PSJA COLLEGE 3
READY.CONNECTED.COMPLETE™

2024 - 2025

BENEFITS
ENROLLMENT GUIDE

Contact Information

BENEFITS STAFF

EMPLOYEE BENEFITS SUPERVISOR
Maricruz Gonzalez
(956)354-2000 ext: 1151
maricruz.gonzalez@psjaisd.us

INSURANCE SPECIALIST
Alma Mata
(956)354-2029 ext: 1142
alma.mata@psjaisd.us

INSURANCE CLERK
Michelle Murillo
(956)354-2029 ext: 1141
michelle.murillo@psjaisd.us

INSURANCE AGENTS

MEDICAL & DISABILITY INSURANCE
PURO ASEGURO INC
Melba Figueroa
(956)783-1137 Office
(956)328-9075 Mobile
melba@puroaseguro.com

DENTAL, VISION, TERM LIFE, WHOLE LIFE, ACCIDENT, CANCER & CRITICAL ILLNESS
TAMEZ FINANCIAL GROUP
Carlos Tamez
(956)973-1904 Office
Tamezfinancialgr@rgv.rr.com

PROVIDER CONTACTS

HEALTH
Blue Cross Blue Shield
(800) 521-2227
www.bcbstx.com
Group # 297209

PHARMACY- MAIL ORDER
Express Scripts Pharmacy
(833)715-0942
Register: express-scripts.com/rx

PHARMACY- SPECIALTY MEDS
Accredo
(833)721-1619

FLEXIBLE SPENDING ACCOUNT
David K. Young Consulting
(210)558-0999
www.dkyoung.com

DENTAL
Blue Cross Blue Shield of Texas
(800)521-2227
Group ID: 349705

VISION
Avesis
(800)828-9341
www.avesis.com
Group No: 30916-1014

BASIC LIFE & OPTIONAL TERM LIFE
Dearborn National
Customer Service: 877-442-4207
Group No. VF028311

WHOLE LIFE
VOYA
Customer Service: (800)527-5024
Claims Center: (888)238-4840
Claims Center | Voya Financial

PROVIDER CONTACTS

DISABILITY
Hartford
(866)547-9124 (English & Spanish)
7:00 AM -7:00 PM CST
Policy No: 715177

LEGAL PLAN
Legal Shield
(281)750-5317
https://deannelyes.wearelegalshield.com

CANCER
Allstate Benefits
(800)521-3535
https://www.allstateatwork.com/mybenefits/user/login
**Cancer Screening Benefit included*

ACCIDENT / CRITICAL ILLNESS
Hartford
ClaimFiling Assistance: (866)547-4205
Claims Online: Visit Supplemental Insurance Claims Portal
https://www.TheHartford.com/benefits/myclaim
Claims by Phone: (Only for Health Screening/Acc Protection Benefit)
Phone: (866)-547-4205
Claims Mail or Fax: Download claim form online at
https://www.TheHartford.com/benefits/myclaim
Fax: (469) 417-1952
Fax/Mail To: The Hartford Supplemental Insurance Benefit Dept.
P.O. Box 99906, Grapevine, TX 76099
** Accident Insurance: Health Screening Test or Accident Prevention benefit included*
**Critical Illness: Health Screening Test benefit included*

MEDICAL INSURANCE

BLUE CROSS BLUE SHIELD

Pharr-San Juan- Alamo ISD

Blue Cross Blue Shield of Texas

Health Benefits Highlight Sheet

Effective 09/01/2024

Type of Services	PLAN A State Plan		PLAN B High Plan		PLAN C Base Plan	
Medical Services	In-Network (Your Cost)	Out-of-Network (Your Cost)	In-Network (Your Cost)	Out-of-Network (Your Cost)	In-Network (Your Cost)	Out-of-Network (Your Cost)
Deductible Individual / Family	$0 / $0	$500 / $1,000	$500 / $1,000	$1,000 / $2,000	$750 / $1,500	$1,500 / $3,000
Out-of-Pocket Limit Individual / Family	$1,000 / $3,000	$2,000 / $6,000	$1,200 / $3,600	$2,500 / $7,500	$1,700 / $5,100	$3,000 / $9,000
Office Visit Co-Pay	$15	30% coinsurance	$15	30% coinsurance	$15	30% coinsurance
Preventive Care	No Charge	30% coinsurance	No Charge	30% coinsurance	No Charge	30% coinsurance
Diagnostic Test X-ray, blood work. Copay may apply	No Charge	30% coinsurance	No Charge	30% coinsurance	No Charge	30% coinsurance
Imaging CT/PET Scans & MRIs	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Urgent Care Copay Deductible does not apply	$50	30% coinsurance	$75	30% coinsurance	$100	30% coinsurance
Emergency Room Care Copay Copay waived if admitted. Deductible does not apply	$50 Plus 10% coinsurance	$50 Plus 10% coinsurance	$75 Plus 20% coinsurance	$75 Plus 20% coinsurance	$100 Plus 30% coinsurance	$100 Plus 30% coinsurance
Hospital Stay Facility & Physician/Surgeon Fees	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Pharmacy Services	Mail Order Service is through Express Scripts. Specialty Medication can *only* be filled at retail pharmacy or by using Accredo.					
Retail Rx 31 days supply Generic / Preferred Brand / Non-Preferred Brand	$10 / $30 / $30	$10 / $30 / $30 Member must file claim	$10 / $30 / $30	$10 / $30 / $30 Member must file claim	$10 / $30 / $30	$10 / $30 / $30 Member must file claim
Mail Order 90 days supply Generic / Preferred Brand / Non-Preferred Brand	$0 / $75 / $75	Not Covered	$0 / $75 / $75	Not Covered	$0 / $75 / $75	Not Covered
Specialty Medication Deductible does NOT apply	10% coinsurance up to $100 maximum	Not Covered	10% coinsurance up to $100 maximum	Not Covered	10% coinsurance up to $100 maximum	Not Covered
Separate Prescription Drug Out of Pocket Limit:	$1,000 Individual / $2,000 Family		$1,000 Individual / $2,000 Family		$1,000 Individual / $2,000 Family	

NEW! Express Scripts Pharmacy will be your new mail order prescription provider. Use Accredo for specialty medications.

Members may use Accredo to get their specialty medications if a retail pharmacy does not have the medication.

Remaining available refills were transferred to Express Scripts mail order and Accredo specialty.

Go to BAM website and sign into Express Scripts (ESI) for new mail order medications and Accredo to start the process for new specialty refills.

Monthly Rates	PLAN A State Plan		PLAN B High Plan		PLAN C Base Plan	
Coverage Type	Employee	Working Couple	Employee	Working Couple	Employee	Working Couple
Employee Only	$378.00	N/A	$193.00	N/A	$0	N/A
Emp + Child(ren)	$749.00	N/A	$556.00	N/A	$368.00	N/A
Emp + Spouse	$978.00	$578.00	$660.00	$260.00	$571.00	$0
Family	$1,485.00	$1,085.00	$917.00	$517.00	$601.00	$0

Programs & Services Offered through Blue Cross Blue Shield

$0 Copay — Virtual Visits with MDLIVE

Visit a board-certified doctor, 24/7/365 for non-emergency situations at no cost.

Allergies	Asthma	Cold/flu	Ear Problems (Age 12+)
Pink Eye	Rash	Sinus Infections	Nausea

Activate your account or schedule a virtual visit!

1. Go to Blue Access for Members or MDLIVE.com/bcbstx
2. Download the MDLIVE app
3. Call MDLIVE at (888)680-8646
4. Text BCBSTX to 635-483. (MDLIVE's online assistant Sophie will help activate your account.)

Licensed counselors and psychiatrist available by appointment to help you with anxiety, depression, trauma and loss.

Well OnTarget Member Wellness Portal

Explore the Wellness world and take a snapshot of your health with Well OnTarget

- Take a Health Assessment (HA)
- Self-Management Programs
- Health & Fitness Trackers
- News & Education
- Motivation with Blue Points Program
- Fitness Program Membership
- Pregnancy & High-risk Maternity support
- Support for Parenting

Get Started on Well OnTarget!

1. Visit wellontarget.com portal to login. (You can use your BAM username and password)
2. For Fitness, Login to BAM, under "Quick Links," choose "Fitness Program." or **(888) 762-BLUE (2583)**
3. Parenting & Pregnancy Support, contact a BCBSTX representative or visit bcbstx.com

BCBS Mobile Apps for BAM, MDLive, Well on Target, Fitness, and Ovia health apps for Pregnancy, Parenting & Fertility!

Blue Cross Blue Shield

PSJA ISD Group Number:	297209
BCBSTX Customer Service	(800) 521-2227
BCBSTX Website:	www.bcbstx.com
Preauthorization Medical:	(800) 441-9188
Preauthorization MH/CD:	(800) 528-7264
Blue Card Access:	(800) 810-2583
Provider Services:	(800) 451-0287
Employee Assist Program (EAP):	(800) 327-1393 (TTY 711)
EAP Online Registration:	BetterHelp.com/Magellan

Mail Order Program & Specialty Medications

Mail Order Program: Express Scripts Pharmacy
Call (833) 715-0942
Register at express-scripts.com/rx

Specialty Medications: Accredo
Register: (833) 721-1619
Manage Prescriptions at accredo.com

Blue Access for Members (BAM)

You and all covered dependents age 18 and up can create a BAM account

View Your Health Benefits	View Your Claims
Find Providers & Hospitals	Find Medical & RX Forms
View or Print ID Card	Download the App

Use the Cost Estimator tool for price on treatment

Register for BAM Now!

1. Go to bcbstx.com/member
2. Click Log into My Account
3. Use the information on your BCBSTX ID card to sign up
4. Or text * **BCBSTXAPP** to **33633** to get the BCBSTX App

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-521-2227 or at www.bcbstx.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $750 Individual / $1,500 Family Out-of-Network: $1,500 Individual / $3,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services that charge a copay, prescription drugs, emergency room services, and certain preventive care, diagnostic test, home health, skilled nursing, and hospice are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Per occurrence: $150 Out-of-Network inpatient admission. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: $1,700 Individual / $5,100 Family Out-of-Network: $3,000 Individual / $9,000 Family Prescription drug limit: $1,000 Individual / $2,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, preauthorization penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit; deductible does not apply	30% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	$15 copay/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No Charge for child immunizations Out-of-Network through the 6th birthday.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge; deductible does not apply	30% coinsurance	Office visit copay may apply.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Generic drugs	$10 retail/No Charge mail order copay/prescription; deductible does not apply	$10 copay/prescription; deductible does not apply	Prescription drug out-of-pocket limit: $1,000 Individual / $2,000 Family Retail covers a 31-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. Out-of-Network mail order is not covered. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Out-of-Network pharmacy, member must file claim.
	Preferred brand drugs	$30 retail/$75 mail order copay/prescription; deductible does not apply	$30 copay/prescription; deductible does not apply	
	Non-preferred brand drugs	$30 retail/$75 mail order copay/prescription; deductible does not apply	$30 copay/prescription; deductible does not apply	
	Specialty drugs	10% coinsurance up to $100 max/prescription; deductible does not apply	Not Covered	Specialty drugs must be obtained from In-Network specialty pharmacy provider. Specialty retail limited to a 30-day supply. Mail order is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Facility Charges: $100 copay/visit plus 30% coinsurance; deductible does not apply ER Physician Charges: 30% coinsurance	Facility Charges: $100 copay/visit plus 30% coinsurance; deductible does not apply ER Physician Charges: 30% coinsurance	Emergency room copay waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Ground and air transportation covered.
	Urgent care	$100 copay/visit; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	$150 inpatient admission deductible for Out-of-Network providers. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit; deductible does not apply 30% coinsurance for other outpatient services	30% coinsurance office visit 50% coinsurance for other outpatient services	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your plan policy for more details.
	Inpatient services	30% coinsurance	50% coinsurance	$150 inpatient admission deductible for Out-of-Network providers. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$15 copay/visit; deductible does not apply	30% coinsurance	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	$150 inpatient admission deductible for Out-of-Network providers. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
If you need help recovering or have other special health needs	Home health care	No Charge; deductible does not apply	30% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required.
	Rehabilitation services	$15 copay/office visit; deductible does not apply 30% coinsurance for other outpatient services	30% coinsurance office visit 50% coinsurance for other outpatient services	Limited to 35 visits each per calendar year. Includes, but is not limited to, occupational, physical, and manipulative therapy.
	Habilitation services	$15 copay/office visit; deductible does not apply 30% coinsurance for other outpatient services	30% coinsurance office visit 50% coinsurance for other outpatient services	
	Skilled nursing care	No Charge; deductible does not apply	30% coinsurance	Limited to 25 days per calendar year. Preauthorization is required.
	Durable medical equipment	30% coinsurance	50% coinsurance	None
	Hospice services	No Charge; deductible does not apply	30% coinsurance	Preauthorization is required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$15 copay/visit; deductible does not apply	30% coinsurance	Limited to 1 visit per calendar year.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment (diagnosis of infertility covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (35 visits per year)
- Hearing aids (1 per ear per 36-month period)
- Routine eye care (Adult) (1 exam per year)

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$750
Specialist copayment	$15
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$20
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,730**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$750
Specialist copayment	$15
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$700
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,480**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$750
Specialist copayment	$15
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાયેકમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसको सहायता कर रहे है उसके, प्रश्न है, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Áta'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-521-2227 or at www.bcbstx.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $500 Individual / $1,000 Family Out-of-Network: $1,000 Individual / $2,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services that charge a copay, prescription drugs, emergency room services, and certain preventive care, diagnostic test, home health, skilled nursing, and hospice are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Per occurrence: $150 Out-of-Network inpatient admission. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: $1,200 Individual / $3,600 Family Out-of-Network: $2,500 Individual / $7,500 Family Prescription drug limit: $1,000 Individual / $2,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, preauthorization penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit; deductible does not apply	30% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	$15 copay/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No Charge for child immunizations Out-of-Network through the 6th birthday.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge; deductible does not apply	30% coinsurance	Office visit copay may apply.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Generic drugs	$10 retail/No Charge mail order copay/prescription; deductible does not apply	$10 copay/prescription; deductible does not apply	Prescription drug out-of-pocket limit: $1,000 Individual / $2,000 Family Retail covers a 31-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. Out-of-Network mail order is not covered. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Out-of-Network pharmacy, member must file claim.
	Preferred brand drugs	$30 retail/$75 mail order copay/prescription; deductible does not apply	$30 copay/prescription; deductible does not apply	
	Non-preferred brand drugs	$30 retail/$75 mail order copay/prescription; deductible does not apply	$30 copay/prescription; deductible does not apply	
	Specialty drugs	10% coinsurance up to $100 max/prescription; deductible does not apply	Not Covered	Specialty drugs must be obtained from In-Network specialty pharmacy provider. Specialty retail limited to a 30-day supply. Mail order is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Facility Charges: $75 copay/visit plus 20% coinsurance; deductible does not apply ER Physician Charges: 20% coinsurance	Facility Charges: $75 copay/visit plus 20% coinsurance; deductible does not apply ER Physician Charges: 20% coinsurance	Emergency room copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground and air transportation covered.
	Urgent care	$75 copay/visit; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	$150 inpatient admission deductible for Out-of-Network providers. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit; deductible does not apply 20% coinsurance for other outpatient services	30% coinsurance office visit 40% coinsurance for other outpatient services	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your plan policy for more details.
	Inpatient services	20% coinsurance	40% coinsurance	$150 inpatient admission deductible for Out-of-Network providers. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$15 copay/visit; deductible does not apply	30% coinsurance	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	$150 inpatient admission deductible for Out-of-Network providers. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
If you need help recovering or have other special health needs	Home health care	No Charge; deductible does not apply	30% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required.
	Rehabilitation services	$15 copay/office visit; deductible does not apply 20% coinsurance for other outpatient services	30% coinsurance office visit 40% coinsurance for other outpatient services	Limited to 35 visits each per calendar year. Includes, but is not limited to, occupational, physical, and manipulative therapy.
	Habilitation services	$15 copay/office visit; deductible does not apply 20% coinsurance for other outpatient services	30% coinsurance office visit 40% coinsurance for other outpatient services	
	Skilled nursing care	No Charge; deductible does not apply	30% coinsurance	Limited to 25 days per calendar year. Preauthorization is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	No Charge; deductible does not apply	30% coinsurance	Preauthorization is required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$15 copay/visit; deductible does not apply	30% coinsurance	Limited to 1 visit per calendar year.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment (diagnosis of infertility covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (35 visits per year)
- Hearing aids (1 per ear per 36-month period)
- Routine eye care (Adult) (1 exam per year)

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$15
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,260**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$15
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$50
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,170**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$15
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
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ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાયદેસર બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nêu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-521-2227 or at www.bcbstx.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0 Individual / $0 Family Out-of-Network: $500 Individual / $1,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. Per occurrence: $200 Out-of-Network inpatient admission. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: $1,000 Individual / $3,000 Family Out-of-Network: $2,000 Individual / $6,000 Family Prescription drug limit: $1,000 Individual / $2,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, preauthorization penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	30% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	$15 copay/visit	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No Charge for child immunizations Out-of-Network through the 6th birthday.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	Office visit copay may apply.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Generic drugs	$10 retail/No Charge mail order copay/prescription	$10 copay/prescription	Prescription drug out-of-pocket limit: $1,000 Individual / $2,000 Family Retail covers a 31-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. Out-of-Network mail order is not covered. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Out-of-Network pharmacy, member must file claim.
	Preferred brand drugs	$30 retail/$75 mail order copay/prescription	$30 copay/prescription	
	Non-preferred brand drugs	$30 retail/$75 mail order copay/prescription	$30 copay/prescription	
	Specialty drugs	10% coinsurance up to $100 max/prescription	Not Covered	Specialty drugs must be obtained from In-Network specialty pharmacy provider. Specialty retail limited to a 30-day supply. Mail order is not covered.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	Facility Charges: $50 copay/visit plus 10% coinsurance ER Physician Charges: 10% coinsurance	Facility Charges: $50 copay/visit plus 10% coinsurance ER Physician Charges: 10% coinsurance	Emergency room copay waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Ground and air transportation covered.
	Urgent care	$50 copay/visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	$200 inpatient admission deductible for Out-of-Network providers. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit 10% coinsurance for other outpatient services	30% coinsurance	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your plan policy for more details.
	Inpatient services	10% coinsurance	30% coinsurance	$200 inpatient admission deductible for Out-of-Network providers. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$15 copay/visit	30% coinsurance	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	$200 inpatient admission deductible for Out-of-Network providers. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required.
	Rehabilitation services	$15 copay/office visit 10% coinsurance for other outpatient services	30% coinsurance	Limited to 35 visits each per calendar year. Includes, but is not limited to, occupational, physical, and manipulative therapy.
	Habilitation services	$15 copay/office visit 10% coinsurance for other outpatient services	30% coinsurance	
	Skilled nursing care	No Charge	30% coinsurance	Limited to 25 days per calendar year. Preauthorization is required.
	Durable medical equipment	10% coinsurance	30% coinsurance	None
	Hospice services	No Charge	30% coinsurance	Preauthorization is required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$15 copay/visit	30% coinsurance	Limited to 1 visit per calendar year.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment (diagnosis of infertility covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (35 visits per year)
- Hearing aids (1 per ear per 36-month period)
- Routine eye care (Adult) (1 exam per year)

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$800**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
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فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
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Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

DENTAL INSURANCE

BLUE CROSS BLUE SHIELD

BlueCross BlueShield of Texas

Customer Service: 800-521-2227

Pharr-San Juan-Alamo ISD Dental Summary

Core Plan

Deductible Calendar Year	
Individual	$75
Family	$225
Annual Plan Maximum Per Covered Member	$1,000
ORTHODONTICS 50%	
Orthodontic Treatment -Child Only up to age 19	
Lifetime Maximum per person $1000	
No Waiting Period	

PREVENTIVE	**80%**
Periodic Oral Evaluation	
Prophylaxis (cleanings)	
Topical Fluoride Applications	
Full Mouth/ Panoramic X-rays	
Periapical X-rays	
Sealants	
Space Maintainer	
BASIC	**70%**
Amalgams	
Resin-based composite restorations	
Non-Surgical Extractions	
Other Services	**50%**
Surgical or Non-Surgical Periodontic Services	
Palliative Treatment (emergency)	
Deep Sedation/ General Anesthesia	
Endodontic Services	
Oral Surgery Services	
MAJOR	**50%**
Single Crown Restorations	
Inlay/ Onlay Restorations	
Labial Veneer Restoration	
Crowns placed over implants	
Complete and Removable Partial Dentures	
Fixed Bridgework	
Prefabricated crowns	
Recementations	
Post and Core, Pin Retention and Crown Bridge repairs	

