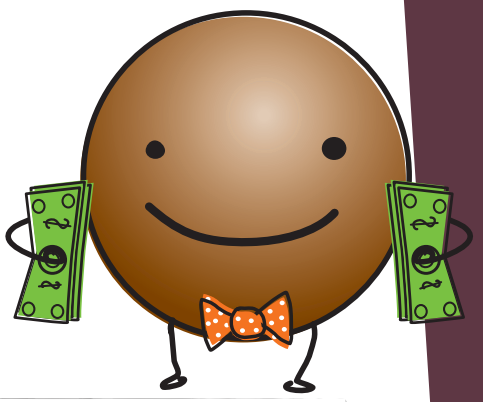
* Maximum amount increased by $50 in 2018.

Here's the important stuff:

You are able to carry forward $500 of unused FSA funds from the 2018/2019 plan year into the next plan year (2019/2020). For the expenses you incur September 1, 2018 through August 31, 2019, you must file your claims for reimbursement by September 30, 2019. Any unused balance of $500 or less will roll over to the next plan year, and any unused balance of over $500 will be forfeited.

	ANNUAL CONTRIBUTION LIMITS
HEALTHCARE FSA	$2,650
DEPENDENT CARE FSA	$5,000
HEALTH SAVINGS ACCOUNT	$3,450 single $6,900 family
FSA/HSA DEBIT CARDS	• No one-time printing fee • No monthly fee charged to your account

Contributions are now deducted over 24 pay periods, from September 1, 2018 through August 16, 2019.



For more information, please refer to
https://www.springbranchisd.com/about/departments/talent-operations/benefits/flexible-spending-health-savings

A Health savings account (HSA) acts similar to the FSAs except the money is yours to keep. There is no "use it or lose it" feature.

Ok great! But how does an HSA work?

- YOU MUST ENROLL IN TRS-ACTIVECARE 1-HD TO PARTICIPATE.
- YOU CANNOT CONTRIBUTE TO BOTH AN HSA AND AN FSA AT THE SAME TIME.
- UNUSED MONEY ROLLS OVER TO NEXT YEAR.
  There is no limit to how much money you can have in your HSA at any time.
- UNUSED MONEY STAYS IN YOUR ACCOUNT AND CONTINUES TO EARN INTEREST.
  You may also choose to invest the money for the long-term in a variety of mutual funds offered by the Plan Administrator.
- YOU CAN CONTINUE TO USE THE FUNDS IN YOUR HSA FOR QUALIFIED MEDICAL EXPENSES EVEN IF YOU ARE NO LONGER ENROLLED IN A QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (HDHP).
- IF YOU CONTINUE TO BE ENROLLED IN A QUALIFIED HDHP, YOU CAN CONTINUE TO CONTRIBUTE TO YOUR HSA. IF YOU ARE NO LONGER ENROLLED IN A QUALIFIED HDHP PLAN YOU MAY NOT CONTRIBUTE TO YOUR HSA.
- HSA FUNDS ARE AVAILABLE AS THEY ARE PAYROLL DEDUCTED
  (Unlike FSA funds, which are available when the plan year begins.)

If you are considering enrolling in the HSA contact Discovery Benefits at 866-451-3399 or customerservice@discoverybenefits.com.

Life Insurance and Accidental Death & Dismemberment (AD&D)

Here's a topic most people don't want to think about, but should.

If something were to happen to you, how financially secure would your loved ones be? Would your spouse be able to keep your home? Would your children be able to afford college? How would all the bills get paid?

To help alleviate some of the worry, the District, with The Hartford, offers Life Insurance and AD&D coverage.

Options for life insurance coverage are available for you, the employee, and your spouse and children.

All benefit eligible employees automatically receive $10,000 in Basic Term Life Insurance provided for you by the District.

Because accidents happen – always unexpectedly and often quickly – there is the employee AD&D Insurance included in your policy.

SUPPLEMENTAL LIFE INSURANCE:

In addition to the District provided life insurance, you are able to purchase additional life insurance for yourself. You are also able to purchase life insurance for your spouse, and/or your child(ren).

You can elect to buy additional life insurance for yourself in $20,000 increments up to a maximum of $500,000, not to exceed seven times your annual earnings.

You are able to buy life insurance coverage for your spouse in $20,000 increments up to $300,000, not to exceed 100% of your coverage amount, at the same rate as your life insurance. You are also able to buy $5,000 or $10,000 of coverage for your dependent child(ren). Life insurance rates are shown below.

EMPLOYEE GUARANTEED ISSUE AMOUNT WITHOUT A PHA: increments of $20,000 up to $300,000 or 7 times earnings
SPOUSE GUARANTEED ISSUE AMOUNT WITHOUT A PHA: increments of $20,000 up to $60,000

Employees and/or spouses who currently have life insurance or are coming onto the plan for the first time (late entrant) can increase their coverage 1-5 increments (employees) or 1-3 increments (spouses) up to the guaranteed issue (GI) amount during open enrollment without providing a Personal Health Application (PHA). Refer to the plan rider for more information.

PHA is required for New Hires if you have elected coverage greater than the Guarantee Issue amounts shown above. During Annual Open Enrollment, PHA is required if you are electing new coverage or increasing existing coverage in excess of $100,000 for employee life coverage or $60,000 for spouse life coverage. Any increase in coverage that exceeds the Guarantee Issue amount shown above would also require PHA.

PHA is required if you are electing life insurance for yourself and/or your spouse and you are not already covered or you are choosing to increase coverage. (Employees and spouses who are currently enrolled have the opportunity to increase coverage during open enrollment.) Benefits will not be in effect until your PHA is approved by The Hartford.

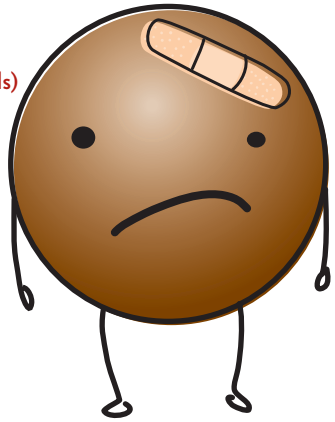
New Hires: If you apply for coverage within 31 days of your hire date, you're eligible for up to $300,000 in coverage on yourself, $60,000 on your spouse and $10,000 on all eligible dependents without providing a PHA.

HOW MUCH IS IT?

EMPLOYEE/SPOUSE LIFE INSURANCE:

FOR EXAMPLE:
IF YOU CHOOSE TO PURCHASE $20,000 OF ADDITIONAL LIFE INSURANCE AND YOU ARE 35 YEARS OLD, YOUR COST WILL BE $0.86 PER PAYCHECK FOR 24 PAY PERIODS.

AGE	PER PAYCHECK (24 Pay Periods) RATE/$20,000
<35	$0.45
35-39	$0.45
40-44	$0.84
45-49	$0.92
50-54	$1.28
55-59	$1.93
60-64	$3.47
65+*	$3.46**
70-74*	$4.46**
75-79*	$4.81**
80+*	$3.21**



*COVERAGE AMOUNTS FOR AGES 65 AND OVER REDUCE DUE TO AGE REDUCTION (SEE AGE REDUCTION TABLE ON THE SBISD BENEFITS WEBSITE).
**PREMIUM IS BASED ON AGE REDUCED POLICY AMOUNT.

DEPENDENT CHILD LIFE INSURANCE:

$0.12 FOR $5,000
$0.23 FOR $10,000

For more information, please refer to
https://www.springbranchisd.com/about/departments/talent-operations/benefits/life

Disability Insurance

Chances are, work plays an important role in your life. So what if a disabling injury or sickness kept you from the workplace? How long would your savings hold out? How would you maintain your independence? Certainly, there's a lot depending on your income. That's why SBISD has teamed up with Cigna to offer disability income protection insurance. Should a disability prevent you from working and earning a living, this insurance can help. It's valuable insurance designed to help protect against the big what ifs in life.

- IT CAN HELP REPLACE A PORTION OF YOUR INCOME WHEN YOU ARE DISABLED AS THE RESULT OF A COVERED SICKNESS OR INJURY.
- BENEFITS PAID YEAR-ROUND REGARDLESS OF WHETHER SCHOOL IS IN SESSION.
- MATERNITY IS COVERED THE SAME AS ILLNESS.
- IT IS AVAILABLE TO YOU AT AFFORDABLE GROUP RATES.
- PREMIUMS ARE CONVENIENTLY PAYROLL-DEDUCTED.

Cigna is our new disability insurance carrier!

A quick definition of the terms you will see in the below rate chart:

BENEFIT AMOUNT: You may select a monthly benefit amount in $100 increments. (Minimum benefit of $200, not to exceed 66 2/3% of your monthly earnings. Don't worry, Cigna will calculate the amount.)

BENEFIT WAITING PERIOD: The benefit waiting period is the period of time that you must be continuously disabled before benefits become payable. 14, 30, 90 and 180 day waiting periods are available.

FIRST DAY HOSPITAL BENEFIT: If you are inpatient hospital confined for at least 4 hours during the benefit waiting period and you have elected a benefit waiting period of 14 or 30 days, benefits will become payable on the first day of your hospital confinement.

PRE-EXISITNG CONDITION LIMITATION: Benefits are not payable on pre-exisiting conditions. A "pre-exisiting condition" means any injury or sickenss for which you received medical treatment, care, or services within 3 months before your effective date.

For more information, please refer to
https://www.springbranchisd.com/about/departments/talent-operations/benefits/disability

HOW MUCH IS IT?

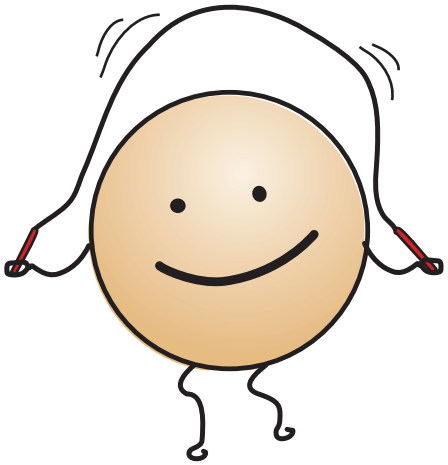
	OPTION A	OPTION B
MAXIMUM BENEFIT PERIOD For Accident and Sickness	Pays to age 65	Pays ONE year
BENEFIT AMOUNT	Monthly $100 increments	Monthly $100 increments
BENEFIT WAITING PERIODS		
14 Days	$3.14 per $100 up to 66 2/3% of your income	$1.38 per $100 up to 66 2/3% of your income
30 Days	$2.98 per $100 up to 66 2/3% of your income	$1.22 per $100 up to 66 2/3% of your income
90 Days	$2.44 per $100 up to 66 2/3% of your income	$0.92 per $100 up to 66 2/3% of your income
180 Days	$2.18 per $100 up to 66 2/3% of your income	$0.64 per $100 up to 66 2/3% of your income
FIRST DAY HOSPITAL BENEFIT		
14 Days	Paid first day of stay	Paid first day of stay
30 Days	Paid first day of stay	Paid first day of stay
90 Days	Not applicable	Not applicable
180 Days	Not applicable	Not applicable

Cigna is our new EAP provider!