Core Plan Rates	
Employee Only	$0.00
Family	$30.27

Working Couple Rates	
Family	$16.88

Buy Up Plan

Deductible Calendar Year	
Individual	$75
Family	$225
Annual Plan Maximum Per Covered Member	$1,500
ORTHODONTICS 50%	
Orthodontic Treatment -Child Only up to age 19	
Lifetime Maximum per person $1000	
No Waiting Period	

PREVENTIVE	**80%**
Periodic Oral Evaluation	
Prophylaxis (cleanings)	
Topical Fluoride Applications	
Full Mouth/ Panoramic X-rays	
Periapical X-rays	
Sealants	
Space Maintainer	
BASIC	**80%**
Amalgams	
Resin-based composite restorations	
Non-Surgical Extractions	
Other Services	**80%**
Surgical or Non-Surgical Periodontic Services	
Palliative Treatment (emergency)	
Deep Sedation/ General Anesthesia	
Endodontic Services	
Oral Surgery Services	
MAJOR	**50%**
Single Crown Restorations	
Inlay/ Onlay Restorations	
Labial Veneer Restoration	
Crowns placed over implants	
Complete and Removable Partial Dentures	
Fixed Bridgework	
Prosthetic placed over implants	
Prefabricated crowns	
Recementations	
Post and Core, Pin Retention and Crown Bridge repairs	

Buy Up Plan Rates	
Employee Only	$3.89
Family	$42.99

Working Couple Rates	
Family	$29.60

VISION INSURANCE

AVESIS

PSJA ISD

Group Number: 30916-1014
Plan Number: TX125125FZ1-L1

avēsis

Member Copay	
Vision Exam	$10 copay
Materials Applies to frame or spectacle lenses, if applicable.	$15 copay

Frequency	
Vision Exam	Once every 12 months
Lenses or Contact Lenses	Once every 12 months
Frame	Once every 24 months

Vision Care Services	In-Network Member Cost*	Out-of-Network Reimbursement
Vision Exam		
Includes refraction	Covered in full after $10 copay	Up to $35
Retinal Imaging	Up to $45 member out-of-pocket (OOP) maximum	N/A
Contact Lens Fit and Follow-up (CLEFFU)		
Standard CLEFFU	Up to $50 member OOP maximum	N/A
Custom CLEFFU	Up to $75 member OOP maximum	N/A
Frame Allowance		
Up to 20% discount above frame allowance.*	$125 allowance	Up to $45
Standard Spectacle Lenses		
Single Vision	Covered in full after $ copay	Up to $25
Bifocal	Covered in full after $ copay	Up to $40
Trifocal	Covered in full after $ copay	Up to $50
Lenticular	Covered in full after $ copay	Up to $80
All Other Progressives	Balance after $50 allowance + up to 20% off retail	Up to $40
Preferred Pricing Options*	**Level 1 Option Package**	
Polycarbonate (Single Vision/Multi-Focal)	$40/$44 member OOP maximum	N/A
Standard Scratch-Resistant Coating	$17 member OOP maximum	N/A
Ultraviolet Screening	$15 member OOP maximum	N/A
Solid or Gradient Tint	$17 member OOP maximum	N/A
Standard Anti-Reflective Coating	$45 member OOP maximum	N/A
Standard Progressives†	$50 allowance	Up to $40
Premium Progressives	Balance after $50 allowance + up to 20% off retail	Up to $40
Plastic Photochromic (Single Vision/Multi-Focal)	$70/$80 member OOP maximum	N/A
Polarized	$75 member OOP maximum	N/A
PGX/PBX	$40 member OOP maximum	N/A
Other Lens Options	Provider discount up to 20%	N/A
Contact Lenses‡		
Elective	$125 allowance	Up to $106
Medically Necessary§	Covered in full	Up to $250
Refractive Laser Surgery		
Up to 25% provider discount.¥	Onetime/lifetime $150 indemnity allowance	Onetime/lifetime $150 indemnity allowance

Avēsis vision insurance products are underwritten by Fidelity Security Life Insurance Company® (FSL), Kansas City, MO, when insured by FSL. Approved by FSL 4/23. Administered by Avēsis. Policy # VC-16, Form M-9059.

Rates

Employee Paid - Monthly	
Employee Only	$ 4.20
Employee + Spouse	$ 7.21
Employee + Child(ren)	$ 7.62
Employee + Family	$ 11.46

Here's How It Works

1. Find a provider at www.avesis.com.
2. Make an appointment.
3. Visit the provider for service.
4. Pay any copays or additional expenses.

How can we help you?

Avēsis Website:
www.avesis.com

Customer Service:
800-828-9341
7 a.m. - 8 p.m. EST

LASIK Provider:
877-712-2010

^Hearing Provider:
844-366-0039 TTY: 711

*Discounts are not insured benefits.

†After $50 allowance, the member's out of pocket cost is $75 for L1 progressives or $110 for L2 progressives.

‡In lieu of frame and spectacle lenses.

§Enhanced benefit for certain conditions.

¥Save up to 25% on average LASIK prices when you use Qualsight (visit qualsight.com/-avesis for more information).

^Discounts available on hearing tests and hearing aids via Amplifon.

At participating Walmart/Sam's locations, retail pricing for your plan is $68. At participating Costco locations, retail pricing is $69.99.

Using Out-of-Network Providers

Members who elect to use an out-of-network provider must pay the provider in full at the time of service and submit a claim to Avēsis for reimbursement, unless the provider accepts an assignment of benefits. Reimbursement levels are in accordance with the out-of-network reimbursement schedule previously listed. Out-of-network benefits are subject to the same eligibility, availability, frequency of benefits, and limitation and exclusion provisions of the plan, and are in lieu of services provided by a participating Avēsis provider. Out-of-network claim forms can be obtained by contacting Avēsis' Customer Service Center or your group administrator, or by visiting www.avesis.com.

Termination Provisions

The coverage will continue as long as the group policy remains in force, the premiums are paid, and as long as the employee and any covered dependents remain eligible and the employees coverage remains in force.

Notes and Disclaimers

The contact lens allowance may be used all at once or throughout the plan year as needed or may be applied toward contact lenses only. Refractive Laser Surgery is considered an elective procedure, and may involve potential risks to patients. Avēsis is not responsible for the outcome of any refractive surgery. Discounts on materials are not available at Walmart locations. Members may not use their contact lens allowance toward fitting fees at Walmart and are responsible for any out-of-pocket fees associated with fittings there. Discounts on materials are not available at Costco locations. ID cards are not required for services.

Limitations and Exclusions

Some provisions, benefits, exclusions, or limitations listed herein may vary depending on your state of residence.

Limitations

Vision Examination and Vision Materials. Fees charged by a Provider for services other than Vision Examination or covered Vision Materials must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Period.

Exclusions

No benefits will be paid for services or materials connected with or charges arising from:

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; Aniseikonic lenses;
2. Medical and/or surgical treatment of the eye, eyes, or supporting structures;
3. Any eye or Vision Examination, or any corrective eyewear, required by an Employer as a condition of employment and safety eyewear, unless specifically covered under the Policy;
4. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, state, or subdivisions thereof;
5. Plano (non-prescription) lenses;
6. Non-prescription sunglasses;
7. Two pair of glasses in lieu of bifocals; or
8. Services or materials provided by any other group benefit plan providing vision care.

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Period when Vision Materials would next become available.

Refractive Surgery Vision Benefit Exclusions

Benefits are not payable for any of the following:

1. Routine vision examinations or corrective vision materials, including corrective eyeglasses, fittings, lenses, frames, or contact lenses; or
2. Medical or surgical procedures, services, or treatments:
   a. not specifically covered under this Rider;
   b. provided free of charge in the absence of insurance
   c. payable under any Workers' Compensation law or similar statutory authority
   d. payable under governmental plan or program, whether Federal, state, or subdivisions thereof.

Avēsis
10400 N 25th Ave.,
Suite 200,
Phoenix, AZ 85021

BASIC LIFE INSURANCE

BLUE CROSS BLUE SHIELD

BlueCross BlueShield of Texas

Group Benefit Program Summary for

Pharr-San Juan-Alamo ISD

Group Term Life

The death of a family member can mean not only dealing with the loss of a loved one, but the loss of financial security as well. With Blue Cross and Blue Shield of Texas' Group Term Life plan, an employee can achieve peace of mind by giving their family the financial security they can depend on.

Basic Term Life is voluntary for NAFT employees.

Eligibility	All Other Active Full-Time Employees
Group Term Life Benefit: Employee	$20,000
Guarantee Issue Amount - Employee	$20,000
Group Term Life Age Reduction Schedule	Benefits reduce by 33% of the original amount at age 70; and further reduce by: 50% of the original amount at age 75.
Waiver of Premium	Elimination Period: 3 Months; Duration: To age 65
Accelerated Death Benefit (ADB)	Benefit: Up to 80% of the employee's life insurance; Life expectancy: 24 months or less
Portability Feature (Life Coverage)	Included (employee)
Conversion	Included
Beneficiary Resource Service	Includes grief, legal and financial counseling for beneficiaries, funeral planning; and online legal library, including templates to create a legal will and other legal documents.
Travel Resource Services	Helps travelers with the unexpected that may take place while traveling. Services include emergency medical assistance, financial, legal and communication assistance and access to other critical services and resources available via the Internet.

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

BlueCross BlueShield of Texas

Group Accidental Death & Dismemberment (AD&D)

Group AD&D is an additional death benefit that pays in the event a covered employee dies or is dismembered in a covered accident. AD&D benefit is a 24-hour coverage.

Group AD&D Benefit: Employee	$55,000
AD&D Age Reduction Schedule	Benefits reduce by 33% of the original amount at age 70; and further reduce by: 50% of the original amount at age 75.

AD&D Schedule of Loss*	Principal Sum
Loss of Life	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of speech and hearing	100%
Loss of sight of both eyes	100%
Loss of one hand and sight of one eye	100%
Loss of one foot and sight of one eye	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Loss of sight of one eye	50%
Loss of one hand or one foot	50%
Loss of speech or hearing	50%
Loss of thumb and index finger of the same hand	25%
Uniplegia	25%

*Loss must occur within 365 days of accident.

AD&D PRODUCT FEATURES INCLUDED:

- Seatbelt Benefit
- Airbag Benefit
- Repatriation Benefit
- Education Benefit
- Day Care Benefit
- Public Conveyance Benefit
- In the Line of Duty Benefit

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

BlueCross BlueShield of Texas

Group Benefit Program Summary for

Pharr-San Juan-Alamo ISD

Group Term Life

The death of a family member can mean not only dealing with the loss of a loved one, but the loss of financial security as well. With Blue Cross and Blue Shield of Texas' Group Term Life plan, an employee can achieve peace of mind by giving their family the financial security they can depend on.

Eligibility	All Active Full-Time Superintendents
Group Term Life Benefit: Employee	$70,000
Guarantee Issue Amount - Employee	$70,000
Group Term Life Age Reduction Schedule	Benefits reduce by 33% of the original amount at age 70; and further reduce by: 50% of the original amount at age 75.
Waiver of Premium	Elimination Period: 3 Months; Duration: To age 65
Accelerated Death Benefit (ADB)	Benefit: Up to 80% of the employee's life insurance; Life expectancy: 24 months or less
Portability Feature (Life Coverage)	Included (employee)
Conversion	Included
Beneficiary Resource Service	Includes grief, legal and financial counseling for beneficiaries, funeral planning; and online legal library, including templates to create a legal will and other legal documents.
Travel Resource Services	Helps travelers with the unexpected that may take place while traveling. Services include emergency medical assistance, financial, legal and communication assistance and access to other critical services and resources available via the Internet.

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

BlueCross BlueShield of Texas

Group Accidental Death & Dismemberment (AD&D)

Group AD&D is an additional death benefit that pays in the event a covered employee dies or is dismembered in a covered accident. AD&D benefit is a 24-hour coverage.

Group AD&D Benefit: Employee	$55,000
AD&D Age Reduction Schedule	Benefits reduce by 33% of the original amount at age 70; and further reduce by: 50% of the original amount at age 75.

AD&D Schedule of Loss*	Principal Sum
Loss of Life	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of speech and hearing	100%
Loss of sight of both eyes	100%
Loss of one hand and sight of one eye	100%
Loss of one foot and sight of one eye	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Loss of sight of one eye	50%
Loss of one hand or one foot	50%
Loss of speech or hearing	50%
Loss of thumb and index finger of the same hand	25%
Uniplegia	25%

*Loss must occur within 365 days of accident.

AD&D PRODUCT FEATURES INCLUDED:

- ▲ Seatbelt Benefit
- ▲ Airbag Benefit
- ▲ Repatriation Benefit
- ▲ Education Benefit
- ▲ Day Care Benefit
- ▲ Public Conveyance Benefit
- ▲ In the Line of Duty Benefit

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

Quote ID: 182440

Generation Date: 07/14/2023

Payment Now, Paperwork Later

Losing a loved one can be emotionally and financially overwhelming.

DearbornCares provides an advance payment of the life insurance benefit to help beneficiaries cover their immediate expenses, such as funeral costs and medical bills.

- Pays up to a total of $50,000 of employer-paid basic life insurance benefits
- Available for covered employees and retirees
- Available on claims with 1, 2 or 3 named beneficiaries
- No death certificate required

DearbornCares Claim Process

Once the employer is notified of the death, they will submit the life insurance claim to us, and then we will mail the payment check within 48 hours of confirmation. No additional paperwork is required at that time. Any remaining basic life benefit, if available, will be handled using our standard process.

While we know this service won't fix everything, we hope it makes a difficult time a little easier.

Advance Payment of up to a total of **$50,000** in 48 hours*. **Why? Because we care.**

Contact human resources to learn more.

*Pays up to a total of $50,000 to beneficiaries (maximum 3) of employer-paid basic life insurance benefits in 48 hours of confirmation of eligibility. The advance payment is either distributed to 1 beneficiary or divided up between 2 or 3 beneficiaries, as designated by the insured.

For employee use only. This information is only a product highlight. DearbornCares has exclusions and limitations. The service may be canceled by the insurer at any time.

750126.0420

TERM LIFE - PLAN 1

BLUE CROSS BLUE SHIELD

BlueCross BlueShield of Texas

Group Benefit Program Summary for

Pharr-San Juan-Alamo ISD

Supplemental Term Life

The death of a family member can mean not only dealing with the loss of a loved one, but the loss of financial security as well. With Blue Cross and Blue Shield of Texas' Group Term Life plan, an employee can achieve peace of mind by giving their family the financial security they can depend on.

Eligibility	Plan 1: All Active Full-Time Superintendents, Department Heads, Teachers and Administrators
Group Term Life Benefit: Employee	$25,000 - $40,000 in increments of $15,000
Grandfathering	$40,000 provided minimum participation requirement is met
Guarantee Issue Amount - Employee	$40,000 (subject to eligibility rules and enrollment status guidelines)
Group Term Life Age Reduction Schedule	Same as Basic Life
Premium Waiver Type	Same as Basic Life
Accelerated Death Benefit (ADB)	Same as Basic Life
Portability Feature (Life Coverage)	Included
Conversion	Included

TERM LIFE - PLAN 2

BLUE CROSS BLUE SHIELD

Supplemental Life
PREMIUM RATE GRID

BlueCross BlueShield of Texas

Pharr-San Juan-Alamo ISD

Eligibility

All Active Full-Time Employees, including Superintendents, Department Heads, Teachers, and Administrators

Supplemental Life

Employee Benefit: **$10,000 to $500,000 in $10,000 increments.**

Spouse Benefit: **$5,000 to $150,000 in $5,000 increments. (not to exceed 100% of the employee benefit)**

Note: Spouse may not have coverage unless the employee has coverage.

The Spouse amount may not exceed the amount for which the employee is eligible.

Guarantee Issue*

Employee	**$230,000**
Spouse	**$50,000**

*Assumes 69% participation

Child Coverage

Birth to 14 days:	**$10,000**
15 days to 6 months:	**$10,000**
6 months to age 26:	**$10,000**

Life and AD&D benefits reduce by 33% of the original amount at age 70 and further reduce by 50% of the original amount at age 75.

Employee Supplemental Life

Monthly rates per $1,000

Age	Rates
Under 20	$0.029
20-24	$0.029
25-29	$0.029
30-34	$0.038
35-39	$0.057
40-44	$0.076
45-49	$0.124
50-54	$0.190
55-59	$0.285
60-64	$0.475
65-69	$0.789
70+	$1.416

Dependent Life (Children)

Monthly Premium per Family Life

$10,000 $1.30

Supplemental Life

Premium Cost (Based on 12 payroll deductions per year)

	ATTAINED AGE											
Benefit Amount	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$10,000	$0.29	$0.29	$0.29	$0.38	$0.57	$0.76	$1.24	$1.90	$2.85	$4.75	$7.89	$14.16
$20,000	$0.58	$0.58	$0.58	$0.76	$1.14	$1.52	$2.48	$3.80	$5.70	$9.50	$15.78	$28.32
$30,000	$0.87	$0.87	$0.87	$1.14	$1.71	$2.28	$3.72	$5.70	$8.55	$14.25	$23.67	$42.48
$40,000	$1.16	$1.16	$1.16	$1.52	$2.28	$3.04	$4.96	$7.60	$11.40	$19.00	$31.56	$56.64
$50,000	$1.45	$1.45	$1.45	$1.90	$2.85	$3.80	$6.20	$9.50	$14.25	$23.75	$39.45	$70.80
$60,000	$1.74	$1.74	$1.74	$2.28	$3.42	$4.56	$7.44	$11.40	$17.10	$28.50	$47.34	$84.96
$70,000	$2.03	$2.03	$2.03	$2.66	$3.99	$5.32	$8.68	$13.30	$19.95	$33.25	$55.23	$99.12
$80,000	$2.32	$2.32	$2.32	$3.04	$4.56	$6.08	$9.92	$15.20	$22.80	$38.00	$63.12	$113.28
$90,000	$2.61	$2.61	$2.61	$3.42	$5.13	$6.84	$11.16	$17.10	$25.65	$42.75	$71.01	$127.44
$100,000	$2.90	$2.90	$2.90	$3.80	$5.70	$7.60	$12.40	$19.00	$28.50	$47.50	$78.90	$141.60
$150,000	$4.35	$4.35	$4.35	$5.70	$8.55	$11.40	$18.60	$28.50	$42.75	$71.25	$118.35	$212.40
$200,000	$5.80	$5.80	$5.80	$7.60	$11.40	$15.20	$24.80	$38.00	$57.00	$95.00	$157.80	$283.20
$250,000	$7.25	$7.25	$7.25	$9.50	$14.25	$19.00	$31.00	$47.50	$71.25	$118.75	$197.25	$354.00
$300,000	$8.70	$8.70	$8.70	$11.40	$17.10	$22.80	$37.20	$57.00	$85.50	$142.50	$236.70	$424.80
$350,000	$10.15	$10.15	$10.15	$13.30	$19.95	$26.60	$43.40	$66.50	$99.75	$166.25	$276.15	$495.60
$400,000	$11.60	$11.60	$11.60	$15.20	$22.80	$30.40	$49.60	$76.00	$114.00	$190.00	$315.60	$566.40
$450,000	$13.05	$13.05	$13.05	$17.10	$25.65	$34.20	$55.80	$85.50	$128.25	$213.75	$355.05	$637.20
$500,000	$14.50	$14.50	$14.50	$19.00	$28.50	$38.00	$62.00	$95.00	$142.50	$237.50	$394.50	$708.00

Supplemental Life
PREMIUM RATE GRID

BlueCross BlueShield of Texas

Pharr-San Juan-Alamo ISD

Eligibility

All Active Full-Time Employees, including Superintendents, Department Heads, Teachers, and Administrators

Supplemental Life

Employee Benefit: **$10,000 to $500,000 in $10,000 increments.**

Spouse Benefit: **$5,000 to $150,000 in $5,000 increments. (not to exceed 100% of the employee benefit)**

Note: Spouse may not have coverage unless the employee has coverage.