Employee Assistance Program (EAP)... How does it work?

Everybody needs other kinds of help and support from time to time.

Spring Branch ISD has contracted with Cigna to provide a Employee Assistance Program (EAP) for you, your spouse and eligible dependents. Cigna's EAP provides free, confidential counseling by experienced licensed counselors. You can easily access a comprehensive network of providers with expertise in the following:



- MARRIAGE & FAMILY ISSUES
- STRESS MANAGEMENT
- DEPRESSION
- ADOLESCENT COUNSELING
- SUBSTANCE ABUSE
- ANXIETY
- LEGAL SERVICES

EAP is a great and confidential way for you to learn more about services available to you that you might not even be aware exist.

Employees and their immediate family members will have access to 3 free face-to-face counseling sessions per problem, per family, per plan year.

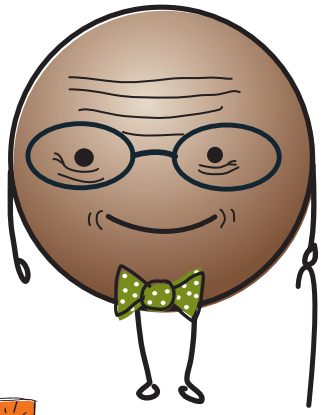
For more information call 800-538-3543 or visit cignabehavioral.com/cgi.

HOW MUCH IS IT? THIS BENEFIT IS PROVIDED TO YOU AT NO COST TO YOU AND YOUR FAMILY MEMBERS.

For more information, please refer to
https://www.springbranchisd.com/about/departments/talent-operations/benefits/employee-assistance-program

Long-Term Care

The last thing many of us want is to be a burden on our loved ones as we grow older.



The possibility of needing long-term care is something that we all must face as we enter our twilight years, and this type of care doesn't come cheap. The cost of living in an assisted care facility can range anywhere from $30,000 to $70,000 a year or more. For many people, Medicaid or Medicare will not pay the full amount.

A long-term care benefit provides the insured with the funds to pay for necessary long-term assisted care.

To learn more about long-term care insurance, we suggest you discuss options with a financial professional, and visit the Genworth website.

For more information, please refer to
https://www.springbranchisd.com/about/departments/talent-operations/benefits/long-term-care

PLEASE SEE FULL PLAN BROCHURE FOR COMPLETE COVERAGE DETAILS.

Hospital Indemnity Insurance

Allstate is our hospital indemnity insurance provider!

Can you cover all of your medical expenses?

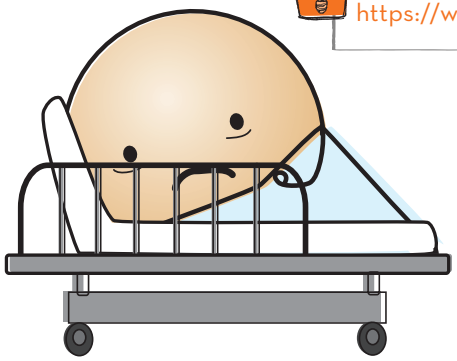
Hospital indemnity insurance can relieve some of the financial worry by helping to cover some of the out-of-pocket costs associated with a trip to the hospital resulting in in-patient hospital care.

Spring Branch ISD offers TWO different plan options. Both plan OPTIONS include the following:

- FIRST DAY HOSPITAL CONFINEMENT BENEFIT – NO ANNUAL LIMIT
- NO WAITING PERIOD – PAYS EVERY TIME YOU ARE ADMITTED AND CONFINED IN A HOSPITAL
- NO PRE-EXISTING CONDITIONS
- DAILY BENEFITS (180 DAY MAXIMUM)
- INTENSIVE CARE (ICU) BENEFITS (180 DAY MAXIMUM)
- MATERNITY HOSPITALIZATION IS INCLUDED IN COVERAGE AFTER POLICY IN EFFECT FOR 10 MONTHS
- EXCLUDES MENTAL HEALTH & SUBSTANCE ABUSE
- COVERAGE CAN BE PURCHASED FOR YOU AND YOUR ENTIRE FAMILY (COST IS NOT DETERMINED BY AGE)

Plan Options:	HIGH PLAN	LOW PLAN
First Day Hospital Confinement Benefit	$800 per day per person, no limit	$350 per day per person, no limit
Daily Hospital Confinement Benefit	$300 per day, up to 180 days ($54,000)	$100 per day,up to 180 days ($18,000)
Intensive Care Unit (ICU)	$300 per day, up to 180 days ($54,000)	$100 per day, up to 180 days ($18,000)

For more information, please refer to
https://www.springbranchisd.com/about/departments/talent-operations/benefits/hospital-indemnity



HOW MUCH IS IT? PER PAYCHECK (24 Pay Periods)

HIGH PLAN		LOW PLAN	
Employee Only	$8.91	Employee Only	$3.38
Employee + Spouse	$23.21	Employee + Spouse	$8.84
Employee + Child(ren)	$15.41	Employee + Child(ren)	$5.85
Employee + Family	$29.71	Employee + Family	$11.31

24-Hour Accident Insurance

Allstate is our 24-hour accident insurance provider!