The Spouse amount may not exceed the amount for which the employee is eligible.

Guarantee Issue*

Employee	**$230,000**
Spouse	**$50,000**

*Assumes 69% participation

Child Coverage

Birth to 14 days:	**$10,000**
15 days to 6 months:	**$10,000**
6 months to age 26:	**$10,000**

Life and AD&D benefits reduce by 33% of the original amount at age 70 and further reduce by 50% of the original amount at age 75.

Spouse Supplemental Life

Monthly rates per $1,000

Age	Rates
Under 20	$0.029
20-24	$0.029
25-29	$0.029
30-34	$0.038
35-39	$0.057
40-44	$0.076
45-49	$0.124
50-54	$0.190
55-59	$0.285
60-64	$0.475
65-69	$0.789
70+	$1.416

Dependent Life (Children)

Monthly Premium per Family Life

$10,000 $1.30

Supplemental Life

Premium Cost (Based on 12 payroll deductions per year)

	ATTAINED AGE											
Benefit Amount	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$5,000	$0.15	$0.15	$0.15	$0.19	$0.29	$0.38	$0.62	$0.95	$1.43	$2.38	$3.95	$7.08
$10,000	$0.29	$0.29	$0.29	$0.38	$0.57	$0.76	$1.24	$1.90	$2.85	$4.75	$7.89	$14.16
$15,000	$0.44	$0.44	$0.44	$0.57	$0.86	$1.14	$1.86	$2.85	$4.28	$7.13	$11.84	$21.24
$20,000	$0.58	$0.58	$0.58	$0.76	$1.14	$1.52	$2.48	$3.80	$5.70	$9.50	$15.78	$28.32
$25,000	$0.73	$0.73	$0.73	$0.95	$1.43	$1.90	$3.10	$4.75	$7.13	$11.88	$19.73	$35.40
$30,000	$0.87	$0.87	$0.87	$1.14	$1.71	$2.28	$3.72	$5.70	$8.55	$14.25	$23.67	$42.48
$35,000	$1.02	$1.02	$1.02	$1.33	$2.00	$2.66	$4.34	$6.65	$9.98	$16.63	$27.62	$49.56
$40,000	$1.16	$1.16	$1.16	$1.52	$2.28	$3.04	$4.96	$7.60	$11.40	$19.00	$31.56	$56.64
$45,000	$1.31	$1.31	$1.31	$1.71	$2.57	$3.42	$5.58	$8.55	$12.83	$21.38	$35.51	$63.72
$50,000	$1.45	$1.45	$1.45	$1.90	$2.85	$3.80	$6.20	$9.50	$14.25	$23.75	$39.45	$70.80
$55,000	$1.60	$1.60	$1.60	$2.09	$3.14	$4.18	$6.82	$10.45	$15.68	$26.13	$43.40	$77.88
$60,000	$1.74	$1.74	$1.74	$2.28	$3.42	$4.56	$7.44	$11.40	$17.10	$28.50	$47.34	$84.96
$65,000	$1.89	$1.89	$1.89	$2.47	$3.71	$4.94	$8.06	$12.35	$18.53	$30.88	$51.29	$92.04
$70,000	$2.03	$2.03	$2.03	$2.66	$3.99	$5.32	$8.68	$13.30	$19.95	$33.25	$55.23	$99.12
$75,000	$2.18	$2.18	$2.18	$2.85	$4.28	$5.70	$9.30	$14.25	$21.38	$35.63	$59.18	$106.20
$100,000	$2.90	$2.90	$2.90	$3.80	$5.70	$7.60	$12.40	$19.00	$28.50	$47.50	$78.90	$141.60
$125,000	$3.63	$3.63	$3.63	$4.75	$7.13	$9.50	$15.50	$23.75	$35.63	$59.38	$98.63	$177.00
$150,000	$4.35	$4.35	$4.35	$5.70	$8.55	$11.40	$18.60	$28.50	$42.75	$71.25	$118.35	$212.40

AD&D LIFE INSURANCE

BLUE CROSS BLUE SHIELD

BlueCross BlueShield of Texas

Voluntary Group AD&D Insurance Plan Design Summary for
Pharr-San Juan-Alamo ISD

Eligibility:	All Active Full-Time Employees
Voluntary Employee AD&D Benefit:	$10,000 - $500,000 in increments of $10,000, not to exceed 10 times annual earnings
Voluntary Family AD&D Benefit:	Spouse Only: 50% Spouse with Children: 40% Child Only: 15%, not to exceed $25,000 Child with Spouse: 10%, not to exceed $25,000
Age Reduction Schedule *Benefits are reduced by the percentage indicated and are calculated from the original amount at the attainment of the age shown*	33% at age 70 50% at age 75 Benefits terminate at Retirement

Additional AD&D Features

Seat Belt Benefit	10% - $25,000
Air Bag Benefit	15% - $15,000
Education Benefit	5% - $2,500 per year; Up to four years
Repatriation Benefit	20% - $20,000
Bereavement Counseling Benefit	$250 per session; Maximum 10 sessions
Coma Benefit	1% - 100 months
Common Disaster Benefit	Employee Principal Sum to a maximum of $250,000
Day Care Benefit	3% - $3,000 per year; Maximum 5 years
Public Conveyance Benefit	100% - $500,000
Spouse Training Benefit	5% - $10,000

Exclusions and Limitations*

- Disease of the mind or body, and any medical or surgical treatment thereof
- Infection
- Suicide or attempted suicide
- Intentionally self-inflicted injury
- War
- Travel or flight in any aircraft while a member of the crew
- Under the influence of any narcotic
- Intoxication
- Participation in a riot
- Any heart, coronary or circulatory malfunction
- Commission of a felony

* *Refer to the policy and certificate for other exclusions and limitations that may apply*

BlueCross BlueShield of Texas

Portability & Conversion

Conversion

Conversion is available to an employee and eligible spouses and dependent children if his or her life insurance, or a portion of it, terminates. An employee may convert to an individual policy without evidence of insurability, provided the application and premium payment is made within 31 days following termination of coverage.

Portability

Portability allows an insured employee and eligible spouses and dependent children to take their term life coverage that is similar to what is offered by the employer with them, if their coverage terminates for reasons other than divorce, disability, retirement or termination of the group policy.

FREQUENTLY ASKED QUESTIONS CONTINUED

The following side-by-side comparison chart answers the most frequently asked questions about each option.

	Conversion	Portability
Can you port and convert coverage?	No, employees and dependents can either port or convert coverage, not both. However, if an employee elects the portability benefit, any amounts of life insurance that are not ported may be converted.	
Can an employee designate a new beneficiary when he or she ports or converts coverage?	Yes, employees can designate a new beneficiary at any time. Both the conversion and portability forms include a beneficiary designation section.	
Will medical questions need to be answered to apply for coverage?	Evidence of insurability will not be required.	Employees may continue an amount up to the full amount of his or her term life benefit without evidence of insurability.
How do you apply for portability or conversion?	Your employer will provide portability and conversion forms to employees. These forms can also be found on www.bcbstx.com We must receive a written application and first premium for the life insurance policy within 31 days after life insurance	
Does ported or converted life coverage generate cash value?	Conversion replaces group life insurance with a whole life policy, which can generate cash value after being in force for a number of years.	There is no cash value associated with a ported policy of coverage.
Are portability and conversion rates different from the group policy rates?	Yes, insureds are charged the standard conversion age-banded rates based on their age at the time of application. The rate does not change as the insured ages.	Yes, insureds are charged the standard portability age-banded rates based on their age at the time of application. Portability rates change (rise) as the insured ages.

FREQUENTLY ASKED QUESTIONS CONTINUED

	Conversion	Portability
What requirements must the employee meet to be eligible to port or convert coverage?	An employee may convert if the termination of coverage is a result of termination of employment or the employee is no longer in a class that is eligible for life insurance. In either situation, the converted amount may not exceed the amount in force at the date of termination. The employee must have been covered for group term life for the preceding 5 years.	(1) Been insured for a specified period of time, usually one year (2) Be younger than 60 years of age unless otherwise stated in the certificate (3) Life coverage, or a portion of it, must have terminated for reasons other than sickness, injury, retirement or termination of the master policy (4) Must be able to perform the material and substantial duties of any gainful occupation for which they are qualified for by education, training and experience (5) Must not have exercised the right to convert, under the conversion of life insurance provision, the amount of life insurance he or she elects under the portability benefit. If he or she elects the portability benefit, any amounts of Life Insurance that are not ported may be converted
When does portability or conversion coverage end?	Conversion coverage will end on the date the insured fails to pay premium when due; the date the insured requests conversion coverage to be cancelled; or the date the insured reaches age 99 or dies, whichever occurs first.	Portability coverage will end: • When attaining the limiting age • The date the employee returns to work • The date the dependent ceases to meet the definition of an eligible dependent • The date the insured requests portability coverage to be cancelled
If the group plan terminates, will the portability coverage also terminate?	N/A	No, this is not the case under our standard contract.
When an employee is terminated, will he or she receive a letter in the mail offering portability and conversion options?	No, the employer is responsible for advising employees of their portability and conversion rights. Your employer will provide portability or conversion forms to employees. These forms can also be found on bcbstx.com.	
If a full-time employee becomes part-time, can he or she port or convert his or her coverage?	Yes	Yes
When an employee's benefit reduces due to a salary change, can the employee port or convert the amount he or she is reduced by?	No	No

Coverage options may not be available in all states and may vary by group. This piece is for illustrative purposes only and is not a contract. It is intended to provide only a brief summary of the policy advertised. The policy provides the actual terms of the policy, including any exclusions, conditions and limitations to coverage. If there is a conflict between the terms and conditions of the insurance policy and certificate and the statements in this document, the policy and certificate will control.

CANCER INSURANCE

ALLSTATE

Benefit Amounts

HOSPITAL CONFINEMENT BENEFITS		1 Unit	3 Units
Continuous Hospital Confinement (daily)		$100	$300
Extended Benefits (daily, beginning on day 71 of hospital confinement)		$100	$300
Government or Charity Hospital (daily)		$100	$300
Private Duty Nursing Services (daily)		$100	$300
Extended Care Facility (daily)		$100	$300
At Home Nursing (daily)		$100	$300
Freestanding Hospice Care Center (daily) or		1. $100	1. $300
Hospice Care Team (per visit)		2. $100	2. $300
RADIATION, CHEMOTHERAPY BENEFITS		2 Units	4 Units
Radiation/Chemotherapy for Cancer (every 12 months)		$5,000	$10,000
Blood, Plasma, and Platelets (every 12 months)		$5,000	$10,000
SURGERY AND RELATED BENEFITS		1 Unit	2 Units
Surgery	1. Inpatient 2. Outpatient	$1,500	$3,000
Anesthesia (% of surgery)		25%	25%
Ambulatory Surgical Center (daily)			
Second Surgical Opinion			
Bone Marrow or Stem Cell Transplant	1. Autologous 2. Non-autologous 3. Non-autologous for leukemia	1. $ 500 2. $1,250 3. $2,500	1. $1,000 2. $2,500 3. $5,000
TRANSPORTATION AND LODGING BENEFITS		1 Units	1 Units
Ambulance (per confinement)		$100	$100
Non-Local Transportation (per trip or mile)	Coach Fare	$0.40	$0.40
Outpatient Lodging (daily)		$50	$50
Family Member Lodging (daily) and		1. $50	1. $50
Transportation (per trip or mile)	Coach Fare	2.$.0.40	2.$.0.40
MISCELLANEOUS BENEFITS		1 Units	1 Units
Inpatient Drugs and Medicine (daily)		$25	$25
Physician's Attendance (daily)		$50	$50
Physical or Speech Therapy (daily)		$50	$50
New or Experimental Treatment (per 12 months.)		$5,000	$5,000
Prosthesis		$2,000	$2,000
Comfort/Anti-Nausea Benefit (yearly)		$200	$200
Waiver of Premium (primary insured only)		Yes	Yes
ADDITIONAL BENEFITS		3 Units	5 Units
Cancer Initial Diagnosis		$3,000	$5,000
		4 Units	6 Units
Intensive Care	1. Hospital Confinement (daily) 2. Air/Surface Ambulance	1. $ 400 2. Charges	1. $ 600 2. Charges
		2 Units	4 Units
Cancer Screening (yearly)		$50	$100

Allstate BENEFITS

Group Voluntary Cancer 2 (Texas)

Monthly

PLAN DESIGN TWO TIER	EE	F
Option 1 1 Unit Hospital Benefits, 2 Units Radiation Chemotherapy, 1 Unit Surgery & Related Benefits, 1 Unit Miscellaneous Benefits, 2 Units Wellness Cancer Screening, 3 Units Cancer Initial Diagnosis, 4 Units Intensive Care	$ 14.52	$ 25.36
Option 2 3 Units Hospital Benefits, 4 Units Radiation Chemotherapy, 3 Units Surgery & Related Benefits, 1 Unit Miscellaneous Benefits, 4 Units Wellness Cancer Screening, 5 Units Cancer Initial Diagnosis, 4 Units Intensive Care	$ 29.28	$ 50.56

EE=Employee Only | F = Family

In addition to cancer, the policy also covers Muscular Dystrophy, Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thallasemia, Rocky Mountain Spotted Fever, Legionnaire's Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, Primary Biliary Cirrhosis.

ACCIDENT INSURANCE

THE HARTFORD

GROUP VOLUNTARY ACCIDENT INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

Nearly 3 million emergency department visits every year are caused by youth sports.[1]

Pharr-San Juan-Alamo Independent School District

With Accident insurance, you'll receive payment(s) associated with a covered injury and related services. You can use the payment in any way you choose – from expenses not covered by your major medical plan to day-to-day costs of living such as the mortgage or your utility bills.

To learn more about Accident insurance, visit
thehartford.com/employee-benefits/employees

COVERAGE INFORMATION

This insurance provides benefits when injuries, medical treatment and/or services occur as the result of a covered accident. Unless otherwise noted, the benefit amounts payable under each plan are the same for you and your dependent(s).

PLAN INFORMATION		
Coverage Type		Off-job only
BENEFITS		
EMERGENCY, HOSPITAL & TREATMENT CARE		
Accident Follow-Up	Up to 3 visits per accident	$50
Acupuncture/Chiropractic Care/PT	Up to 10 visits each per accident	$25
Ambulance – Air	Once per accident	$1,500
Ambulance – Ground	Once per accident	$400
Blood/Plasma/Platelets	Once per accident	$400
Child Care	Up to 30 days per accident while insured is confined	$25
Daily Hospital Confinement	Up to 365 days per lifetime	$200
Daily ICU Confinement	Up to 30 days per accident	$400
Diagnostic Exam	Once per accident	$100
Emergency Dental	Once per accident	Up to $300
Emergency Room	Once per accident	$200
Health Screening Benefit or Accident Prevention Benefit	Once per year for each covered person	$50
Hospital Admission	Once per accident	$1,500
Initial Physician Office Visit	Once per accident	$50
Lodging	Up to 30 nights per lifetime	$150
Medical Appliance	Once per accident	$100
Rehabilitation Facility	Up to 15 days per lifetime	$100
Transportation	Up to 3 trips per accident	$500
Urgent Care	Once per accident	$50
X-ray	Once per accident	$50
SPECIFIED INJURY & SURGERY		
Abdominal/Thoracic Surgery	Once per accident	$1,500
Arthroscopic Surgery	Once per accident	$150
Burn	Once per accident	Up to $10,000
Burn – Skin Graft	Once per accident for third degree burn(s)	50% of burn benefit
Concussion	Up to 3 per year	$150
Dislocation	Once per joint per lifetime	Up to $6,000
Eye Injury	Once per accident	Up to $300

Fracture	Once per bone per accident	Up to $8,000
Hernia Repair	Once per accident	$150
Joint Replacement	Once per accident	$500
Knee Cartilage	Once per accident	Up to $750
Laceration	Once per accident	Up to $600
Ruptured Disc	Once per accident	$800
Tendon/Ligament/Rotator Cuff	Once per accident	Up to $1,200
CATASTROPHIC		
Accidental Death	Within 90 days; Spouse @ 50% and child @ 25%	$50,000
Common Carrier Death	Within 90 days	3 times death benefit
Coma	Once per accident	Up to $10,000
Dismemberment	Once per accident	Up to $50,000
Home Health Care	Up to 30 days per accident	$50
Paralysis	Once per accident	Up to $50,000
Prosthesis	Once per accident	Up to $2,000
FEATURES		
Ability Assist® EAP[2] – 24/7/365 access to help for financial, legal or emotional issues		Included
HealthChampion[SM3] – Administrative & clinical support following serious illness or injury		Included

PREMIUMS

The amounts shown are monthly amounts (12 payments/deductions per year):[4]

COVERAGE TIER	
Employee Only	**$3.66** ($0.12 per day)
Employee & Spouse/Partner	**$5.76** ($0.19 per day)
Employee & Child(ren)	**$6.07** ($0.20 per day)
Employee & Family	**$9.57** ($0.32 per day)

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible for this insurance if you are an active full-time employee who works at least 20 hours per week on a regularly scheduled basis.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

Yes. Any reference to "spouse" in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage – it is available without having to provide information about your or your family's health. All you have to do is elect the coverage to become insured.

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Premiums are provided above. You may elect insurance for you only, or for you and your dependent(s), by choosing the applicable coverage tier.

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period.

WHEN DOES THIS INSURANCE BEGIN?

Insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

WHEN DOES THIS INSURANCE END?

This insurance will end when you or your dependents no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this coverage with you. Coverage may be continued for you and your dependent(s) under a group portability policy. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for portability are described in the certificate.

[1]National Health Statistics Reports, November 2019. CDC/National Center for Health Statistics: https://www.cdc.gov/nchs/data/nhsr/nhsr133-508.pdf, as viewed as of 10/14/2020
[2]AbilityAssist® services are offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Ability Assist is a registered trademark of The Hartford. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.
[3]HealthChampion services are provided through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford doesn't provide basic hospital, basic medical, or major medical insurance. HealthChampion specialists are only available during business hours. Inquiries outside of this timeframe can either request a call-back the next day or schedule an appointment. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Health Champion is a service mark of ComPsych. Services may not be available in all states.
Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.
[4]Rates and/or benefits may be changed on a class basis.

The Buck's Got Your Back ®

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP ACCIDENT INSURANCE

LIMITATIONS AND EXCLUSIONS

The benefits payable are based on the insurance in effect on the date of the covered accident, subject to the definitions, limitations, exclusions and other provisions of the policy.

You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

This insurance does not provide benefits for any loss that results from or is caused by:

- Suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted injury
- War or act of war, whether declared or undeclared, or a nuclear, chemical, biological, or radiological event
- A covered person's participation in a felony, riot or insurrection
- A covered person's service in the armed forces or units auxiliary to it
- A covered person's taking drugs, unless as prescribed by or administered by a physician, or being intoxicated as defined by the jurisdiction in which the cause of loss was incurred
- A covered person's sickness or bacterial infection
- A covered person's participation in bungee jumping or hang gliding
- A covered person's participation or competition in semi-professional or professional sports
- Cosmetic surgery or any other elective procedure that is not medically necessary
- While a covered person is on any aircraft: as a pilot, crewmember or student pilot; as a flight instructor or examiner; if it is owned, operated or leased by or on behalf of the policyholder, or any employer or organization whose eligible persons are covered under the policy; or being used for tests, experimental purposes, stunt flying,racing or endurance tests
- Operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test

All exclusions may not be applicable, or may be adjusted, as required by state regulations in the situs state of a group.

NOTICES

THIS IS A LIMITED ACCIDENT ONLY BENEFIT POLICY

THIS POLICY IS A LIMITED ACCIDENT ONLY BENEFIT POLICY.

This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage. In New York: This Accident policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. IMPORTANT NOTICE—THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

5962g NS 05/21 Accident Form Series includes GBD-2000, GBD-2300, or state equivalent.

The Buck's Got Your Back ®

RESUMEN DE BENEFICIOS DEL SEGURO COLECTIVO Y VOLUNTARIO POR ACCIDENTE

Los casi 3 millones de visitas anuales a la sala de emergencias se deben a la práctica de deportes por parte de niños y adolescentes.[1]

Distrito escolar independiente de Pharr-San Juan-Alamo

Con el seguro por accidente, usted recibirá pagos relacionados con una lesión con cobertura y servicios afines. Puede utilizarlos para pagar lo que usted elija: desde los gastos que el seguro médico principal no cubre hasta los costos de vida diarios, como la hipoteca o las facturas de los servicios públicos.

Para saber más sobre el seguro por accidente, visite:
thehartford.com/employee-benefits/employees

INFORMACIÓN DE LA COBERTURA

Con este seguro se brindan beneficios en el caso de que las lesiones, el tratamiento o los servicios médicos sean consecuencia de un accidente con cobertura. Excepto que se establezca lo contrario, las cantidades pagaderas en cada plan son iguales tanto para usted como para sus dependientes.

INFORMACIÓN DEL PLAN		
Tipo de cobertura		Solo fuera del trabajo
BENEFICIOS		
ATENCIÓN DE EMERGENCIA, HOSPITALARIA Y PARA TRATAMIENTO		
Seguimiento luego del accidente	Hasta 3 consultas por accidente	$50
Acupuntura/quiropraxia/fisioterapia	Hasta 10 consultas por accidente para cada uno	$25
Ambulancia - aérea	Una vez por accidente	$1,500
Ambulancia - terrestre	Una vez por accidente	$400
Sangre/plasma/plaquetas	Una vez por accidente	$400
Guardería	Hasta 30 días por accidente mientras el asegurado está internado	$25
Internación diaria en hospital	Hasta 365 días en toda la vida	$200
Internación diaria en UCI	Hasta 30 días por accidente	$400
Examen diagnóstico	Una vez por accidente	$100
Emergencia odontológica	Una vez por accidente	Hasta $300
Sala de emergencias	Una vez por accidente	$200
Beneficio para examen de salud o para prevenir accidentes	Una vez al año para cada persona con cobertura	$50
Ingreso al hospital	Una vez por accidente	$1,500
Primera consulta con un médico	Una vez por accidente	$50
Alojamiento	Hasta 30 noches en toda la vida	$150
Equipo médico	Una vez por accidente	$100
Centro de rehabilitación	Hasta 15 días en toda la vida	$100
Transporte	Hasta 3 viajes por accidente	$500
Atención de urgencia	Una vez por accidente	$50
Radiografía	Una vez por accidente	$50
LESIÓN Y CIRUGÍA ESPECÍFICAS		
Cirugía abdominal/torácica	Una vez por accidente	$1,500
Cirugía artroscópica	Una vez por accidente	$150
Quemadura	Una vez por accidente	Hasta $10,000
Quemadura – Injerto de piel	Una vez por accidente para las quemaduras de tercer grado	50 % del beneficio por quemaduras
Contusión	Hasta 3 por año	$150
Luxación	Una vez por articulación en toda la vida	Hasta $6,000
Lesión ocular	Una vez por accidente	Hasta $300

Fractura	Una vez por hueso por accidente	Hasta $8,000
Reparación de hernia	Una vez por accidente	$150
Reemplazo de articulación	Una vez por accidente	$500
Cartílago de rodilla	Una vez por accidente	Hasta $750
Laceración	Una vez por accidente	Hasta $600
Desgarro de disco	Una vez por accidente	$800
Tendón/ligamento/manguito rotador	Una vez por accidente	Hasta $1,200
CATASTRÓFICO		
Muerte por accidente	En 90 días. Cónyuge al 50 % e hijo al 25 %	$50,000
Muerte en transporte público	En 90 días	3 veces el beneficio por fallecimiento
Coma	Una vez por accidente	Hasta $10,000
Pérdida de miembros	Una vez por accidente	Hasta $50,000
Cuidados domiciliarios	Hasta 30 días por accidente	$50
Parálisis	Una vez por accidente	Hasta $50,000
Prótesis	Una vez por accidente	Hasta $2,000
CARACTERÍSTICAS		
Ability Assist® EAP[2] (Programa de asistencia a empleados) – Acceso a asistencia por problemas financieros, legales o emocionales las 24 horas del día durante todo el año.		Incluida
HealthChampion[SM3] – Apoyo administrativo y clínico luego de una enfermedad o lesión grave.		Incluida

PRIMAS

Los montos que figuran a continuación son mensuales (12 pagos/descuentos al año):[4]

NIVEL DE COBERTURA	
Únicamente para el empleado	**$3.66** ($0.12 por día)
Empleado y cónyuge o pareja	**$5.76** ($0.19 por día)
Empleado e hijo/s	**$6.07** ($0.20 por día)
Empleado y familia	**$9.57** ($0.32 por día)

PREGUNTAS Y RESPUESTAS

¿QUIÉN ES ELEGIBLE?

Usted es elegible para tener este seguro si es un empleado activo y de jornada completa que trabaja por lo menos 20 horas semanales en horarios programados habitualmente.

Su cónyuge e hijo/s también son elegibles para tener la cobertura. Estos últimos deben ser menores de 26 años.

¿PUEDO ASEGURAR A MI CONCUBINO O PAREJA POR UNIÓN CIVIL?

Sí, toda referencia que se haga a «cónyuge» incluye a su concubino, pareja por unión civil o equivalente, según se reconoce y permite en la ley.

¿TENGO GARANTIZADA LA COBERTURA?

El seguro es una cobertura con emisión garantizada; es decir, está disponible sin que deba brindar información sobre la salud de usted ni la de su familia. Lo único que tiene que hacer para estar asegurado es elegir la cobertura.

¿CUÁNTO CUESTA EL SEGURO Y CÓMO LO ABONO?

Las primas figuran en la tabla anterior. Puede elegir el seguro solamente para usted o para usted y sus dependientes, según el nivel de cobertura que corresponda.

Las primas se pagarán automáticamente mediante descuentos a la nómina, de acuerdo con su autorización durante el proceso de inscripción. Así, no tendrá que preocuparse de hacer un cheque o si se olvida de realizar un pago.

¿CUÁNDO PUEDO INSCRIBIRME?

Puede inscribirse en cualquier período de inscripción previsto o dentro de los 31 días a partir de la fecha en que tuvo un cambio en su situación familiar.

¿CUÁNDO COMIENZA EL SEGURO?

El seguro entrará en vigencia según los términos del certificado (generalmente, el primer día del mes posterior a la fecha en que eligió la cobertura).

Usted tiene que estar trabajando de manera activa para su empleador el día en que la cobertura entre en vigencia. Su cónyuge e hijo/s deben estar realizando actividades normales y no estar internados (en la casa, hospital o institución de salud), excepto que ya estuviesen asegurados con la aseguradora anterior.

¿CUÁNDO TERMINA EL SEGURO?

El seguro concluirá cuando usted o sus dependientes ya no reúnan las condiciones correspondientes para tenerlo, haya primas impagas, ya no realice tareas activas, deje de trabajar para su empleador o ya no se ofrezca la cobertura.

¿PUEDO CONTINUAR CON EL SEGURO SI DEJO DE TRABAJAR PARA MI EMPLEADOR O SI YA NO SOY UN MIEMBRO DEL GRUPO?

Sí, puede seguir con la cobertura. La cobertura para usted y sus dependientes puede continuar con una póliza de transferibilidad colectiva. Su cónyuge también puede mantener el seguro en determinadas circunstancias. Los términos específicos y las circunstancias habilitantes para la transferibilidad se describen en el certificado.

[1] National Health Statistics Reports (Informes de estadísticas sanitarias nacionales), noviembre de 2019. CDC (Centros para el Control y la Prevención de Enfermedades)/Centro nacional de estadísticas sanitarias: https://www.cdc.gov/nchs/data/nhsr/nhsr133-508.pdf, consultado el 14/10/2020.
[2] Los servicios de AbilityAssist® los brinda ComPsych® mediante The Hartford. ComPsych no se encuentra afiliado a The Hartford y no provee servicios de seguros. The Hartford no es responsable ni contraerá ninguna obligación por los bienes y servicios que presta ComPsych, y se reserva el derecho a suspender cualquiera de estos servicios en cualquier momento. AbilityAssist es una marca registrada de The Hartford. Es posible que los servicios no estén disponibles en todos los estados. Para obtener más información, visite https://www.thehartford.com/employee-benefits/value-added-services.
[3] Los servicios de HealthChampion los brinda ComPsych® mediante The Hartford. ComPsych no se encuentra afiliado a The Hartford y no provee servicios de seguros. The Hartford no brinda seguros hospitalarios básicos, ni seguros de salud básicos o principales. Los especialistas de HealthChampion solo se encuentran disponibles durante las horas de atención. Para consultas fuera de ese horario, puede solicitar que lo llamen al día siguiente o coordinar una cita. The Hartford no es responsable ni contraerá ninguna obligación por los bienes y servicios que presta ComPsych, y se reserva el derecho a suspender cualquiera de estos servicios en cualquier momento. Health Champion es una marca de servicios de ComPsych. Es posible que los servicios no estén disponibles en todos los estados.
Para obtener más información, visite: https://www.thehartford.com/employee-benefits/value-added-services.
[4] Pueden modificarse las tasas o los beneficios según la clase.

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The Hartford remunera tanto a los productores internos como a los externos, así como a otros, por la venta y la prestación de sus productos. Para obtener más información sobre las prácticas de remuneración de Hartford, consulte el sitio web: http://thehartford.com/group-benefits-producer-compensation. La serie de formularios del seguro por accidente incluye GBD-2000, GBD-2300 o su equivalente estatal. 5962g NS 08/21

LIMITACIONES Y EXCLUSIONES

En la cobertura del seguro se contemplan ciertas limitaciones y exclusiones. En el certificado se detallan todas las disposiciones, limitaciones y exclusiones de esta cobertura de seguro. Puede solicitar una copia a su empleador.

SEGURO COLECTIVO POR ACCIDENTE

LIMITACIONES Y EXCLUSIONES

Los beneficios que corresponde pagarse se basan en el seguro vigente a la fecha del accidente con cobertura, sujetos a las definiciones, las limitaciones, las exclusiones y demás disposiciones de la póliza.

Tanto usted como sus dependientes deben ser ciudadanos o residentes legales de los Estados Unidos, sus territorios y protectorados.

Con este seguro no se brindan beneficios para pérdidas que hayan sido consecuencia de o causadas por:

- Suicidio o intento de suicidio, ya sea estando la persona en su sano juicio o no, o lesiones autoinfligidas intencionalmente.
- Guerra o acto bélico, ya sea declarado o no, o un hecho nuclear, químico, biológico o radiológico.
- La participación de una persona con cobertura en un delito grave, disturbio o levantamiento.
- El servicio de una persona con cobertura en las fuerzas armadas o sus unidades auxiliares.
- Que una persona con cobertura consuma drogas, a no ser que un médico se las haya administrado o según indicación médica, según la definición que establece la jurisdicción en donde ocurrió la causa del siniestro.
- La enfermedad o infección bacteriana de una persona con cobertura.
- Que una persona con cobertura haga puenting o aladeltismo.
- Que una persona con cobertura participe o compita en deportes semiprofesionales o profesionales.
- Cirugía cosmética u otro procedimiento optativo que no es necesario desde el punto de vista médico.
- Mientras una persona con cobertura se encuentra en una aeronave: como piloto, miembro de la tripulación o aprendiz de piloto; como instructor o evaluador de vuelo; si el titular de la póliza es el propietario, la maneja o la alquila, ya sea él o en su nombre, así como otro empleador u organización cuyas personas que son elegibles están cubiertas con la póliza; o se utiliza para realizar pruebas, experimentos, vuelos de acrobacia, carreras o pruebas de resistencia.
- Manejar una aeronave, aprender a hacerlo, prestar servicios como miembro de la tripulación en una o saltar o tirarse de una.
- Subirse a cualquier vehículo motor o manejarlo en una carrera, espectáculo de acrobacia o prueba de velocidad.

Pueden no corresponder todas las exclusiones, o pueden adaptarse, según lo exijan las normas del estado *in situ* del grupo.

AVISOS

SE TRATA DE UNA PÓLIZA LIMITADA MEDIANTE LA QUE SE OTORGAN BENEFICIOS POR ACCIDENTE ÚNICAMENTE

CON ESTA PÓLIZA LIMITADA SE OTORGAN BENEFICIOS POR ACCIDENTE ÚNICAMENTE.

Este plan de beneficios de salud limitado (1) no es una cobertura de salud principal y (2) no cumple con la obligación individual establecida por la Ley de Cuidado de la Salud Asequible (ACA, según sus siglas en inglés) porque no reúne las condiciones para ofrecer una cobertura mínima y esencial. En Nueva York: Con esta póliza se brinda únicamente un seguro por ACCIDENTE. NO se ofrece un seguro hospitalario básico, ni un seguro de salud básico o principal, según la definición del Departamento de Servicios Financieros de Nueva York. AVISO IMPORTANTE: CON ESTA PÓLIZA NO SE BRINDA COBERTURA POR ENFERMEDAD.

5962g NS 05/21 La serie de formularios del seguro por accidente incluye GBD-2000, GBD-2300 o su equivalente estatal.

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CRITICAL ILLNESS

THE HARTFORD

GROUP VOLUNTARY CRITICAL ILLNESS INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

In the US, an estimated 40 out of 100 men and 39 out of 100 women will develop cancer during their lifetime.[1]

Pharr-San Juan-Alamo Independent School District

Facing a serious illness can be challenging both emotionally and financially. Major medical insurance may pick up most of the tab, but can still leave out-of-pocket expenses that add up quickly. Critical Illness insurance can provide a lump-sum benefit upon diagnosis of a covered illness that can be used however you choose - from expenses related to treatment, to deductibles or day-to-day costs of living such as the mortgage or your utility bills.

To learn more about Critical Illness insurance, visit **thehartford.com/employee-benefits/employees**

COVERAGE INFORMATION

Benefit amounts for covered illnesses are based on the coverage amount in effect for you or an insured dependent at the time of diagnosis.

COVERAGE AMOUNT	
Employee Coverage Amount	$10,000; $20,000 or $30,000
Spouse Coverage Amount	50% of your coverage amount
Child(ren) Coverage Amount	50% of your coverage amount
COVERED ILLNESSES	**BENEFIT AMOUNTS**
CANCER CONDITIONS	
Benign Brain Tumor; Invasive Cancer	100% of coverage amount
Non-invasive Cancer	25% of coverage amount
Non-melanoma Skin Cancer	$250 once per lifetime for each covered person
VASCULAR CONDITIONS	
Heart Attack (Myocardial Infarction); Heart Failure/Transplant; Stroke	100% of coverage amount
Coronary Artery Bypass Graft	25% of coverage amount
OTHER SPECIFIED CONDITIONS	
Coma	25% of coverage amount
End Stage Renal Failure	100% of coverage amount
Loss of Vision	100% of coverage amount
Major Organ Failure/Transplant	100% of coverage amount
Paralysis	100% of coverage amount
NEUROLOGICAL CONDITIONS	
Advanced Multiple Sclerosis; Advanced Parkinson's; Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's); Advanced Alzheimer's Disease	25% of coverage amount
ADDITIONAL BENEFITS	**BENEFIT AMOUNTS**
Health Screening Benefit	$100 once per year per covered person
FEATURES	**DETAILS**
Coverage Maximum – Primary Insured & Spouse	500% of coverage amount
Coverage Maximum – Child(ren)	300% of coverage amount
Ability Assist® EAP[3]– 24/7/365 access to help for financial, legal or emotional issues	
HealthChampion[SM4] – Administrative and clinical support following serious illness or injury	

PREMIUMS

See the Premium Worksheet.[5]

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible for this insurance if you are an active full-time employee who works at least 20 hours per week on a regularly scheduled basis.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

Yes. Any reference to “spouse” in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage – it is available without having to provide information about your or your family's health. All you have to do is elect the coverage to become insured.

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Premiums are provided on the Premium Worksheet. You have a choice of coverage amounts. You may elect insurance for you only, or for you and your dependent(s), by choosing the applicable coverage tier.

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don’t have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period, or within 31 days of the date you have a change in family status.

WHEN DOES THIS INSURANCE BEGIN?

Insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

WHEN DOES THIS INSURANCE END?

This insurance will end when you (or your dependents) no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this coverage with you. Coverage may be continued for you and your dependent(s) under a group portability policy. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for portability are described in the certificate.

[1]Cancer Facts and Figures, 2020. American Cancer Society: https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2020/cancer-facts-and-figures-2020.pdf, as viewed on October 14, 2020.

[3]AbilityAssist® services are offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Ability Assist is a registered trademark of The Hartford. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.

[4]HealthChampion℠ services are provided through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford doesn’t provide basic hospital, basic medical, or major medical insurance. HealthChampion℠ specialists are only available during business hours. Inquiries outside of this timeframe can either request a call-back the next day or schedule an appointment. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Health Champion is a service mark of ComPsych. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.

[5]Rates and/or benefits may be changed on a class basis. Rates are based on the age of the insured person and increase on the policy anniversary date on or following your birthday as you enter each new age category.

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LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP CRITICAL ILLNESS INSURANCE

LIMITATIONS AND EXCLUSIONS

The benefits payable are based on the insurance in effect on the date of the diagnosis of a covered illness, subject to the definitions, limitations, exclusions and other provisions of the policy.

You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

Benefit Separation Periods. If a covered person is diagnosed with a covered illness, and is subsequently diagnosed with another covered illness, the following separation periods apply between benefit payments. If the subsequent diagnosis is for: 1) A different, non-related covered illness than the first diagnosis (e.g. a cancer illness then a vascular illness), then a 6 month separation period applies; 2) A covered illness that is related to the first (e.g. two vascular illnesses, like heart attack and stroke), then a 6 month separation period applies; 3) The same covered illness as the first (e.g. two heart attacks) as allowed by the Recurrence Benefit, then a 12 month separation period applies.

Exclusions. This insurance does not provide benefits for any loss that results from or is caused by:

- Suicide, attempted suicide or intentionally self-inflicted injury, whether sane or insane
- War or act of war, declared or undeclared
- A covered person's participation in a felony, riot or insurrection
- A covered person's engaging in any illegal occupation
- A covered person's service in the armed forces or units auxiliary to them

General Limitations. Benefits under the policy are not payable for any covered illness:

- Diagnosed prior to the effective date of insurance for a covered person (except for newborn children)
- Diagnosed during an applicable benefit separation period
- For which a covered person has already received a benefit payment under the policy, unless the covered illness is included in a recurrence provision
- For which a covered person has already received a benefit payment under the recurrence provision

In addition, benefits are not payable for any critical illness not included as a covered illness in your certificate.

NOTICES

THIS POLICY PROVIDES LIMITED BENEFITS FOR SPECIFIED DISEASES ONLY.

This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage. In New York: This policy provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

Please note: For residents of CA, GA, NJ and NY, since this is a limited benefit health product, persons without comprehensive health benefits from an individual or group health insurance policy or an HMO, or an employer plan providing essential health benefits are not eligible for this insurance. In addition, NY residents covered by another Critical Illness or specified disease plan are not eligible for coverage. For residents of CT, ID, ME, NH, and WV, a person covered by any Title XIX program (Medicaid or any similar name) is not eligible for this insurance.

5962f NS 05/21 Critical Illness Form Series includes GBD-2600, GBD-2700, or state equivalent.

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Premium Worksheet

Rates and/or benefits can change.

You are considered a tobacco user if you have used any form of tobacco or nicotine replacement in the past 12 months.

VOLUNTARY CRITICAL ILLNESS INSURANCE
Monthly Premium Amount (Cost per Pay Period – 12/Year)
Premiums are based on the employee's current age and increase as the employee enters each new age category.

NON-TOBACCO USER

Benefit Amount	Coverage Tier	Under 29	30-39	40-49	50-59	60-69	70-79	80+
$10,000	Employee & Child(ren)	$2.40	$4.20	$7.90	$14.00	$22.70	$29.70	$45.60
	Employee & Family	$4.40	$7.60	$14.10	$24.60	$39.90	$52.00	$79.90
$20,000	Employee & Child(ren)	$4.80	$8.40	$15.80	$28.00	$45.40	$59.40	$91.20
	Employee & Family	$8.80	$15.20	$28.20	$49.20	$79.80	$104.00	$159.80
$30,000	Employee & Child(ren)	$7.20	$12.60	$23.70	$42.00	$68.10	$89.10	$136.80
	Employee & Family	$13.20	$22.80	$42.30	$73.80	$119.70	$156.00	$239.70

VOLUNTARY CRITICAL ILLNESS INSURANCE
Monthly Premium Amount (Cost per Pay Period – 12/Year)
Premiums are based on the employee's current age and increase as the employee enters each new age category.