Receive lump-sum benefits based on the injury you receive and the treatment you need.

24-Hour Accident Insurance pays a benefit for covered accidental injuries that you can use for whatever you see fit, such as out-of-pocket expenses not covered by your health insurance. The policy provides 24 hour coverage for you and your dependents.

Common covered benefits:

- **INJURIES:** fractures, dislocations, lacerations, eye injuries, torn knee cartilage, ruptured discs and burns
- **MEDICAL SERVICES & TREATMENTS:** ambulance, emergency care, therapy services, medical testing (including x-rays, MRIs, CT scans), medical appliances and certain types of surgeries
- **HOSPITALIZATION:** hospital confinement and urgent care
- **ADDITIONAL BENEFITS:** accidental death and dismemberment

Example:

JOE DISLOCATED HIS ANKLE AT THE GYM. HE GOES TO THE EMERGENCY ROOM AND GETS AN X-RAY. JOE RECEIVES A SPECIFIC BENEFIT AMOUNT FOR THE CARE HE RECEIVED:

	HIGH PLAN	LOW PLAN
X-RAY IN AN EMERGENCY ROOM	$ 200	$ 100
COMPLETE ANKLE DISLOCATION	$ 1,600	$ 800
3 PHYSICAL THERAPY VISITS	$ 180	$ 90
TOTAL BENEFIT PAID TO JOE	$ 1,980	$ 990

HOW MUCH IS IT? PER PAYCHECK (24 Pay Periods)

HIGH PLAN		LOW PLAN	
Employee Only	$6.76	Employee Only	$4.08
Employee + Spouse	$11.69	Employee + Spouse	$7.05
Employee + Child(ren)	$14.49	Employee + Child(ren)	$8.61
Employee + Family	$18.69	Employee + Family	$11.20

PLEASE SEE FULL PLAN BROCHURE FOR COMPLETE COVERAGE DETAILS.

For more information, please refer to
https://www.springbranchisd.com/about/departments/talent-operations/benefits/accident-insurance

What is a Legal Plan?

Legal plans are "preventive medicine" to help you avoid legal problems. Plus, you are covered if you or a family member face a situation requiring legal advice or services.

Headquartered in Houston, Texas, LegalEASE/Nationwide is our legal plan carrier!

Have you ever:

- Received a speeding ticket?
- Been audited?
- Had a dispute with a neighbor?
- Purchased a home?
- Signed a contract?
- Prepared a will?

When most people find themselves in these situations, the majority do not seek advice or help from a qualified lawyer. It may cost too much or they may not know where to begin to seek help. Add in the stress, and the entire process is intimidating! Spring Branch ISD has contracted with LegalEASE to help you. LegalEASE, a Houston based national employee benefits company that specializes in legal benefits, is a network of over 18,000 Network Attorneys and Law Firm Providers to help you obtain professional, experienced and quality care when you face a personal legal problem.

A Legal membership gives you access to a quality law firm 24/7, 365 days a year! Benefits include:

- ASSISTANCE AND REPRESENTATION FOR UNCONTESTED DIVORCE, SEPARATION, ADOPTION AND NAME CHANGE
- WILL PREPARATION
- CONTRACT AND DOCUMENT REVIEW
- TRIAL DEFENSE SERVICES
- BASIC IDENTITY THEFT SERVICES

Info Armor–Credit Monitoring & Identity Restoration

Identity theft is the fastest growing crime in America today. A professional thief can assume your identity in just a few hours. Would you know what to do if it happened to you or a family member? It can take countless hours and an average of $1,200 in the quest to clear your name.

When you enroll in the LegalEASE/Nationwide Plan you are also eligible to purchase Info Armor ID Theft/Credit monitoring! Benefits include:

- CONTINUOUS CREDIT MONITORING: SUSPICIOUS ACTIVITY WILL BE BROUGHT TO YOUR ATTENTION, PROVIDING YOU WITH EARLY DETECTION
- FULL ACCESS AND COVERAGE WITH IDENTITY THEFT ATTORNEYS
- PREVENTION CONSULTATIONS WITH IN-HOUSE ID THEFT COUNSELORS
- IDENTITY RESTORATION: A TRAINED EXPERT WILL TAKE THE STEPS TO HELP RESTORE YOUR NAME AND YOUR CREDIT

HOW MUCH IS IT?

	PER PAYCHECK (24 Pay Periods)
Family LegalEASE Plan	$7.98
Family LegalEASE Plan + Info Armor*	$11.40

* You must purchase the LegalEASE Plan to access Info Armor.

For more information, please refer to https://www.springbranchisd.com/about/departments/talent-operations/benefits/legal

Group Cancer & Specified Disease Insurance

MetLife is our Group Cancer & Specified Disease Insurance provider!

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] MetLife offers you and your family coverage in the event you are diagnosed with cancer or 32 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 air or ground ambulance can add up quickly and be very costly. MetLife cancer insurance 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 ASSIGNED.
- COVERAGE CAN BE PURCHASED FOR YOU AND YOUR ENTIRE FAMILY.
- INCLUDES COVERAGE FOR 32 OTHER SPECIFIED DISEASES INCLUDING: MUSCULAR DYSTROPHY, ALS, MULTIPLE SCLEROSIS, SICKLE CELL ANEMIA AND LYME DISEASE.

Benefits Include Two Plan Options:

	HIGH PLAN	LOW PLAN
Radiation/Chemotherapy	Up to $2,500 per month	Up to $500 per day
Blood, Plasma and Platelets	Up to $200 per day	Up to $200 per day
Initial Diagnosis Benefit	$5,000	$2,500
Hospital Confinement	$400 per day, up to 60 days $1,200 per day, begins on 61st day	$200 per day, up to 60 days $600 per day, begins on 61st day
Wellness Benefit	$100 per calendar year	$75 per calendar year

BOTH PLANS INCLUDE THE FOLLOWING:

- LODGING AND NON-LOCAL TRANSPORTATION BENEFIT FOR PATIENT AND FAMILY
- INTENSIVE CARE BENEFIT OF $325 FOR EACH DAY OF HOSPITAL ICU CONFINEMENT FOR ANY REASON
- SURGERY BENEFIT UP TO $3,000

HOW MUCH IS IT?

	PER PAYCHECK (24 Pay Periods)
HIGH PLAN	
Employee Only	$16.75
Employee + Spouse	$27.98
Employee + Child(ren)	$20.20
Employee + Family	$31.44
LOW PLAN	
Employee Only	$10.53
Employee + Spouse	$17.90
Employee + Child(ren)	$12.97
Employee + Family	$20.34

[1] Cancer Facts & Figures, American Cancer Society 2009.

Group Cancer and Specified Disease Insurance is underwritten by MetLife and administered by Bay Bridge Administrators.

For more information, please refer to
https://www.springbranchisd.com/about/departments/talent-operations/benefits/cancer-coverage

Critical Illness

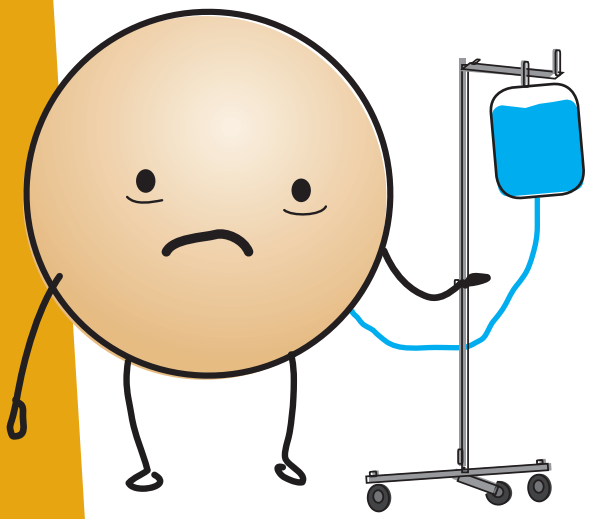
Critical Illness coverage is through AFLAC!

A critical illness can mean unforeseen expenses that may be difficult to pay, especially if you aren't working. Hospital stays, medical treatments and surgeries can add up and become costly. AFLAC critical illness coverage helps offset some of the expenses your health insurance may not cover.

- BENEFITS WILL BE PAID DIRECTLY TO YOU.
- COVERAGE CAN BE PURCHASED FOR YOU AND YOUR ENTIRE FAMILY.
- COVERAGE IS NOT INTENDED TO REPLACE YOUR HEALTH INSURANCE.
- INCLUDES COVERAGE FOR HEART ATTACKS, STROKES, RENAL FAILURE, AND A NUMBER OF OTHER ILLNESSES SPECIFICALLY IDENTIFIED IN THE POLICY.
  (Please see benefits website for full listing and additional information.)
- CANCER COVERAGE IS NOT INCLUDED IN THE POLICY.
- PLAN PAYS 100% OF COVERAGE AMOUNT ON COVERED CRITICAL ILLNESSES UNLESS OTHERWISE NOTED.
  (Please see benefits website for additional details.)
- ANNUAL WELLNESS BENEFIT IS INCLUDED.
- NO PRE-EXISTING CONDITION LIMITATIONS!
- THIS POLICY IS GUARANTEED ISSUE!

Benefits Include Two Plan Options:

	HIGH PLAN	LOW PLAN
Employee Coverage Amount	$20,000	$10,000
Spouse Coverage Amount	$10,000	$5,000
Child Coverage Amount	$10,000	$5,000



HOW MUCH IS IT?

PER PAYCHECK (24 Pay Periods)

HIGH PLAN:	AGE	Employee Only or Employee + Child	Employee + Spouse or Family
	<30	$4.51	$7.62
	30-39	$6.01	$9.87
	40-49	$8.67	$13.85
	50-59	$12.95	$20.27
	60+	$20.01	$30.86

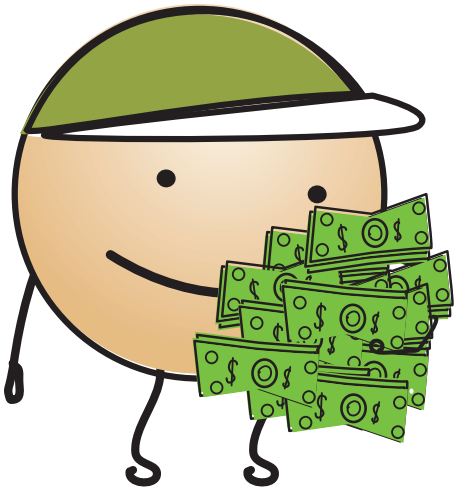
LOW PLAN:	AGE	Employee Only or Employee + Child	Employee + Spouse or Family
	<30	$3.40	$6.51
	30-39	$4.15	$7.26
	40-49	$5.48	$8.59
	50-59	$7.62	$10.73
	60+	$11.15	$14.26

For more information, please refer to
https://www.springbranchisd.com/about/departments/talent-operations/benefits/critical-illness

Retirement Planning with 403(b) & 457(b)

A secure, comfortable retirement is every worker's dream.