TOBACCO USER

Benefit Amount	Coverage Tier	Under 29	30-39	40-49	50-59	60-69	70-79	80+
$10,000	Employee & Child(ren)	$3.10	$5.80	$12.50	$20.90	$34.60	$45.60	$70.20
	Employee & Family	$5.40	$10.00	$21.10	$35.40	$58.30	$77.00	$118.50
$20,000	Employee & Child(ren)	$6.20	$11.60	$25.00	$41.80	$59.20	$91.20	$140.40
	Employee & Family	$10.80	$20.00	$42.20	$70.80	$116.60	$144.00	$237.00
$30,000	Employee & Child(ren)	$9.30	$17.40	$37.50	$62.70	$103.80	$136.80	$210.60
	Employee & Family	$16.20	$30.00	$63.30	$106.20	$174.90	$231.00	$355.50

5962f NS 07/21 Critical Illness Form Series includes GBD-1700, GBD-1701, or state equivalent.

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CREATION DATE: 7/5/2022
PHARR-SAN JUAN-ALAMO INDEPENDENT SCHOOL DISTRICT/00141548

RESUMEN DE BENEFICIOS DEL SEGURO COLECTIVO Y VOLUNTARIO POR ENFERMEDAD GRAVE

THE HARTFORD

Se prevé que, en Estados Unidos, unos 40 de cada 100 varones y cerca de 39 de cada 100 mujeres tendrán cáncer en algún momento de sus vidas.[1]

Distrito escolar independiente de Pharr-San Juan-Alamo

Enfrentar una enfermedad grave puede ser complejo tanto a nivel emocional como económico. Si bien es posible que el seguro médico principal pague la mayor parte de los costos, puede haber gastos que se acumulan rápidamente y que corren por cuenta del asegurado. Con el seguro por enfermedad grave puede abonarse el beneficio en un solo pago en el momento del diagnóstico de una afección con cobertura y utilizarse para pagar lo que usted elija: desde los gastos relacionados con el tratamiento hasta deducibles o costos de vida diarios, como la hipoteca o las facturas de los servicios públicos.

Para saber más sobre el seguro por enfermedad grave, visite: **thehartford.com/employee-benefits/employees**

INFORMACIÓN DE LA COBERTURA

Los montos de los beneficios para las enfermedades con cobertura se establecen de acuerdo con la cantidad de cobertura que esté vigente en el momento del diagnóstico para usted o un dependiente asegurado.

MONTOS DE LA COBERTURA	
Monto de la cobertura para el empleado	$10,000; $20,000 o $30,000
Monto de la cobertura para el cónyuge	50 % del monto de su cobertura
Monto de la cobertura para hijo/s	50 % del monto de su cobertura
ENFERMEDADES CON COBERTURA	**MONTO DEL BENEFICIO**
ENFERMEDADES DE CÁNCER	
Tumor cerebral benigno, cáncer invasivo	100 % del monto de la cobertura
Cáncer no invasivo	25 % del monto de la cobertura
Cáncer de piel, excepto el melanoma	$250 una vez en toda la vida para cada persona con cobertura
ENFERMEDADES VASCULARES	
Ataque al corazón (infarto de miocardio), insuficiencia cardíaca/trasplante de corazón, ataque cerebrovascular	100 % del monto de la cobertura
Injerto de revascularización coronaria	25 % del monto de la cobertura
OTRAS ENFERMEDADES ESPECÍFICAS	
Coma	25 % del monto de la cobertura
Insuficiencia renal en fase terminal	100 % del monto de la cobertura
Pérdida de la visión	100 % del monto de la cobertura
Insuficiencia/trasplante de órgano principal	100 % del monto de la cobertura
Parálisis	100 % del monto de la cobertura
ENFERMEDADES NEUROLÓGICAS	
Esclerosis múltiple avanzada, enfermedad de Parkinson avanzada, esclerosis lateral amiotrófica (ELA o enfermedad de Lou Gehrig), enfermedad de Alzheimer avanzada	25 % del monto de la cobertura
BENEFICIOS ADICIONALES	**MONTO DEL BENEFICIO**
Beneficio para examen de salud	$100 una vez al año por persona con cobertura
CARACTERÍSTICAS	**DETALLES**
Máximo de la cobertura – Asegurado principal y cónyuge	500 % del monto de la cobertura
Máximo de la cobertura – Hijo/s	300 % del monto de la cobertura
Ability Assist® EAP[3] (Programa de asistencia a empleados) – Acceso a asistencia por problemas financieros, legales o emocionales las 24 horas del día durante todo el año.	
HealthChampion[SM4] – Apoyo administrativo y clínico luego de una enfermedad o lesión grave.	

PRIMAS

Consulte la planilla con las primas.[5]

PREGUNTAS Y RESPUESTAS

¿QUIÉN ES ELEGIBLE?

Usted es elegible para tener este seguro si es un empleado activo y de jornada completa que trabaja por lo menos 20 horas semanales en horarios programados habitualmente.

Su cónyuge e hijo/s también son elegibles para tener la cobertura. Estos últimos deben ser menores de 26 años.

¿PUEDO ASEGURAR A MI CONCUBINO O PAREJA POR UNIÓN CIVIL?

Sí, toda referencia que se haga a «cónyuge» incluye a su concubino, pareja por unión civil o equivalente, según se reconoce y permite en la ley.

¿TENGO GARANTIZADA LA COBERTURA?

El seguro es una cobertura con emisión garantizada; es decir, está disponible sin que deba brindar información sobre la salud de usted ni la de su familia. Lo único que tiene que hacer para estar asegurado es elegir la cobertura.

¿CUÁNTO CUESTA EL SEGURO Y CÓMO LO ABONO?

Las primas figuran en la planilla correspondiente. Tiene varias cantidades de cobertura para elegir. Puede elegir el seguro solamente para usted o para usted y sus dependientes, según el nivel de cobertura que corresponda.

Las primas se pagarán automáticamente mediante descuentos a la nómina, de acuerdo con su autorización durante el proceso de inscripción. Así, no tendrá que preocuparse de hacer un cheque o si se olvida de realizar un pago.

¿CUÁNDO PUEDO INSCRIBIRME?

Puede inscribirse en cualquier período de inscripción previsto o dentro de los 31 días a partir de la fecha en que tuvo un cambio en su situación familiar.

¿CUÁNDO COMIENZA EL SEGURO?

El seguro entrará en vigencia según los términos del certificado (generalmente, el primer día del mes posterior a la fecha en que eligió la cobertura).

Usted tiene que estar trabajando de manera activa para su empleador el día en que la cobertura entre en vigencia. Su cónyuge e hijo/s deben estar realizando actividades normales y no estar internados (en la casa, hospital o institución de salud), excepto que ya estuviesen asegurados con la aseguradora anterior.

¿CUÁNDO TERMINA EL SEGURO?

El seguro concluirá cuando usted (o sus dependientes ya no reúnan las condiciones correspondientes para tenerlo, haya primas impagas, ya no realice tareas activas, deje de trabajar para su empleador o ya no se ofrezca la cobertura.

¿PUEDO CONTINUAR CON EL SEGURO SI DEJO DE TRABAJAR PARA MI EMPLEADOR O SI YA NO SOY UN MIEMBRO DEL GRUPO?

Sí, puede seguir con la cobertura. La cobertura para usted y sus dependientes puede continuar con una póliza de transferibilidad colectiva. Su cónyuge también puede mantener el seguro en determinadas circunstancias. Los términos específicos y las circunstancias habilitantes para la transferibilidad se describen en el certificado.

[1] Cancer Facts and Figures (Datos y números sobre el cáncer), 2020. Sociedad Estadounidense contra el Cáncer: https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2020/cancer- facts-and-figures-2020.pdf, consultado el 14 de octubre de 2020.

[3] Los servicios de AbilityAssist® los brinda ComPsych® mediante The Hartford. ComPsych no se encuentra afiliado a The Hartford y no provee servicios de seguros. The Hartford no es responsable ni contraerá ninguna obligación por los bienes y servicios que presta ComPsych, y se reserva el derecho a suspender cualquiera de estos servicios en cualquier momento. Ability Assist es una marca registrada de The Hartford. Es posible que los servicios no estén disponibles en todos los estados.Para obtener más información, visite: https://www.thehartford.com/employee-benefits/value-added-services.

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[5] Pueden modificarse las tasas o los beneficios según la clase. Las tasas se determinan según la edad de la persona asegurada y aumentan en la fecha de aniversario de la póliza en su cumpleaños o posteriormente cuando usted ingresa en una nueva categoría etaria.

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LIMITACIONES Y EXCLUSIONES

En la cobertura del seguro se contemplan ciertas limitaciones y exclusiones. En el certificado se detallan todas las disposiciones, limitaciones y exclusiones de esta cobertura de seguro. Puede solicitar una copia a su empleador.

SEGURO COLECTIVO POR ENFERMEDAD GRAVE

LIMITACIONES Y EXCLUSIONES

Los beneficios que corresponde pagarse se basan en el seguro vigente a la fecha del diagnóstico de una enfermedad con cobertura, sujetos a las definiciones, las limitaciones, las exclusiones y demás disposiciones de la póliza.

Tanto usted como sus dependientes deben ser ciudadanos o residentes legales de los Estados Unidos, sus territorios y protectorados.

Períodos de separación entre beneficios. Si a una persona que está cubierta se le diagnostica una afección con cobertura y, posteriormente, se le diagnostica otra enfermedad con cobertura, corresponderán los siguientes períodos de separación entre el pago de los beneficios. Si el diagnóstico posterior se trata de: 1) una enfermedad que está cubierta, que es diferente y que no guarda relación con el primer diagnóstico (ej.: cáncer seguido de una enfermedad vascular), corresponderá un período de separación de 6 meses; 2) una enfermedad que está cubierta y que tiene relación con la primera (ej.: dos enfermedades vasculares, como un ataque al corazón y un ataque cerebrovascular), habrá un período de separación de 6 meses; 3) la misma enfermedad con cobertura que la primera (ej.: dos ataques al corazón), según lo permitido en la cláusula de recurrencia, corresponderá un período de separación de 12 meses.

Exclusiones. Con este seguro no se brindan beneficios para pérdidas que hayan sido consecuencia de o causadas por:

- Suicidio, intento de suicidio o lesiones autoinfligidas intencionalmente, ya sea estando la persona en su sano juicio o no.
- Guerra o acto bélico, ya sea declarado o no.
- La participación de una persona con cobertura en un delito grave, disturbio o levantamiento.
- La participación de una persona con cobertura en alguna actividad ilegal.
- El servicio de una persona con cobertura en las fuerzas armadas o sus unidades auxiliares.

Limitaciones generales. Los beneficios que se brindan con la póliza no se abonan para ninguna enfermedad con cobertura:

- Que se haya diagnosticado antes de la fecha en la que el seguro entrara en vigencia para una persona con cobertura (excepto recién nacidos).
- Que se haya diagnosticado durante el período de separación que correspondiera entre beneficios.
- Para la cual una persona con cobertura ya haya recibido el pago de los beneficios con esta póliza, excepto que la enfermedad con cobertura se encuentre en la cláusula de recurrencia.
- Para la cual una persona con cobertura ya haya recibido el pago de los beneficios por medio de la cláusula de recurrencia.

Además, no se abonan beneficios por ninguna afección grave que no se encuentre incluida en su certificado como una enfermedad con cobertura.

AVISOS

CON ESTA PÓLIZA SE BRINDAN BENEFICIOS LIMITADOS PARA ENFERMEDADES ESPECÍFICAS ÚNICAMENTE.

Este plan de beneficios de salud limitado (1) no es una cobertura de salud principal y (2) no cumple con la obligación individual establecida por la Ley de Cuidado de la Salud Asequible (ACA, según sus siglas en inglés) porque no reúne las condiciones para ofrecer una cobertura mínima y esencial. En Nueva York: Con esta póliza se brinda una cobertura de salud con beneficios limitados únicamente. NO se ofrece un seguro hospitalario básico, ni un seguro de salud básico o principal, según la definición del Departamento de Servicios Financieros de Nueva York.

Tenga en cuenta lo siguiente: Si reside en California, Georgia, Nueva Jersey o Nueva York, dado que se trata de un producto con beneficios de salud limitados, las personas que no cuenten con beneficios de salud integrales mediante una póliza de seguros de salud individual o colectiva, un seguro de salud (HMO, por sus siglas en inglés) o un plan del empleador que brinde beneficios de salud esenciales, no son elegibles para tener este seguro. Además, los residentes de Nueva York que estén cubiertos por otro plan por enfermedad grave o enfermedad específica no son elegibles para obtener la cobertura. Para lo residentes de Connecticut, Idaho, Maine, Nuevo Hampshire y Virginia Occidental: La persona que tenga la cobertura de un programa del Título XIX (ya sea Medicaid o de nombre similar) no es elegible para tener el seguro.

5962f NS 05/21 La serie de formularios del seguro por enfermedad grave incluye GBD-2600, GBD-2700 o su equivalente estatal.

Planilla con las primas

Pueden modificarse las tasas o los beneficios.

Se lo considera consumidor de tabaco si utilizó alguna forma de tabaco o reemplazo de la nicotina en los últimos 12 meses.

SEGURO VOLUNTARIO POR ENFERMEDAD GRAVE
Monto de la prima mensual (costo por período de pago – 12/año)
Las primas se calculan de acuerdo con la edad actual del empleado y aumentan conforme este ingresa en una nueva categoría etaria.

NO CONSUME TABACO

Monto del beneficio	Nivel de cobertura	Menor de 29	30-39	40-49	50-59	60-69	70-79	80 en adelante
$10,000	Empleado e hijo/s	$2.40	$4.20	$7.90	$14.00	$22.70	$29.70	$45.60
	Empleado y familia	$4.40	$7.60	$14.10	$24.60	$39.90	$52.00	$79.90
$20,000	Empleado e hijo/s	$4.80	$8.40	$15.80	$28.00	$45.40	$59.40	$91.20
	Empleado y familia	$8.80	$15.20	$28.20	$49.20	$79.80	$104.00	$159.80
$30,000	Empleado e hijo/s	$7.20	$12.60	$23.70	$42.00	$68.10	$89.10	$136.80
	Empleado y familia	$13.20	$22.80	$42.30	$73.80	$119.70	$156.00	$239.70

SEGURO VOLUNTARIO POR ENFERMEDAD GRAVE
Monto de la prima mensual (costo por período de pago – 12/año)
Las primas se calculan de acuerdo con la edad actual del empleado y aumentan conforme este ingresa en una nueva categoría etaria.

CONSUME TABACO

Monto del beneficio	Nivel de cobertura	Menor de 29	30-39	40-49	50-59	60-69	70-79	80 en adelante
$10,000	Empleado e hijo/s	$3.10	$5.80	$12.50	$20.90	$34.60	$45.60	$70.20
	Empleado y familia	$5.40	$10.00	$21.10	$35.40	$58.30	$77.00	$118.50
$20,000	Empleado e hijo/s	$6.20	$11.60	$25.00	$41.80	$59.20	$91.20	$140.40
	Empleado y familia	$10.80	$20.00	$42.20	$70.80	$116.60	$144.00	$237.00
$30,000	Empleado e hijo/s	$9.30	$17.40	$37.50	$62.70	$103.80	$136.80	$210.60
	Empleado y familia	$16.20	$30.00	$63.30	$106.20	$174.90	$231.00	$355.50

5962f NS 07/21 La serie de formularios del seguro por enfermedad grave incluye GBD-1700, GBD-1701 o su equivalente estatal.

The Buck's Got Your Back®

FECHA DE ELABORACIÓN: 5/7/2022
DISTRITO ESCOLAR INDEPENDIENTE DE PHARR-SAN JUAN-ALAMO/00141548

HOW TO SUBMIT A CLAIM FOR CRITICAL ILLNESS AND ACCIDENT INSURANCE

Experiencing an illness and/or an accident can be challenging. Now you need to file a claim, and the process may seem overwhelming. But The Hartford is here to make this as easy as possible.

REFERENCE THE ACTION STEPS AND RESOURCES BELOW TO HELP YOU WITH YOUR CLAIM.

ACTION	
When should a claim be filed?	**Critical Illness*** • After a physician has diagnosed you or a covered dependent with a covered illness. • After you or a covered dependent have undergone a health screening and are eligible for a wellness or health screening benefit.
	Accident • After you or your covered dependents receive services performed as a result of an accident. • After you or a covered dependent have undergone a health screening and are eligible for a wellness or health screening benefit.
Who can file a claim and how?	Anyone insured under the policy, or an authorized representative, can file a claim at any time, from anywhere. You can file your claim in different ways depending on what's most convenient to you: **1. ONLINE** • Visit the Supplemental Insurance Claims Portal at TheHartford.com/benefits/myclaim. • Register for access if you have not done so already. (Please note: We must have current eligibility from your benefits administrator for you and any dependents to be eligible to register on the portal.) • Log in to the portal. • Click on **"Complete Your Claim Form Online"** under the Quick Links section. • Follow the prompts to complete and submit a claim. **2. FILE A CLAIM OVER THE PHONE** (Applicable to Health Screening Benefit/Accident Protection Benefit Only) • File your claim by calling **866-547-4205** • Available Monday through Friday, 8:00 a.m. – 6:00 p.m. EST. **3. SUBMIT A CLAIM VIA MAIL OR FAX** • Download a claim form at **TheHartford.com/benefits/myclaim**. • Complete the form and mail or fax it to: The Hartford Supplemental Insurance Benefit Department P.O. Box 99906 Grapevine, TX 76099 Fax Number: 469-417-1952 For assistance filing your claim, call **866-547-4205**

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ACTION	
What information will you need to provide when submitting your claim?	• The form will ask you to provide some information about you, and if you're filing the claim for a dependent, their information as well. • Then, select which type of claim you're filing. Continue through the form, only filling out the relevant sections. • In the Benefit Information section, check off each box that applies to the event or services you received as a result of your covered illness and/or accident. • Be sure you sign the Authorization to Obtain and Disclose Information (which helps us obtain information for the claim from medical providers, if needed) and sign the claim form itself. In addition to filling out the form, you'll also need to provide supporting documentation to prove the claim. **Examples of documents include:** ER, urgent care, physician visit or hospital discharge papers; exam, lab or test results/reports; physician notes; Explanation of Benefits (EOBs) from your health insurance provider; itemized medical or hospital bills; or medical records. Please call us for guidance with your claim submission – we're happy to help you understand how to complete the claim successfully. By thoroughly completing the form and gathering your documentation, we'll be able to better serve you and ensure your claim is processed as quickly as possible. We may also need to work with medical providers to fully prove your claim, but we'll let you know during the claims process if this is necessary.
What happens next?	After you submit your claim, our dedicated claims team will review the claim and contact you with any questions or to request additional information needed for your claim. Our goal is to ensure you receive all benefits you're entitled to, as quickly as possible. We will review your total voluntary benefits coverage with The Hartford to determine if you might be eligible for additional benefits based on other insurance policies you've purchased. If you are filing a Critical Illness claim and forgot to tell us about an accident for an Accident claim, for example, we've got you covered. Once the claim has been approved, the standard turnaround time for benefits to be paid is between 3-10 business days.[1] Standard mail times will apply (if applicable). In the meantime, if you filed your claim online, you can use the site to monitor your claim status and access additional claims-related information at **TheHartford.com/benefits/myclaim**. For all claims, claims status or questions, you are welcome to call **866-547-4205**

TO GET STARTED,

visit **TheHartford.com/benefits/myclaim**

Or for assistance contact our Customer Service Center at **866-547-4205**

THE HARTFORD

[1] Based on average claims turnaround time.

5704 05/21

CÓMO PRESENTAR UNA RECLAMACIÓN PARA RECIBIR LOS BENEFICIOS DEL SEGURO POR ENFERMEDAD CRÍTICA E ACCIDENTE

Experimentar una enfermedad y/o un accidente puede ser difícil. Ahora es momento de presentar una reclamación, un proceso que puede parecer abrumador. Pero The Hartford está aquí para hacerlo lo más fácil posible.

CONSULTE LOS SIGUIENTES PASOS Y RECURSOS PARA AYUDARLE A PRESENTAR SU RECLAMACIÓN.