Because we're living longer, healthier lives, we can expect to spend more time in retirement than our parents and grandparents did. To help reach your retirement goals, Spring Branch ISD offers you the following retirement plans.



403(b) Plan Highlights

- PRE-TAX CONTRIBUTIONS MADE BY EMPLOYEES
- CONTRIBUTION LIMIT OF $18,500 FOR 2018
- ROTH 403(b) AVAILABLE
- CATCH-UP CONTRIBUTION OF $6,000 AVAILABLE FOR AGE 50+
- SEE LIST OF APPROVED COMPANIES
- TRANSFERS AVAILABLE FROM ANOTHER EMPLOYER'S 403(b) PLAN
- LOANS ARE AVAILABLE, SUBJECT TO AVAILABILITY AND CERTAIN CONDITIONS

457(b) Plan Highlights

- PRE-TAX CONTRIBUTIONS MADE BY EMPLOYEES
- CONTRIBUTION LIMIT OF $18,500 FOR 2018
- CATCH-UP CONTRIBUTION OF $6,000 AVAILABLE FOR AGE 50+
- ROLLOVERS FROM ANOTHER QUALIFIED PLAN ARE AVAILABLE
- LOANS ARE AVAILABLE. SEE LOAN AGREEMENT AND APPLICATION FORM

How do I enroll?

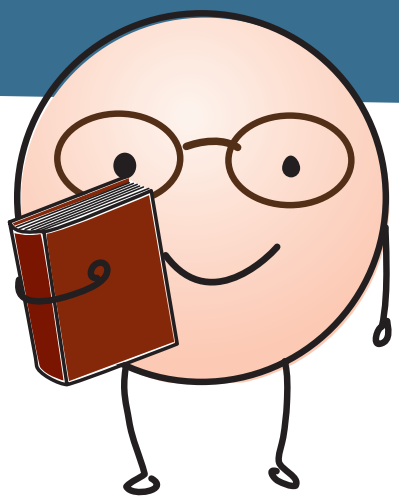
All of our retirement plans are administered by TCG Administrators. You may enroll at any time using one of the options below:

- Call TCG Administrators at 800-943-9179
- Go to http://tcgservices.com/documents/#/137/403b or http://tcgservices.com/documents/#/137/457b
  - Click on "Register"
  - Enter your Social Security Number and the plan password for enrolling:

    403(b) password for enrolling: **SBISD403**

    457(b) password for enrolling: **SBISD457**

For more information, please refer to TCG Administrators at tcgservices.com or call 800-943-9179.
Additional information can be found on the SBISD website.
403(b) Certified Companies: http://www.trs.state.tx.us/403b/documents/certified_companies_list.pdf



Enrolling in Benefits...

Making your decisions, adding it all up, and moving forward.

WHEW. That's a lot of information for you to absorb. Congratulations!

The next step is to decide what plans you are enrolling in and who you would like to enroll. The following page has easy instructions on how to enroll online using THE*benefits*HUB.

Before you log on, please be sure to have the following information available:

1. YOU AND YOUR DEPENDENTS SOCIAL SECURITY NUMBERS
2. DATES OF BIRTH FOR ALL YOUR DEPENDENTS
3. BENEFICIARIES' ADDRESSES AND SOCIAL SECURITY NUMBERS

NEW HIRES:

- **If you are a new hire in August**, you will make your benefit elections online via THE*benefits*HUB. See instructions on the following pages. *Please note if you want your medical insurance to be effective on your date of hire you must submit a TRS Enrollment Application and Change Form to the benefits department.*

- **If you are a mid-year new hire**, you will make your benefit elections online via THE*benefits*HUB. See instructions on the following pages. *Please note that if you want your medical insurance to be effective on your date of hire you must submit a TRS Enrollment Application and Change Form to the benefits department.* **All elections must be made within 31 days of your start date.**

NEED HELP?

- CONTACT EMPLOYEE BENEFITS AT 713-464-1511 OR EMAIL BENEFITS@SPRINGBRANCHISD.COM.

Here's how to enroll online using THEbenefitsHUB:

How do I enroll? With THEbenefitsHUB, you have access to benefits 24 hours a day, 7 days a week, from anywhere that you have Internet access.

1. **Go to** www.mybenefitshub.com/springbranchisd and click the EMPLOYEE LOGIN link. This will take you to the login screen.

   USERNAME: Your **username** is the same username you use to log in to the Spring Branch ISD network. It is the same as your Windows and Outlook username.

   PASSWORD: Your **password** is your full last name (excluding punctuation), followed by the last four (4) digits of your Social Security Number.
   Example: John Doe 987-65-4321 Password: doe4321

   USER NAME: _____ PASSWORD: _____

THEbenefitsHUB will guide you through the simple enrollment process page by page.

2. **Employee Usage Agreement:** This agreement is displayed when you login to the system as an employee. Please read this section to ensure that you understand the terms of your "electronic signature" within THE*benefits*HUB. When you agree with this information, click the CONTINUE BUTTON.

   Change Password: Update your password following your organization's password policy. Once your new password has been set, click the SIGN & CONTINUE button.