PASOS	
¿Cuándo se debe presentar una reclamación?	**Enfermedad crítica*** • Después de que un médico le haya dado un diagnóstico a usted o a un dependiente cubierto que tenga una enfermedad cubierta. • Después de que usted o un dependiente cubierto se hayan realizado un chequeo médico y sean elegibles para recibir un beneficio de chequeo médico o de bienestar.
	Accidente • Después de que usted o sus dependientes cubiertos reciban servicios prestados a causa de un accidente. • Después de que usted o un dependiente cubierto se hayan realizado un chequeo médico y sean elegibles para recibir un beneficio de chequeo médico o de bienestar.
¿Quién puede presentar una reclamación y cómo?	Cualquier asegurado conforme a la póliza, o un representante autorizado, puede presentar una reclamación en cualquier momento y en cualquier lugar. Hay diferentes maneras de presentar una reclamación, según lo que más le convenga: **1. EN LÍNEA** • Visite el Portal de Reclamaciones de Seguros Complementarios en TheHartford.com/benefits/myclaim. • Regístrese para poder acceder si todavía no lo ha hecho. (Nota importante: su administrador de beneficios debe confirmar que usted y sus dependientes son elegibles para poder registrarse en el portal.) • Inicie sesión en el portal.. • Haga clic en **"Complete Your Claim Form Online"** (Completar el formulario de reclamación en línea) debajo de la sección de Enlaces rápidos. • Siga las indicaciones para realizar y presentar una reclamación. **2. POR TELÉFONO** (solo aplica a los beneficios de protección contra accidentes y a los beneficios de chequeo médico) • Para presentar su reclamación llame al **866-547-4205** • Horario de atención de lunes a viernes de 8:00 a.m. a 6:00 p.m. EST. **3. POR CORREO POSTAL O FAX** • Descargue un formulario de reclamación en **TheHartford.com/benefits/myclaim**. • Complete el formulario y envíelo por correo postal o fax a: The Hartford Supplemental Insurance Benefit Department P.O. Box 99906 Grapevine, TX 76099 Número de fax: 469-417-1952. Si necesita ayuda para presentar su reclamación, llame al **866-547-4205**

THE HARTFORD

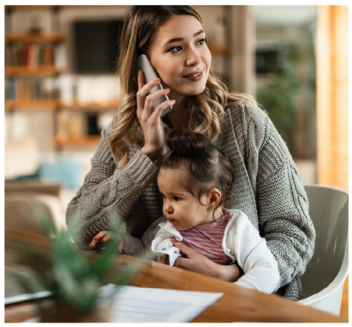
PASOS	
¿Qué información deberá proporcionar al presentar su reclamación?	• En el formulario se le pedirá que proporcione información personal, y si presenta una reclamación en nombre de un dependiente, también deberá proporcionar la información de este. • Posteriormente, seleccione el tipo de reclamación que desea presentar. Continúe con el formulario, completando únicamente las secciones pertinentes. • En la sección "Benefit Information" (Información sobre beneficios), marque cada casilla que aplique al evento o los servicios que recibió a causa de su enfermedad u accidente cubiertos. • Asegúrese de firmar la autorización para obtener y divulgar información (que nos ayuda a obtener información sobre la reclamación de parte de los proveedores médicos, si es necesario) y firme el formulario de reclamación. Además de rellenar el formulario, también deberá proporcionar documentación de respaldo para demostrar la reclamación. **Algunos documentos podrían ser:** documentación de la visita a una sala de emergencias, cuidados urgentes, consultas médicas y alta hospitalaria; resultados/reportes de pruebas o exámenes de laboratorio; notas del médico; Explicación de Beneficios (EOBs, por sus siglas en inglés) de su proveedor de seguro de salud; facturas médicas u hospitalarias desglosadas por artículos; o registros médicos. Llámenos en caso de que necesite ayuda para presentar su reclamación; estaremos muy complacidos de ayudarle a comprender cómo presentarla exitosamente. Si completa el formulario y recopila de manera minuciosa la documentación, podremos darle un mejor servicio y tramitar su reclamación lo antes posible. También puede que necesitemos trabajar con sus proveedores médicos para demostrar completamente su reclamación, pero le avisaremos durante el proceso si esto resulta necesario.
¿Qué sucede después?	Después de que presente su reclamación, nuestro equipo especializado en reclamaciones revisará su reclamación y se pondrá en contacto con usted si tiene alguna pregunta o si desea solicitar información adicional respecto a la misma. Nuestra meta es asegurar que reciba todos los beneficios que le correspondan, lo más rápido posible. Analizaremos su cobertura total de beneficios como voluntario con The Hartford para determinar si usted podría ser elegible para los beneficios adicionales en función de otras políticas de seguro que ha adquirido. Por ejemplo, si presenta una reclamación por enfermedad crítica y se le olvidó contarnos sobre una hospitalización como parte de una reclamación por indemnización hospitalaria, lo tendremos cubierto. Una vez que se haya aprobado la reclamación, el plazo normal de pago de los beneficios es de 3 a 10 días hábiles.[1] Aplicarán los tiempos de envío estándar (si corresponde). Mientras tanto, si usted presentó una reclamación en línea, puede usar el sitio web para monitorear el estado de su reclamación y acceder a información adicional relacionada con su reclamación en **TheHartford.com/benefits/myclaim**. Respecto a cualquier reclamación, no dude en llamar al si desea consultar el estado de su reclamación o tiene alguna pregunta, llamar al **866-547-4205**

PARA COMENZAR,
visite **TheHartford.com/benefits/myclaim**
o llame a nuestro Centro de Servicio al Cliente al **866-547-4205** si.

THE HARTFORD

5704 SP 05/21

FILE A HEALTH SCREENING CLAIM WITH CONFIDENCE



HEALTHY LIFESTYLES ARE REWARDED AT THE HARTFORD

Pharr-San Juan-Alamo ISD offers Accident and Critical Illness insurance coverage from The Hartford that includes a health screening benefit. You and each of your dependents are eligible to receive a health screening benefit per covered person for each year that you're enrolled in the plan and upon filing a claim.[2]

And, if you enroll in more than one coverage, one health screening benefit is eligible for each coverage. Check out the list on the next page to determine if your health screening is eligible for the benefit.

THE HARTFORD MAKES IT EASY TO FILE A CLAIM. JUST FOLLOW THESE STEPS:

STEP 1

Review the list on the next page to determine if your health screening may be eligible for the benefit.

STEP 2

Prepare to file your claim.[1] You'll need the following information:

- Name, address and the group policy number;
- Name of the health screening or test performed and the date completed; and
- Details of where the health screening was received and physician contact information (if applicable).

STEP 3 – OVER THE PHONE

- File your claim by calling **866-547-4205**.
- Phones are open Monday through Friday, 8:00am – 6:00pm EST.

STEP 3 – ONLINE

- Visit the Supplemental Insurance Claims Portal at **TheHartford.com/benefits/myclaim**.
- Register for access if you have not done so already. (Please note: We must have current eligibility from your benefits administrator for you and any dependents to be eligible to register on the portal.)
- Log in to the portal.
- Click on "Complete Your Claim Form Online" under the Quick Links section.
- Follow the prompts to complete and submit a Health Screening Benefit claim.

NEXT STEPS

- Once the claim has been approved, the standard turnaround time for benefits to be paid is between 3–10 business days.[3]
- Standard mail times will apply (if applicable).

TO FILE YOUR HEALTH SCREENING CLAIM:

CALL THIS NUMBER:

866-547-4205
Monday through Friday,
8:00am – 6:00pm EST

VISIT US ONLINE:

TheHartford.com/benefits/myclaim
(Submit a claim online or download your health screening benefit form here.)

YOU'LL NEED TO PROVIDE:

- Name, address and the group policy number.
- Name of the health screening or test performed and the date completed.
- Details of where the health screening was received and physician contact info (if applicable).

MAIL OR FAX THE DOCUMENTATION TO:

THE HARTFORD
SUPPLEMENTAL INSURANCE
BENEFIT DEPARTMENT

P.O. Box 99906
Grapevine, TX 76099
Fax Number: 469-417-1952

(Snap a photo with a mobile device to capture information above.)

ELIGIBLE HEALTH SCREENINGS[4]

- Bone Marrow Testing
- CA15-e (cancer antigen 15-3 blood test for breast cancer)
- CA125 (cancer antigen 125 blood test for ovarian cancer)
- CEA (carcinoembryonic antigen blood test for colon cancer)
- Chest X-Ray
- Colonoscopy
- COVID-19 testing when performed by an appropriately licensed medical professional
- Flexible Sigmoidoscopy
- Hemoccult Stool Analysis
- Mammography (including breast ultrasound)
- Pap Smear (including ThinPrep Pap Test)
- PSA (prostate specific antigen blood test for prostate cancer) Serum Protein Electrophoresis
- Biopsy for Skin Cancer
- Blood Test for Triglycerides
- HPV (Human Papillomavirus) Vaccination
- Lipid Panel (total cholesterol count)
- Doppler Screening for Carotids
- Doppler Screening for Peripheral Vascular Disease
- Thermography
- Echocardiogram
- Ultrasound Screening of the Abdominal Aorta for Abdominal Aortic Aneurysms
- EKG
- Stress Test on Bike or Treadmill
- Fasting Blood Glucose Test
- Serum Cholesterol to determine level of HDL & LDL

Coverage availability varies by state. Not all tests are available in all states.

For additional information, call **866-547-4205**
Monday through Friday, **8:00am – 6:00pm** EST.

THE HARTFORD

Business Insurance
Employee Benefits
Auto
Home

[1] Claims must be submitted within 12 months of screening date.

[2] Each person must complete an eligible health screening. Benefit payment is once per year, per covered person.

[3] Based on average claims turnaround time.

[4] This document explains the typical Health Screening Benefits covered, but in no way changes or affects the policy as actually issued. For a full list of benefits covered, please refer to your company's policy booklet.

Accident Form Series includes GBD-2000, GBD-2300, or state equivalent. Critical Illness Form Series includes GBD-2600, GBD-2700, GBD-3600, GBD-3700, or state equivalent.

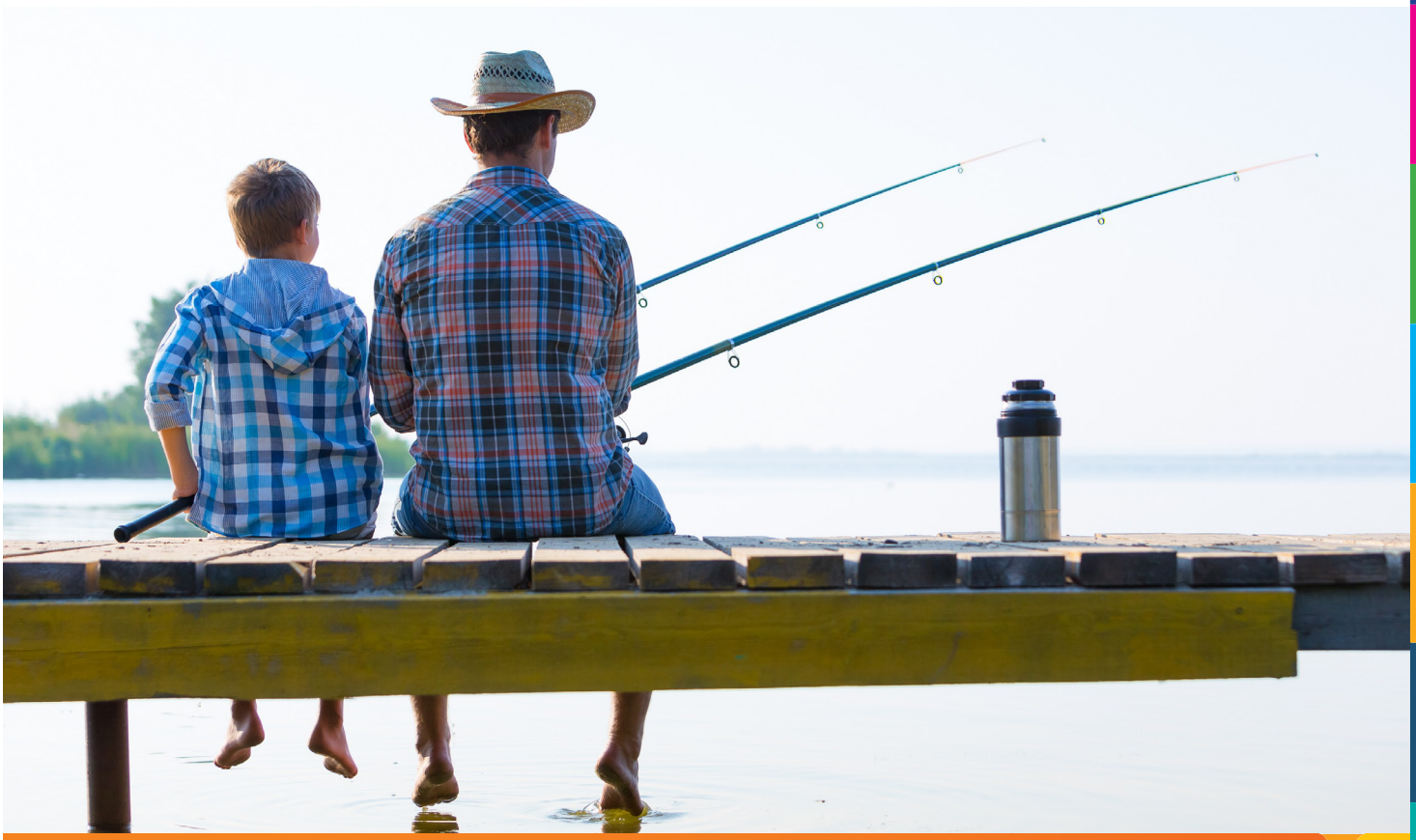
The policy number is 715177
442883 09/20

WHOLE LIFE

VOYA

Premier Whole Life Insurance

Take advantage of guaranteed cash values



Take the first step towards a lifetime of protection for you and your family

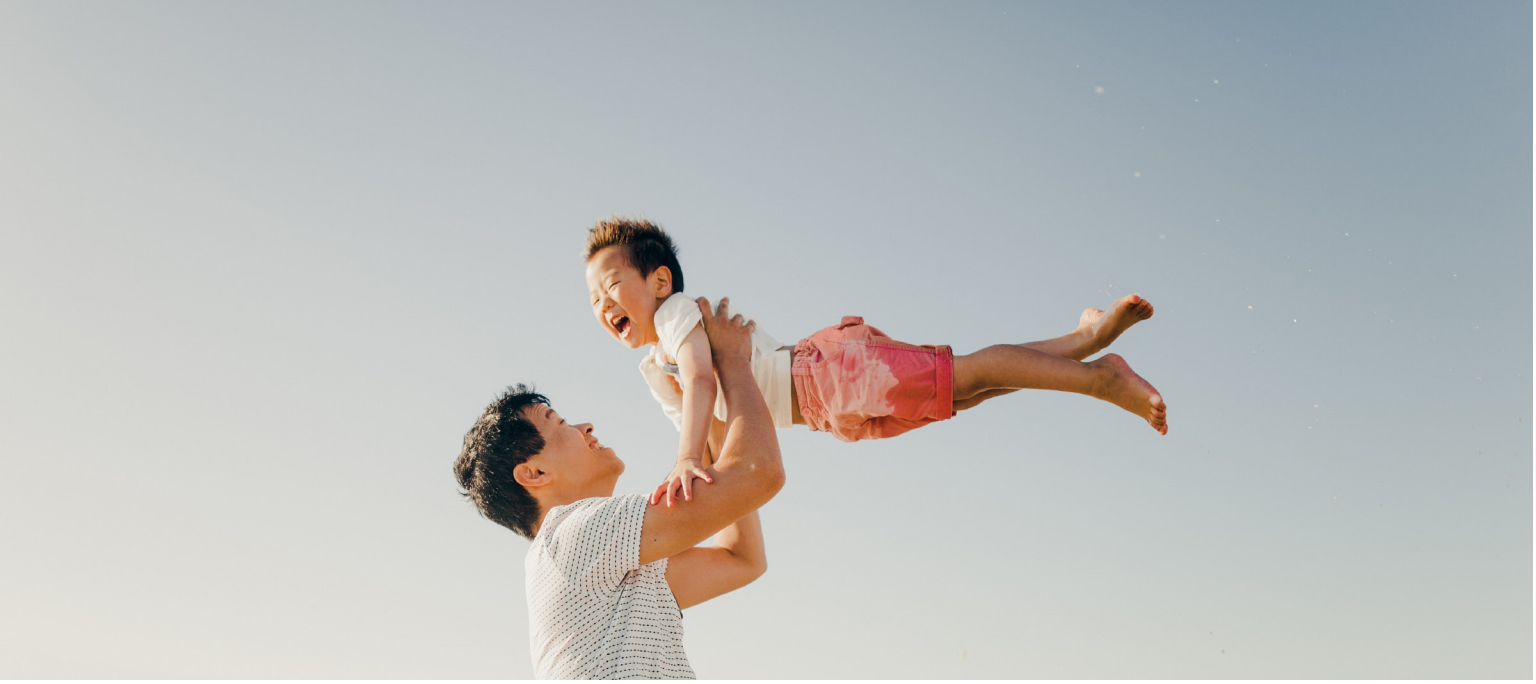
Helping to ensure a lifetime of financial protection for your family is worth talking about. You can take the first step today.

Think about the range of your family's possible financial needs, including: mortgage, secondary school or college education, child care, elder care for your parents, and more.

ReliaStar Life Insurance Company,
a member of the Voya® family of companies

PLAN | INVEST | PROTECT

VOYA FINANCIAL



How do you build a plan of financial protection?

Start with whole life insurance – designed to provide a strong foundation of life insurance coverage. Whether by itself or combined with term life, it can be used in the unfortunate circumstance of the death of a breadwinner or cherished loved one.

What other benefits can whole life insurance provide?

- Coverage isn't tied to your employment – you can take the benefit with you if and when you leave your current employer, and keep it all the way into retirement if you choose.
- The cost you pay for this coverage won't change, which helps with your personal financial planning.
- The policy builds cash value from which you can borrow when needed.

But what if you already own term life insurance?

While you may own term life insurance, the fact is you may not have enough coverage to adequately protect your family or meet their future financial needs. According to a recent study, 35% of households would be financially impacted from the loss of the primary wage earners within 1 month*. A great number of these individuals are under-insured. Combining term and whole life insurance can offer the substantial financial protection you and your family deserve.

Stability for the long run

Whole life insurance complements term life insurance in some important ways, ensuring stability for the long run.

Term Life Insurance	&	Whole Life Insurance
A cost effective way to secure life insurance coverage for a specific period of time		A moderately priced means to secure life insurance coverage for a lifetime, provided sufficient premiums are paid
The cost increases as you get older		The cost stays the same for the life of the policy
Does not accumulate cash value		The investment portion of the policy has the potential to accumulate cash value on a tax-deferred basis You may be able to borrow – generally tax-free** – against your cash value and pay back the loan with interest. Any unpaid loan would be subtracted from the death benefit.

* 2018, LL. Global, Inc and "Life Happens"

** This communication is not intended or written to be used, and cannot be used by the recipient or any other person, for the purpose of avoiding any tax penalties that may be imposed on such person, and cannot be used or referred to, in promoting, marketing, or recommending to another party any transactions or matters addressed herein.

More options, more security

Premier Whole Life Insurance offers a variety of options.

Increases

The death benefit can be increased to meet changing needs. Coverage amount increases up to the policy maximum are allowed after the first policy year. Evidence of insurability may be required.

Payroll deduction

Providing protection for your family has never been easier since your premium is paid through payroll deduction. This eliminates the need to write checks and pay postage.

Portability

Should you leave your current employer or retire, you can take the policy with you and choose one of a number of convenient payment plans.

Guaranteed

The insurance coverage you purchase and the payment amounts are guaranteed to be fixed for the life of the policy as long as you meet the required premium payments. There's no need to worry about whether your policy will be there when you and your family need it most.

Eligibility

To apply for coverage, you must be a permanent benefit eligible employee working 20 or more hours[1] a week and be actively at work at the time of enrollment.

Spouse coverage

Your spouse is eligible to apply for insurance by meeting eligibility requirements.

Child coverage options

Children and grandchildren, ages 15 days through 24 years, are eligible to apply for several coverage options.

Guaranteed cash values

Whole life insurance builds guaranteed cash values as long as you make your payments.