3. **Enter all required personal and dependent information in the Employee Data Entry Sections:** Please review current information for accuracy. Enter in any new or missing information and click on the SAVE & CONTINUE button when you are ready to proceed to the next step. Please Note: All fields in **BOLD** are required.

   Personal Information: Please enter an email address if you have one. If you need to use the Forgot Password link on the Login page, the system will deliver your new login credentials to this email address.

   Emergency Information: Enter an emergency contact and the contact method.

   Dependent Information: To add a dependent, click on the ADD ICON. To edit an existing dependent, click on the PAPER ICON or the name of the dependent. Click on the SAVE button after successfully adding information for each dependent. ***Please make sure to indicate if your child is a full-time student and/or claimed on your tax return as this could affect eligibility on some benefit plans.***

   To revisit any of the sections mentioned click the BACK button to return to the previous section.

4. **Affordable Care Act Reporting Forms:** This section allows you to confirm that you are willing to receive your Form 1095-C electronically via district email. (This is the same format in which you already receive your Form W-2.)

5. **Now you can select the benefits information:** Once all personal and dependent data has been entered, you will have access to enroll online in the benefits for which you are eligible. Each **benefit plan type** will appear individually for you to review. Click the SIGN & CONTINUE button to proceed to the next benefit plan type.

   - **View Benefit Descriptions:** To view, click on the VIEW PLAN OUTLINE OF BENEFITS link or the information icon next to the plan you would like to review. This shows a plan summary and any available links or additional documentation related to this plan.
   - **View Plan Cost:** Click on the CHECKBOX next to each eligible family member or choose the coverage level you would like. The cost will automatically appear in the box to the right of the members' names. The "Election Summary" box will be updated as coverage is adjusted.
   - **View Total Plan Cost:** As you select plans, the cost will be adjusted in the "Election Summary" box under the plans.
   - **Forms: One or more of your Benefit Plans may require a paper form to be submitted with the Insurance Carrier.** If this is the case, THE*benefits*HUB will prompt you to print the necessary forms during your online enrollment session.
   - **View Important Plan Information:** You may expand/collapse specific features or disclaimers of the Plan by clicking on the "Plan Information" section.
   - **Product Summary Video**: Videos are placed throughout the benefit election process. You can access product videos that explain the purpose, function and importance of the benefit package by clicking on the VIDEO icon.

6. **Choose your beneficiaries:** Beneficiaries are required; please choose your beneficiary for each applicable plan.

7. **Review the Consolidated Enrollment Form:** This form will display all data from each of the sections listed above, including personal and enrollment information. You may make changes to anything that is incorrect by clicking on the BENEFIT PLAN name. Once you are finished with the enrollment process, you will be sent to the "Employee Menu" where you may make changes (see Employee Menu Section on the following page...).

8. **FINISHED:** When you have completed your benefit selections, click the MAIN MENU button and you will be redirected to the Employee Menu Screen (see Employee Menu Section on the following page...).

EMPLOYEE MENU:
Once the enrollment is completed in the system, you will see the following Employee Menu icons:

Personal Information:

ACCESS AND EDIT INFORMATION BY SELECTING THE MENU ITEMS UNDER **PERSONAL INFORMATION.** YOU CAN ALSO CHANGE YOUR **PASSWORD** IN THIS SECTION.

Dependent Information:

ACCESS AND EDIT INFORMATION FOR **DEPENDENTS** IN THIS SECTION. MAKE SURE THE HR DEPARTMENT KNOWS OF ANY CHANGES MADE AS THIS MAY CHANGE ELIGIBILITY STATUS OR GIVE AN OPPORTUNITY TO CHANGE ENROLLMENT IN CERTAIN BENEFITS!

Benefits Plan Information

ACCESS AND VIEW BENEFITS IN THIS SECTION. YOU WILL NOT BE ABLE TO CHANGE BENEFIT ELECTIONS UNLESS IT IS AN OPEN ENROLLMENT PERIOD. SEE A QUICK REVIEW OF ALL INFORMATION ON THE CONSOLIDATED ENROLLMENT FORM.

Navigation and Data Entry Tips:

- HELP! If you need assistance while working in THE*benefits*HUB, click **HELP** located at the upper right corner of the screen.
- BACK AND FORTH: Please do not use the web browser's "back" and "forward" arrows while in the system. Use the **BACK** and **SIGN & CONTINUE** navigation buttons instead.
- REQUIRED DATA: As noted on each screen, the **Bold** items are required to allow continuation to the next page. The more information entered, the better the system will work for you; but you may skip non-bolded items if they don't apply.
- MOVING ON: When each page is complete, go to the bottom of the page and click the **SIGN AND CONTINUE** button.
- UNABLE TO FINISH? If for any reason you are unable to complete the enrollment process you may **LOGOUT** and login at a later time. When you login again, you will walk through the same process. The data you previously entered will still remain.

Post-Enrollment Tips:

- WHAT ARE THOSE SYMBOLS? If you "toggle" the cursor/arrow on the icons, the definition of the icons will be revealed.

  = Edit = View
- LINKS... words, names or phrases that become underlined when you put the cursor/arrow on them, these are links that will take you to a certain section.
- SCREEN NAVIGATOR... This line is at the top of your screen. You may click on the links to quickly jump back to those previous screens.