Cash value loans

Once cash value accumulates, you can borrow against that value at the rate shown in the policy. The death benefit will be reduced by the amount of any outstanding loan and unpaid accrued interest.

Suicide clause

For suicide within two years from the policy's date of issue and the effective date of any increases, benefits will be limited to payment of all premiums paid without interest less any policy loan and loan interest.

[1] 16+ hours for healthcare workers

- Protection for a lifetime for you and your loved ones
- Affordable rates with the convenience of payroll deduction
- A policy that builds cash value
- Premiums that won't increase for the life of the policy
- A benefit you can take with you into retirement
- Help with final expenses

Take the **first step**

Take advantage of whole life insurance offered by your employer for benefits you can rely on for the long run.

PLAN | INVEST | PROTECT

VOYA FINANCIAL

DISABILITY INSURANCE

THE HARTFORD

THE HARTFORD DISABILITY

If you have an illness or injury and are not able to work, disability insurance will pay a portion of your salary. You must be an active employee who works at least 20 hours per week. You are eligible on your date of hire.

Plan Options:

When it Begins:

Elimination Pd.	Accident	Illness
Option 1:	0 days	3 days
Option 2:	14 days	14 days
Option 3	30 days	30 days
Option 4:	60 days	60 days
Option 5:	90 days	90 days
Option 6:	180 days	180 days

When it Ends:

Your Options	Plan Description
Option 1: Premium Plan	**Accident & Illness:** Benefits will continue up to social security normal retirement age (SSNRA) or retirement.
Option 2: Select Plan	**Accident:** Benefits will continue up to social security normal retirement age (SSNRA). **Illness:** Benefits will continue up to 5 years for illness.

Key Highlights:

- **Guaranteed Coverage**. *Subject to pre-existing condition limitation.*
- **Benefit Amount Options:** Elect up to 66 2/3% of your monthly earnings, maximum of $8000. Earnings means wages, salary, not extra compensation like stipends.
- **Disability benefits are paid in addition to Paid Leave:** up to 12 months.
- **Benefits reduce with other income or eligible income:** Social Security Disability Insurance, State Teacher Retirement Disability Plans, Worker's Compensation, Other employer-based disability insurance coverage you may have, Unemployment benefits, and Retirement benefits that your employer fully or partially pays for (such as a pension plan)
- **1st Day Hospitalization:** Benefits begin immediately after 24 hours or more of hospitalization. It is only offered for plan options 0/3, 14/14 & 30/30.
- **Pre-Existing Condition:** If diagnosed or received care for a disability condition within 3 consecutive months just prior to the effective date of this policy, your benefit will be limited.

Pre-Existing Conditions:

Pre-Existing Condition Scenarios	Pre-Existing Condition Limitation Coverage
New Hire	Benefits will only be paid up to 30 days for your pre-existing condition.
Open Enrollment: New Application	Benefits will only be paid up to 30 days for your pre-existing condition.
Open Enrollment: Increasing the Benefit Amount	The increased benefit amount will only be paid up to 30 days, then the original amount will be paid for the duration of the eligible disability coverage.
Open Enrollment: Changing to a Better Plan Option	Pre-existing conditions limitation does not apply when changing plan options. Only the benefit amounts are subject to the pre-existing condition rules.

Filing a Claim:

1. Call: **1-866-547-9124**, M-F, 7:00 am – 7:00 pm CST
2. Have the following information ready:
   - Policy Number **715177**
   - Name, address and other key identification information
   - Name of department and last full day of active work
   - The nature of your claim or leave request
   - Physician's name, address, phone and fax numbers
3. You have up to 12 months to file your disability claim.

Puro Aseguro Inc:

1. Call: **956-783-1137**, M-F, 8:00 am – 5:30 pm
2. Visit: 514 S. Veterans Blvd., Ste A, Pharr, TX
3. Email: melba@puroaseguro.com

*Contact us to help file a claim, for questions, and for plan information.

***Please see Hartford's brochures and policy book for plan details, exclusions and limitations.**

Puro Aseguro Inc.
Group Medical & Supplemental Insurance Benefits

BENEFIT HIGHLIGHTS FOR:

Pharr-San Juan-Alamo Independent School District

EDUCATOR DISABILITY INSURANCE OVERVIEW

What is Educator Disability Income Insurance?

Educator Disability insurance combines the features of a short-term and long-term disability plan into one policy. The coverage pays you a portion of your earnings if you cannot work because of a disabling illness or injury. The plan gives you the flexibility to choose a level of coverage to suit your need.

You have the opportunity to purchase Disability Insurance through your employer. This highlight sheet is an overview of your Disability Insurance. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

Why do I need Disability Insurance Coverage?

More than half of all personal bankruptcies and mortgage foreclosures are a consequence of disability[1]

[1] Facts from LIMRA, 2016 Disability Insurance Awareness Month

The average worker faces a **1 in 3 chance** of suffering a job loss lasting 90 days or more due to a disability[2]

[2]Facts from LIMRA, 2016 Disability Insurance Awareness Month

Only 50% of American adults indicate they have enough savings to cover three months of living expenses in the event they're not earning any income[3]

[3]Federal Reserve, Report on the Economic Well-Being of U.S. Households in 2018

ELIGIBILITY AND ENROLLMENT

Eligibility

You are eligible if you are an active employee who works at least 20 hours per week on a regularly scheduled basis.

Enrollment

You can enroll in coverage within 31 days of your date of hire or during your annual enrollment period.

Effective Date

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

Actively at Work

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

THE HARTFORD

FEATURES OF THE PLAN

Benefit Amount

You may purchase coverage that will pay you a monthly flat dollar benefit in $100 increments between $200 and $8,000 that cannot exceed 66 2/3% of your current monthly earnings. Earnings are defined in The Hartford's contract with your employer.

Elimination Period

You must be disabled for at least the number of days indicated by the elimination period that you select before you can receive a Disability benefit payment. The elimination period that you select consists of two numbers. The first number shows the number of days you must be disabled by an accident before your benefits can begin. The second number indicates the number of days you must be disabled by a sickness before your benefits can begin.

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

Maximum Benefit Duration

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

Premium Option: For the **Premium** benefit option – the table below applies to disabilities resulting from **sickness or injury**.

Select Option: For the **Select** benefit option – the table below applies to disabilities resulting from **injury**.

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

Select Option: For the **Select** benefit option – the table below applies to disabilities resulting from **sickness**.

Age Disabled	Maximum Benefit Duration
Prior to 65	5 Years
Age 65-69	To Age 70, but not less than one year
Age 70 and older	1 Year

Mental Illness, Alcoholism and Substance Abuse, Self-Reported or Subjective Illness:

You can receive benefit payments for Long-Term Disabilities resulting from mental illness, alcoholism and substance abuse or self-reported or subjective illness for a total of 24 months for all disability periods during your lifetime.

Duration	Any period of time that you are confined in a hospital or other facility licensed to provide medical care for mental illness, alcoholism and substance abuse does not count toward the 24 months lifetime limit.
Partial Disability	Partial Disability is covered provided you have at least a 20% loss of earnings and duties of your job.
Other Important Benefits	**Survivor Benefit -** If you die while receiving disability benefits, a benefit will be paid to your spouse or child under age 26, equal to three times your last monthly gross benefit. **The Hartford's Ability Assist** service is included as a part of your group Long Term Disability (LTD) insurance program. You have access to Ability Assist services both prior to a disability and after you've been approved for an LTD claim and are receiving LTD benefits. Once you are covered you are eligible for services to provide assistance with child/elder care, substance abuse, family relationships and more. In addition, LTD claimants and their immediate family members receive confidential services to assist them with the unique emotional, financial and legal issues that may result from a disability. Ability Assist services are provided through **ComPsych®,** a leading provider of employee assistance and work/life services. **Travel Assistance Program –** Available 24/7, this program provides assistance to employees and their dependents who travel 100 miles from their home for 90 days or less. Services include pre-trip information, emergency medical assistance and emergency personal services. **Identity Theft Protection** – An array of identity fraud support services to help victims restore their identity. Benefits include 24/7 access to an 800 number; direct contact with a certified caseworker who follows the case until it's resolved; and a personalized fraud resolution kit with instructions and resources for ID theft victims. **Workplace Modification** provides for reasonable modifications made to a workplace to accommodate your disability and allow you to return to active full-time employment.

PROVISIONS OF THE PLAN

Definition of Disability	Disability is defined as The Hartford's contract with your employer. Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical conditions covered by the insurance, and as a result, your current monthly earnings are 80% or less of your pre-disability earnings. One you have been disabled for 24 months, you must be prevented from performing one or more essential duties of any occupation, and as a result, your monthly earnings are 66 2/3% or less of your pre-disability earnings.
Pre-Existing Condition Limitation	Your policy limits the benefits you can receive for a disability caused by a pre-existing condition. In general, if you were diagnosed or received care for a disabling condition within the 3 consecutive months just prior to the effective date of this policy, your benefit payment will be limited, unless: You have been insured under this policy for 12 months before your disability begins. *If your disability is a result of a pre-existing condition, we will pay benefits for a maximum of 1 month.*

Continuity of Coverage	If you were insured under your district's prior plan and not receiving benefits the day before this policy is effective, there will not be a loss in coverage and you will get credit for your prior carrier's coverage.
Recurrent Disability	*What happens if I Recover but become Disabled again?* Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Employee are less than one-half (1/2) the number of days of Your Elimination Period. Any day within such period of Recovery, will not count toward the Elimination Period.
Benefit Integration	Your benefit may be reduced by other income you receive or are eligible to receive due to your disability, such as: • Social Security Disability Insurance • State Teacher Retirement Disability Plans • Workers' Compensation • Other employer-based disability insurance coverage you may have • Unemployment benefits • Retirement benefits that your employer fully or partially pays for (such as a pension plan) Your plan includes a minimum benefit of 25% of your elected benefit.
General Exclusions	You cannot receive Disability benefit payments for disabilities that are caused or contributed to by: • War or act of war (declared or not) • Military service for any country engaged in war or other armed conflict • The commission of, or attempt to commit a felony • An intentionally self-inflicted injury • Any case where Your being engaged in an illegal occupation was a contributing cause to your disability • You must be under the regular care of a physician to receive benefits
Termination Provisions	Your coverage under the plan will end if: • The group plan ends or is discontinued • You voluntarily stop your coverage • You are no longer eligible for coverage • You do not make the required premium payment • Your active employment stops, except as stated in the continuation provision in the policy

THE HARTFORD DISABILITY

Si tiene una enfermedad o lesión y no puede trabajar, el seguro de discapacidad pagará una parte de su salario. Debe ser un empleado activo que trabaje al menos 20 horas por semana. Usted es elegible en su fecha de contratación.

Opciones de Planes:

Cuando Comienza:

Eliminación Pd.	Accidente	Enfermedad
Opción 1:	0 días	3 días
Opcíon 2:	14 días	14 días
Opcíon 3	30 días	30 días
Opcíon 4:	60 días	60 días
Opcíon 5:	90 días	90 días
Opcíon 6:	180 días	180 días

Cuando Termina:

Sus Opciones	Descripción del Plan
Opcíon 1: Plan Premium	**Accidente y Enfermedad:** Los beneficios continuarán hasta la edad normal de jubilación del seguro social (SSNRA) o hasta la jubilación.
Opcíon 2: Plan Seleccionado	**Accidente:** Los beneficios continuarán hasta la edad normal de jubilación del seguro social (SSNRA). **Enfermedad:** Los beneficios continuarán hasta 5 años por enfermedad.

Puntos Clave:

- **Cobertura Garantizada***: Sujeto a limitación de condiciones preexistentes.*
- **Opciones de Cantidad de Beneficios:** Elija hasta el 66 2/3% de sus ingresos mensuales, máximo de $8000. Ganancias significa salarios, salaries, no compensaciones adicionales como estipendios.
- **Los beneficios por discapacidad se pagan además de la licencia pagada:** hasta 12 meses.
- **Los beneficios se reducen con otros ingresos o ingresos elegibles:** Seguro de Incapacidad del Seguro Social, Planes de Incapacidad de Jubilación de Maestros del Estado, Compensación del Trabajador, Otra cobertura de seguro de incapacidad basada en el empleador que pueda tener, Beneficios de desempleo y Beneficios de jubilación que su empleador paga total o parcialmente (como un plan de pensiones).
- **Hospitalización del primer día:** Los beneficios comienzan inmediatamente después de 24 horas o más de hospitalización. Solo se ofrece para las opciones de planes 0/3, 14/14 y 30/30.
- **Condición pre-existente:** Si se le diagnosticó o recibió atención por una condición de discapacidad dentro de los 3 meses consecutivos justo antes de la fecha de vigencia de esta póliza su beneficio será limitado.

Condiciones Pre-existentes:

Escenarios de Condiciones Pre-existentes	Cobertura de limitación de condiciones pre-existentes
Contratación Nueva	Los beneficios solo se pagarán hasta 30 días por su condición preexistente.
Inscripción Abierta: Solicitud Nueva	Los beneficios solo se pagarán hasta 30 días por su condición preexistente.
Inscripción Abierta: Aumento del monto del beneficio	El monto del beneficio aumentado solo se pagará hasta 30 días, luego se pagará el monto original durante la duración de la cobertura de discapacidad elegible.
Inscripción Abierta: Cambiar a una mejor opción de plan	La limitación de condiciones preexistentes no se aplica al cambiar las opciones del plan. Solo los montes de los beneficios están sujetos a las reglas de condiciones preexistentes.

Presentar un Reclamo:

1. Llamar a: **1-866-547-9124**, M-F, 7:00 am – 7:00 pm CST
2. Tenga lista la siguiente información:
   - Número de Póliza **715177**
   - Nombre, dirección y otra información clave de identificación
   - Nombre del departamento y último día complete de trabajo activo
   - La naturaleza de su reclamo o solicitud de licencia.
   - Nombre del médico, dirección, números de teléfono y fax
3. Tiene hasta 12 meses para presentar su reclamo por incapacidad.

Puro Aseguro Inc:

1. Llamar a: **956-783-1137**, M-F, 8:00 am – 5:30 pm
2. Visítenos en: 514 S. Veterans Blvd., Ste A, Pharr, TX
3. Email: melba@puroaseguro.com

*Contáctenos para ayudarlo a presenter un reclamo, preguntas o más información.

Consulte los folletos y el libro de pólizas de Hartford para obtener detalles, exclusiones y limitaciones del plan.

Puro Aseguro Inc.
Group Medical & Supplemental Insurance Benefits

RESUMEN DE BENEFICIOS PARA:

Distrito escolar independiente de Pharr-San Juan-Alamo

RESUMEN DEL SEGURO POR DISCAPACIDAD PARA EDUCADORES

¿De qué se trata el seguro con ingresos por discapacidad para educadores?

Con el seguro por discapacidad para educadores, en una única póliza se combinan las características de los planes por discapacidad de corta y larga duración. Mediante esta cobertura se le paga una parte de sus ganancias en caso de que no pueda trabajar a raíz de una enfermedad o lesión incapacitante. Con el plan se le da flexibilidad para elegir el nivel de cobertura que se ajuste a sus necesidades.

Puede adquirirlo con su empleador. En este resumen de beneficios se le brinda información general del seguro por discapacidad. Una vez que se emita la póliza colectiva a su empleador, usted tendrá a su disposición un certificado de seguro en el que se le explicará detalladamente la cobertura.

¿Por qué necesito tener la cobertura del seguro por discapacidad?

Más de la mitad de las bancarrotas y las ejecuciones hipotecarias de particulares ocurren por discapacidades.[1]

[1] Información de LIMRA, Mes de la concientización sobre los seguros por discapacidades, 2016.

El trabajador promedio tiene **más de un 30 % de posibilidades** de sufrir una pérdida laboral con una duración de 90 días o más a raíz de una discapacidad.[2]

[2] Información de LIMRA, Mes de la concientización sobre los seguros por discapacidades, 2016.

Solo el 50 % de los adultos estadounidenses indica que cuenta con ahorros suficientes para afrontar los gastos de tres meses de manutención en caso de que no genere ningún tipo de ingresos.[3]

[3] Reserva federal, Informe del 2018 sobre el bienestar económico de las familias de Estados Unidos.

ELEGIBILIDAD E INSCRIPCIÓN

Elegibilidad

Usted es elegible si es un empleado activo que trabaja por lo menos 20 horas semanales en horarios programados habitualmente.

Inscripción

Puede anotarse para tener la cobertura dentro de los 31 días posteriores a la fecha de contratación o durante el período de inscripción anual.

Fecha de vigencia

La cobertura entra en vigor conforme con los términos y las condiciones de la póliza. Usted tiene que cumplir con la definición de «trabajar de manera activa» para su empleador el día en que la cobertura entre en vigencia.

Realizar tareas activas

Usted tiene que estar realizando tareas para su empleador en la jornada laboral prevista habitualmente. Ese día, debe realizar todas las tareas habituales como de costumbre y durante la cantidad de horas usuales a cambio de una remuneración o ganancia. Si la escuela está cerrada por vacaciones o recesos escolares normales, «trabajar de manera activa» quiere decir que usted puede presentarse a trabajar para su empleador y realizar todas las tareas habituales

de su ocupación como de costumbre y durante la cantidad de horas usuales como si la escuela estuviese abierta.

LAS CARACTERÍSTICAS DEL PLAN

Monto del beneficio

Puede adquirir una cobertura por la que se le paga un beneficio fijo por mes entre $200 y $8,000 con aumentos cada $100, y no puede superar el 66 2/3 % de las ganancias que actualmente percibe por mes. En el contrato de The Hartford con su empleador se define a qué se llaman «ganancias».

Período de carencia

Para poder cobrar el beneficio por discapacidad, tiene que estar discapacitado al menos por la cantidad de días que se indica en el período de carencia que elija. El período de carencia que elige consta de dos cifras. La primera representa la cantidad de días que debe estar discapacitado a raíz de un accidente para luego comenzar a recibir los beneficios. La segunda indica la cantidad de días que debe estar discapacitado como consecuencia de una enfermedad antes de empezar a percibir los beneficios.

A los empleados que escojan un período de carencia de 30 días o menos, si están internados en un hospital por 24 horas o más a raíz de una discapacidad, se les eliminará dicho plazo y los beneficios se pagarán a partir del primer día de internación.

Duración máxima del beneficio

La duración del beneficio es el plazo máximo durante el cual abonamos beneficios por discapacidad a causa de una enfermedad o lesión, el cual puede variar según la escala seleccionada y la edad en la que ocurra la discapacidad. Consulte las escalas correspondientes que se señalan a continuación de acuerdo con la opción de beneficios **Premium** o **Select** que elija.

Opción Premium: Para la opción de beneficios **Premium**, consulte la siguiente tabla sobre discapacidades a raíz de **lesiones o enfermedades**.

Opción Select: Para la opción de beneficios **Select**, consulte la siguiente tabla sobre discapacidades a raíz de **lesiones**.

Edad en la que quedó discapacitado	Duración máxima del beneficio
Antes de cumplir 63 años	Hasta la edad normal de jubilación o por 48 meses si la supera
63 años	Hasta la edad normal de jubilación o por 42 meses si la supera
64 años	36 meses
65 años	30 meses
66 años	27 meses
67 años	24 meses
68 años	21 meses
A partir de los 69 años	18 meses

Opción Select: Para la opción de beneficios **Select**, consulte la siguiente tabla sobre discapacidades a raíz de **enfermedades**.