We are required to provide to you the following info:

COBRA

CONTINUATION COVERAGE RIGHTS UNDER COBRA You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE? COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

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

WHEN IS COBRA COVERAGE AVAILABLE? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

HOW IS COBRA COVERAGE PROVIDED? Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order for your extension of benefits to be processed you must notify the plan administrator of the determination within 60 days of the determination and before the end of the original 18-month COBRA coverage period. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the plan administrator of the fact within 30 days after the SSA's determination.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to Aetna, or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

PLAN ADMINISTRATOR: Spring Branch ISD Benefits Office, 955 Campbell Rd., Houston, TX 77024, phone: 713-464-1511

COBRA ADMINISTRATOR (MEDICAL): TRS-ActiveCare. Aetna, phone: 833-682-8972

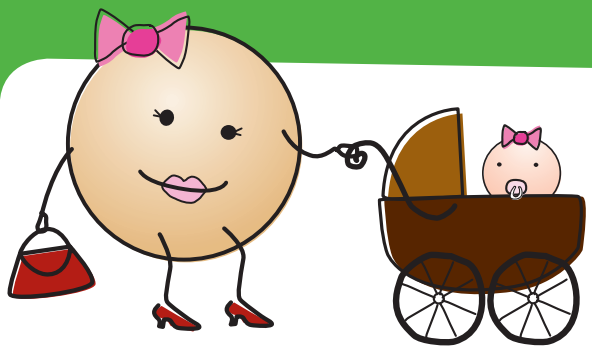
COBRA ADMINISTRATOR (SUPPLEMENTAL BENEFITS): Discovery Benefits, phone: 866-451-3399. Email: cobraadmin@discoverybenefits.com. Go to https://cobra.discoverybenefits.com/ to enroll online and manage your account.

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

BASIC LEAVE ENTITLEMENT FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

MILITARY FAMILY LEAVE ENTITLEMENTS Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.



FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

BENEFITS AND PROTECTIONS During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

ELIGIBILITY REQUIREMENTS Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

DEFINITION OF SERIOUS HEALTH CONDITION A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

USE OF LEAVE An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

SUBSTITUTION OF PAID LEAVE FOR UNPAID LEAVE Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

EMPLOYEE RESPONSIBILITIES Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

EMPLOYER RESPONSIBILITIES Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

UNLAWFUL ACTS BY EMPLOYERS FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

ENFORCEMENT An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

CONTACT INFORMATION:

FOR GENERAL QUESTIONS / TO FIND A MEDICAL DOCTOR		
TRS-ActiveCare Aetna	800-222-9205	https://www.trsactivecareaetna.com
Nurseline	800-556-1555	
Caremark Prescription Benefits	800-222-9205	customerservice@caremark.com (email) https://www2.caremark.com/trsactivecare/
TO INQUIRE ABOUT DENTAL / TO FIND A DENTIST Cigna Dental	800-244-6224	mycigna.com
TO INQUIRE ABOUT VISION **TO FIND A VISION PROVIDER** United Healthcare	800-638-3120 800-839-3242	myuhcvision.com
TO INQUIRE ABOUT FLEXIBLE SPENDING ACCOUNT (FSA) & HEALTH SAVINGS ACCOUNT (HSA) Discovery Benefits	866-451-3399 866-451-3245 fax	discoverybenefits.com customerservice@discoverybenefits.com (email)
Claim submission and receipt upload		discoverybenefits.com or the Discovery Benefits mobile app
TO INQUIRE ABOUT LIFE AND AD&D The Hartford Insurance Company	800-523-2233	thehartfordnetwork.com
TO INQUIRE ABOUT DISABILITY INSURANCE Cigna	800-362-4462	cigna.com/customer-forms (claim forms)
TO INQUIRE ABOUT EMPLOYEE ASSISTANCE PROGRAM Cigna	800-538-3543	cignabehavioral.com/cgi
TO INQUIRE ABOUT HOSPITAL INDEMNITY Allstate	800-937-7039 claims 800-521-3535 customer care	allstatebenefits.com/mybenefits
TO INQUIRE ABOUT ACCIDENT INSURNACE Allstate	800-937-7039 claims 800-521-3535 customer care	allstatebenefits.com/mybenefits
TO INQUIRE ABOUT LONG-TERM CARE Genworth Financial	866-659-1970	genworth.com/trsactivemember
TO INQUIRE ABOUT LEGALEASE SERVICES AND IDENTITY THEFT	888-416-4313	http://legaleaseplan.com/content/springbranchisd
TO INQUIRE ABOUT CRITICAL ILLNESS AFLAC	800-433-3036	aflacgroupinsurance.com
TO INQUIRE ABOUT CANCER AND SPECIFIED DISEASE INSURANCE MetLife / Bay Bridge Administrators	800-845-7519	claims@bbadmin.com
TO SET UP 403(b) AND 457 ACCOUNT INQUIRIES TCG Administrators	800-943-9179	tcgservices.com 403b@tcgservices.com or 457@tcgservices.com (email)
TO INQUIRE ABOUT OTHER RETIREMENT PLANS	800-943-9179	www.trs.state.tx.us, click on "General Information", click on "403(b) Certification and Product Registration"
FOR COBRA SERVICES (Medical) TRS-ActiveCare	833-682-8972	
FOR COBRA SERVICES (Supplemental Insurance) Discovery Benefits To enroll and manage your account	866-451-3399 888-408-7224 fax	discoverybenefits.com cobraadmin@discoverybenefits.com (email) https://cobra.discoverybenefits.com/

Spring Branch Independent School District
Inspiring minds. Shaping lives.