Edad en la que quedó discapacitado	Duración máxima del beneficio
Antes de cumplir 65 años	5 años
Entre 65 y 69 años	Hasta los 70 años, aunque no será por menos de 1 año
A partir de los 70 años	1 año

Enfermedades mentales, alcoholismo, abuso de sustancias, padecimientos subjetivos o informados por usted:	Puede recibir pagos de beneficios por discapacidades de larga duración como consecuencia de enfermedades mentales, alcoholismo, abuso de sustancias o padecimientos subjetivos o informados por usted mismo por un total de 24 meses por todos los períodos de discapacidad a lo largo de toda la vida.
Duración	Todo período durante el cual usted se encuentre internado en un hospital u otro centro habilitado para brindar atención médica para enfermedades mentales, alcoholismo o abuso de sustancias no se contemplará dentro del límite de los 24 meses mencionados anteriormente.
Discapacidad parcial	Está cubierta la discapacidad parcial siempre y cuando haya una pérdida de al menos el 20 % de las ganancias y las tareas de su puesto.
Otros beneficios importantes	Con el **beneficio al sobreviviente**, si usted estaba recibiendo beneficios y fallece, a su cónyuge o hijo menor de 26 años se le pagará un beneficio equivalente al triple del último beneficio mensual en bruto que haya percibido. Los servicios de **Ability Assist de The Hartford** se incluyen como parte del programa del seguro colectivo por discapacidad de larga duración (DLD). Tiene acceso a estos servicios antes de sufrir la discapacidad y una vez que se haya aprobado el reclamo por DLD y ya esté cobrando los beneficios. Desde el momento en que cuenta con la cobertura, puede acceder a servicios para ayudarlo en el cuidado de sus hijos o de personas mayores, con temas de abuso de sustancias, relaciones familiares y mucho más. Además, los reclamantes y su familia inmediata reciben servicios confidenciales para ayudarlos con los temas emocionales, económicos y legales particulares que pueden derivar de una discapacidad. **ComPsych®**, prestador líder en asistencia a los empleados y servicios para conciliar la vida laboral con la personal, brinda los servicios de Ability Assist. El **programa de asistencia al viajero** está disponible las 24 horas del día, los 7 días de la semana, para asistir a los empleados y a sus dependientes cuando viajan a más de 100 millas de distancia de su casa por 90 días o menos. Los servicios que se brindan son información antes del viaje, asistencia médica de emergencia y servicios personales de emergencia. Con la **protección contra la suplantación de la identidad** se ofrece un abanico de servicios para que las víctimas recuperen su identidad. Entre los beneficios se contemplan los siguientes: acceso a un número 800 las 24 horas del día, los 7 días de la semana, contacto directo con una persona certificada que se encargará del caso hasta que se solucione y un paquete de resolución personalizado para combatir el fraude con instrucciones y materiales para las víctimas que sufrieron el robo de su identidad. Con las **modificaciones al lugar de trabajo** se realizan alteraciones razonables al ámbito laboral para adaptarlo a su discapacidad y que usted pueda reintegrarse a un empleo activo y de jornada completa.

LAS DISPOSICIONES DEL PLAN

Definición de «discapacidad»	En el contrato que The Hartford celebró con su empleador se define a qué se llama «discapacidad». Por lo general, el término quiere decir que no puede realizar una o más de las

tareas esenciales de su ocupación a causa de una lesión, enfermedad, embarazo u otra afección de salud que esté cubierta por el seguro. Como resultado, las ganancias que actualmente recibe por mes representan el 80 % o menos de las ganancias previas a su discapacidad.

Tras haber estado discapacitado por 24 meses, no puede llevar a cabo una o más de las tareas esenciales de ninguna ocupación, y por ende, las ganancias que percibe por mes representan el 66 2/3 % o menos de las ganancias previas a su discapacidad.

Limitación por afección preexistente

En la póliza se limitan los beneficios que puede recibir por discapacidades causadas por afecciones preexistentes. En general, si se le diagnosticó una enfermedad incapacitante o recibió tratamiento para ella en los 3 meses consecutivos inmediatamente previos a la fecha de vigencia de esta póliza, el pago de los beneficios se reducirá, excepto que: haya estado asegurado con esta póliza por 12 meses antes de que comenzase su discapacidad.

Si la discapacidad surgió como consecuencia de una afección preexistente, le pagaremos beneficios por 1 mes como máximo.

Cobertura extendida

Si estaba asegurado con el plan anterior del distrito y no recibió beneficios el día previo a la fecha de vigencia de esta póliza, no dejará de tener cobertura y se le dará un crédito por la cobertura que tenía con la aseguradora anterior.

Discapacidad recurrente

¿Qué ocurre si me Recupero pero vuelvo a sufrir una Discapacidad?
El Período de Carencia no se verá interrumpido si hay Recuperaciones durante dicho lapso, toda vez que se haya reintegrado al trabajo como Empleado Activo y el número de días trabajados represente menos de la mitad (1/2) de los días del Período de Carencia.
Ningún día que entre en dicho lapso de Recuperación se contemplará para el Período de Carencia.

Integración de los beneficios

Los beneficios podrían disminuir como consecuencia de otros ingresos que reciba a raíz de su discapacidad, o para los que sea elegible, como por ejemplo:

- seguro por discapacidad del Seguro Social;
- planes para el pago de la jubilación de maestros estatales con discapacidades;
- indemnización laboral;
- otra cobertura de seguros por discapacidad que pudiese tener provista por el empleador;
- beneficios por desempleo;
- beneficios jubilatorios que pague total o parcialmente su empleador (por ejemplo: un plan de pensiones).

En el plan se contempla un beneficio mínimo del 25 % del que haya elegido.

Exclusiones generales

No puede recibir el pago de beneficios por discapacidades que hayan sido consecuencia de o causadas por lo siguiente:

- guerra o acto bélico (ya sea declarado o no);
- servicio militar para algún país en guerra o que tenga otro tipo de conflicto armado;
- cometer un delito grave (o intentar cometerlo);
- lesiones autoinfligidas intencionalmente;

- en cualquier caso en el que estar involucrado en una ocupación ilegal fuera causante de su discapacidad.
- Para obtener los beneficios debe recibir la atención periódica de un médico.

Disposiciones para la cancelación

La cobertura del plan concluirá si:

- el plan colectivo finaliza o se suspende;
- usted anula la cobertura de manera voluntaria;
- ya no es elegible para tener la cobertura;
- no abona el pago obligatorio de las primas;
- deja de tener un empleo de forma activa, excepto según se indica en la cláusula de prórroga de la póliza.

La serie de formularios del seguro por discapacidad incluye GBD-1000, GBD-1200 o su equivalente estatal.

7896 NS 07/20

LEGAL PLAN

LEGAL SHIELD

LegalShield® | IDShield®

PSJA ISD

WWW.PSJAISD.US

HAVE YOU EVER?

- ☐ Needed your Will prepared or updated
- ☐ Been overcharged for a repair or paid an unfair bill
- ☐ Had trouble with a warranty or defective product
- ☐ Signed a contract
- ☐ Received a moving traffic violation
- ☐ Had concerns regarding child support
- ☐ Worried about being a victim of Identity theft
- ☐ Been concerned about your child's identity
- ☐ Lost your wallet
- ☐ Worried about entering personal information online
- ☐ Feared the security of your medical information
- ☐ Been pursued by a collection agency

THE LEGALSHIELD MEMBERSHIP INCLUDES:

Dedicated Law Firm
Legal Advice/Consultation on unlimited personal issues
Letters/Calls made on your behalf
Contracts/Documents Reviewed up to 15 pages
Residential Loan Document Assistance
Lawyers prepare your Will/Living Will/Health Care Power of Attorney/Financial Power of Attorney
Speeding Ticket Assistance
IRS Audit Assistance
Trial Defense (if named defendant/respondent in a covered civil action suit)
Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment)
25% Preferred Member Discount (bankruptcy, criminal charges, DUI, personal injury, etc.)
24/7 Emergency Access for covered situations

Put your law firm in the palm of your hand with the LegalShield mobile app

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under the age 18 for whom the member is the legal guardian; never married dependent children up to age 26 if a full-time college student; or physically or mentally disabled dependent children.

This is general overview and is for illustrative purposes only. Plans and services vary from state to state. See a plan contract for your state of residence for complete terms, coverage, amounts, conditions and exclusions.

THE IDSHIELD MEMBERSHIP INCLUDES:

Social Media Monitoring
Allows you to monitor multiple social media accounts and content feeds for privacy and reputational risks.

Privacy and Security Monitoring
Internet monitoring of your name, date of birth, SSN, email address, phone numbers, and more. Monthly credit score tracking. With the family plan, Minor Identity Protection is included and provides monitoring for up to 8 children under the age of 18 for no additional cost.

Consultation
Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection.

Full Identity Restoration
Complete identity recovery services by Kroll Licensed Private Investigators to its pre-theft status.

$5 Million Service Guarantee
We'll do whatever it takes for as long as it takes to help recover and restore your identity.

Put Identity Theft Protection in the palm of your hand with the IDShield mobile app

IDShield family coverage includes, the member, member's spouse and up to 8 minor children under the age of 18.

Dependents age 18-26 receive consultation and restoration only.

This is a general overview and is for illustrative purposes only. Plans and services vary from state to state. See plan contract for your state of residence for complete terms, coverage, amounts, conditions and exclusions.

PAYMENT METHOD PAYMENT FREQUENCY	Legal + Individual IDShield	Legal + Family IDShield
LegalShield	$14.95	$15.95
IDShield	$8.45	$15.95
Combined	$23.40	$28.90

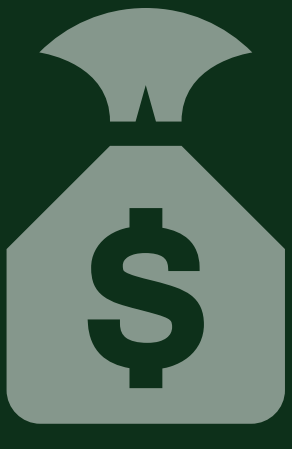
FOR MORE INFORMATION, CONTACT YOUR INDEPENDENT ASSOCIATE:

FLIER_LS+IDS_USA_032918

FLEXIBLE SPENDING ACCOUNT

DAVID K YOUNG

David K. Young Consulting, LLC
BENEFIT CONSULTING & ADMINISTRATION



Don't lose the chance to put up to $915 back into your pocket this year!

Participating in a healthcare flexible spending account (FSA) is like receiving a 30% discount from your medical providers.

How does a healthcare FSA work?

A healthcare FSA is a flexible spending account that allows you to set aside pre-tax dollars for eligible medical, dental, and vision expenses for you and your dependents, even if they are not covered under your primary health plan.

You choose an annual election amount, up to $3,200 *2024 limit. At the beginning of the plan year, your account is pre-funded and your full contribution is immediately available for use. Your election amount is then deducted from your paychecks in equal installments throughout the year.

Why should I enroll in a healthcare FSA?

Almost everyone has some level of predictable and non-reimbursable medical needs.

If you expect to incur medical expenses that won't be reimbursed by another plan, you'll want to take advantage of the savings this plan offers. Money contributed to a healthcare FSA is free from federal and state taxes and remains tax-free when it is spent on eligible expenses. On average, participants enjoy a 30% tax savings on their annual contribution. This means you could be saving up to $915 per year on healthcare expenses!

How do I use my FSA to pay for healthcare expenses?

You can use your benefit card to pay your providers for eligible healthcare expenses, or pay with your personal funds and submit a claim for reimbursement.

Qualifying expenses

What qualifies?

Healthcare FSA funds can cover costs for:

- Copays, deductible payments, coinsurance
- Doctor office visits, exams, lab work, x-rays
- Hospital charges
- Prescription drugs
- Dental exams, x-rays, fillings, crowns, orthodontia
- Vision exams, frames, contact lenses, contact lens solution, laser vision correction
- Physical therapy
- Chiropractic care
- Medical supplies and first aid kits
- Prescribed over-the-counter medications
- And much more…

What doesn't qualify?

Certain expenses are not eligible, for instance:

- Expenses incurred in a prior plan year
- Cosmetic procedures or surgery
- Dental products for general health
- Hygiene products
- Insurance premiums
- Late payment fees charged by healthcare providers

A comprehensive list of eligible expenses can be found at www.dkyoung.com.

Online & mobile access

Get instant access to your account with the **Wealth Care Member Portal** and **Wealth Care Mobile**.

- View your account balance and transaction history
- Submit and view claims
- Upload and store receipts
- View important alerts and communications
- Sign up for direct deposit
- Sign up for text message alerts

Register for the Wealth Care Member Portal at www.dkyoung.com

Download Wealth Care Mobile Search for DK Young Mobile

Helpful hints

- Your full election amount is available on the first day of the plan year, which means you'll have access to the money you need, when you need it.
- You can't change your election amount during the plan year, unless you experience a change in status or qualifying event.
- Save your receipts when you spend your healthcare FSA dollars. You may need itemized invoices to verify the eligibility of expenses or for reimbursement requests.
- The easiest way to manage your account is online at www.dkyoung.com or through the Wealth Care Mobile.
- You may carry over up to $640 *2024 amount of unused healthcare FSA dollars to the next plan year, allowing you to enjoy tax savings without risk.

www.dkyoung.com

11118 Wurzbach Rd, Ste 300 • San Antonio, TX 78230 • 210.558.0999

David K. Young Consulting, LLC
BENEFIT CONSULTING & ADMINISTRATION

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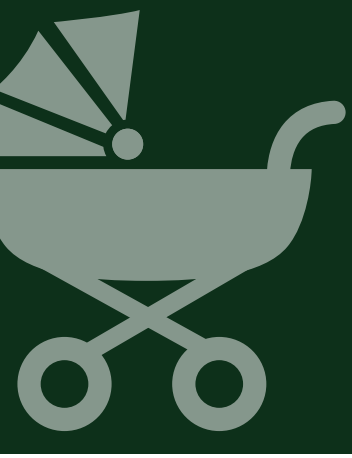

Don't lose the chance to put up to $1,500 back into your pocket this year!

Participating in a dependent care flexible spending account (FSA) is like receiving a 30% discount from your care provider.

How does a dependent care FSA work?

A dependent care FSA is a flexible spending account that allows you to set aside pre-tax dollars for dependent care expenses, such as daycare, that allow you to work or look for work.

You choose an annual election amount, up to $5,000 per family. The money is placed in your account via payroll deduction, in equal installments, and then used to pay for eligible dependent care expenses incurred during the plan year.

Why should I enroll in a dependent care FSA?

Child and dependent care is a large expense for many families. Millions of people rely on child care to be able to work, while others are responsible for older parents or disabled family members.

If you pay for care of dependents in order to work, you'll want to take advantage of the savings this plan offers. Money contributed to a dependent care account is free from federal and state taxes and remains tax-free when it is spent on eligible expenses. On average, participants enjoy a 30% tax savings on their annual contribution. This means you could be saving up to $1,500 per year on dependent care expenses!

How do I use my FSA to pay for dependent care expenses?

You can use your Debit Card to pay your provider for eligible dependent care expenses, or pay with your personal funds and submit a claim for reimbursement.

Qualifying expenses

What qualifies?

Dependent care FSA funds can cover costs for:

- Before school or after school care for children 12 and younger
- Custodial care for dependent adults
- Licensed day care centers
- Nanny / Au Pair
- Nursery schools or preschools
- Late pick-up fees
- Summer or holiday day camps

What doesn't qualify?

Certain expenses are not eligible, for instance:

- Expenses incurred in a prior plan year
- Expenses for non-disabled children 13 and older
- Educational expenses including kindergarten or private school tuition fees
- Food, clothing, sports lessons, field trips, and entertainment
- Overnight camp expenses
- Late payment fees for child care

A comprehensive list of eligible expenses can be found at www.dkyoung.com.

Online & mobile access

Get instant access to your account with the **Wealth Care Member Portal** and **DKYoung Mobile**.

- View your account balance and transaction history
- Submit and view claims
- Upload and store receipts
- View important alerts and communications
- Sign up for direct deposit
- Sign up for text message alerts

Register for the Wealth Care Member Portal at dkyoung.wealthcareportal.com

Download Wealth Care Mobile DKYoung Mobile

Helpful hints

- You must have funds in your dependent care FSA before you can spend them.
- You can't change your election amount during the plan year, unless you experience a change in status or qualifying event.
- Keep your receipts, you will need an itemized invoice for all reimbursement requests.
- The easiest way to manage your account is online at dkyoung.wealthcareportal.com or through the DKYoung Mobile.
- Any unused funds that remain in your account at the end of the year will be forfeited. Plan carefully and use all the money in your dependent care FSA by the end of the plan year.

Important Notices

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PSJA ISD 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. If you are considering joining, 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you 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.
- PSJA ISD has determined that the prescription drug coverage offered by the Insurance plan is, on average for all plan Employees, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare 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. You may also enroll from October 15th through December 7th in 2025. If you enroll from October 15th through December 7th in 2025, your coverage will begin on January 1, 2026.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will you Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with PSJA ISD and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have the coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below 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 PSJA ISD changes. You also may request a copy of this notice at any time.

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 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 1-800-633-4227 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 socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D 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, therefore, whether or not you are required to pay a higher premium (a penalty).

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current PSJA ISD coverage 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 herein.

If you do decide to join a Medicare drug plan and drop your current PSJA ISD coverage, be aware that you and your dependents will not be able to get this coverage back.

HIPAA Special Enrollment Notice

Notice of Special Enrollment Rights for Medical Plan Coverage

As you know, if you have declined enrollment in PSJA ISD health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

PSJA ISD will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in PSJA ISD group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

Patient Protection Disclosure

You do not need prior authorization from BCBSTX or from any other person including a primary care provider in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator.

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). 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 lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please see the Plan's Summary Plan Description for details of the Plan's deductible, benefit percentage, and copayment requirements. If you would like more information on WHCRA benefits, contact Benefits Department.

Newborns' & Mothers' 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 cesarean 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)."

Continuation Coverage Rights Under COBRA

You are receiving this notice because you have recently become covered under PSJA ISD's group health 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 may be available to you when you would otherwise lose your group health coverage. It can also become available to other Employees 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 HR.

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 spouses employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

If the Plan provides health care coverage to retired Employees, the following applies: filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary with respect to the bankruptcy. The retired Employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after PSJA ISD 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, in the event of retired Employee health coverage, 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 PSJA ISD of the qualifying event.

Required Notice

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. Contact your employer and/ or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How is COBRA Coverage Provided?

Once PSJA ISD 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 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitle 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 PSJA ISD 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. Contact PSJA ISD and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

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 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 PSJA ISD. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, 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 at 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 PSJA ISD informed of any address changes. You should also keep a copy, for your records, of any notices you send to PSJA ISD.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call 1-866-444-3272.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State directly for more information on eligibility:

ALABAMA – Medicaid
Website: myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: myakhipp.com
Phone: 1-866-251-4861
Email: customerservice@myakhipp.com
Medicaid Eligibility: health.alaska.gov/dpa/pages/default.aspx

ARKANSAS – Medicaid
Website: myarhipp.com
Phone: 1-855-692-7447

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program: dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: healthfirstcolorado.com
Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711
CHP+: hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI): mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: in.gov/fssa/hip
Phone: 1-877-438-4479
All other Medicaid
Website: in.gov/medicaid
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: dhs.iowa.gov/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: kancare.ks.gov
Phone: 1-800-792-4884
HIPP Phone: 1-800-766-9012

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: chfs.ky.gov/agencies/dms/member/pages/kihipp.aspx
Phone: 1-855-459-6328
Email: kihipp.program@ky.gov
KCHIP Website: kidshealth.ky.gov/pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: medicaid.la.gov or ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Website: mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: dphhs.mt.gov/montanahealthcareprograms/hipp
Phone: 1-800-694-3084
Email: hhshipppprogram@mt.gov

NEBRASKA – Medicaid
Website: accessnebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA - Medicaid
Website: dhcfp.nv.gov
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: state.nj.us/humanservices/dmahs/clients/medicaid
Medicaid Phone: 609-631-2392
CHIP Website: njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: healthcare.oregon.gov/pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: dhs.pa.gov/services/assistance/pages/hipp-program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-5437

RHODE ISLAND – Medicaid & CHIP
Website: eohhs.ri.gov
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: medicaid.utah.gov
CHIP Website: health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: dhhr.wv.gov/bms
mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-699-8447

WISCONSIN – Medicaid and CHIP
Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Services
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866-444-3272

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your Summary Plan Description or contact BCBSTX

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

Employer Name: PSJA ISD
Employer Identification Number (EIN): 74-6001876
Employer Phone Number: 956-354-2000
Employer Address: 601 E Kelly, Pharr, TX 78577
Contact About Coverage: Benefits Dept.
Phone Number: 956-354-2029
Email Address: maricruz.gonzalez@psjaisd.us

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

- As your employer, we offer a health plan to:
- Some employees. Eligible employees are full-time employees and employees who work an average of 20 hours per week.
- With respect to dependents:
- We do offer coverage. Eligible dependents are spouses and children.

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

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

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

Notice of Availability of HIPAA Privacy Notice

Under the Health Insurance Portability and Accountability Act (HIPAA) health plans are required to provide covered individuals with a Privacy Notice that describes, among other things, the uses and disclosures of protected health information that may be received by the plans, your rights regarding that information and the plan's responsibilities.

The PSJA ISD Health Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact:

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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