2024 EMPLOYEE BENEFITS GUIDE

SPC Bldg.
315 Griner St. Del Rio, Texas 78840
Office: 830.778.4100 | www.sfdr-cisd.org

HEALTH BENEFITS

Note: *This PDF is interactive, you may click in on the above navigation bar to jump to desired page throughout the guide. TOC page numbers listed below are also interactive.*

DIRECTORY

For any questions or concerns you may have regarding your 2024 Employee Benefits, you can contact the following;

- For claims assistance, you can contact the insurance carrier. You will need your ID number or Social Security number, date of service and provider name.
- For additional assistance or questions, please contact one of our Benefits Counselors at the Benefits Service Center to learn more about your benefits.

Before you speak with a Benefit Counselor(s), please have the following information ready: dependents' names, birth dates, social security numbers, addresses, and phone numbers.

Benefits Service Center	
Monday - Friday: 8:00 am - 7:00 pm CST **Saturday:** 9:00 am - 3:00 pm CST	(855) 731-4452

Benefit/Carrier	Website	Phone
Medical Kempton	www.kemptongroup.com	800 324-9396
Flexible Spendings Accounts Proficient Benefit Solutions	www.proficientbenefits.com	888-659-8151
Dental MetLife	www.metlife.com	800-942-0854
Vision Eyetopia	www.eyetopia.org	800-662-8264
Basic Term Life and AD&D **Voluntary Term Life** **Disability** The Standard	www.standard.com www.standard.com www.standard.com/yourchoice	800-368-1135
Accident **Critical Illness** **Cancer** Guardian	www.guardianlife.com	888-482-7342
Universal Life Trustmark	www.trustmark.com	847-615-1500
Professional Enrollments Concepts (PEC) Benefits Enrollment Center	N/A	800-324-9396

Staff Member	Email	Phone
San Felipe Del Rio CISD Contact		
Rachel Garcia Employee Benefits Coordinator	Rachel.garcia@sfdr-cisd.org	830-778-4100
Brown & Brown/Alamo Insurance		
Lexy Young Account Manager	lexy.young@bbrown.com	210-524-7123

WELCOME
To Your Employee Benefits

Each year, we strive to offer comprehensive and competitive benefit plans to our employees. In the following pages, you will find a summary of our benefit plans for the **January 1, 2024 to December 31, 2024** Plan Year. Please read this Guidebook carefully as you prepare to make your elections for the upcoming Plan Year.

San Felipe Del Rio CISD will be utilizing Professional Enrollment Concepts' (PEC) services for our benefit communication and enrollment this year. PEC's Benefit Counselors will provide you with a detailed explanation of your entire benefit program. They will review your benefits with you on an individual, confidential basis. They will also be able to discuss any personal situations you may have that could potentially impact your benefit decision.

ABOUT THIS BENEFITS GUIDEBOOK

This Benefits Guidebook describes the highlights of San Felipe Del Rio CISD's benefits program in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents, and not the information in this Guidebook. If there is any discrepancy between the description of the program elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. You should be aware that any and all elements of **San Felipe Del Rio CISD's** benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules, or otherwise as decided by San Felipe Del Rio CISD.

WHAT'S NEW
THIS 2024 YEAR?

- **Complete Medicine : Endocrinologist-Led Telemedicine Diabetes Program** - We have partnered with Complete Medicine, a team of board-certified expert diabetes physicians, Dr. Vidhya Illuri and Dr. Arti Thangudu. These doctors will help make diabetes easier for you. *See page16.*
- **Dependent Health Premium Increase -** This year the dependent health premiums have increased. *See page 5.*
- **New Employee Assistance Program -** *See page 30.*

ELIGIBILITY

San Felipe Del Rio CISD encourages the health and financial well-being of its employees by providing access to quality and affordable healthcare. Eligible Full-Time employees have access to San Felipe Del Rio CISD's comprehensive Benefit Program. Please note that any time during the plan year, San Felipe Del Rio CISD may conduct audit requesting supporting documentation on all eligible dependents.

Please make sure to review this Benefit Guide in detail to learn more about these options.

EMPLOYEE ELIGIBILITY

Full-Time employees who work a minimum of 30 hours per week and are at least 18 years of age are eligible to participate in the benefits program, with an effective date of first of the month following your date of hire. Once your enrollment is completed, you may not make any changes to your elections unless you have a Qualifying Life Event or your hours worked per week drop below the minimum.

DEPENDENT ELIGIBILITY

If you apply for coverage, you may include your dependents. All employees must ensure that only family members who meet the following requirements are enrolled in the San Felipe Del Rio CISD insurance and health care benefit programs.

- Your spouse
- Your eligible children up to age 26 for medical, dental and vision coverage.
- Children" are defined as your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

QUALIFYING LIFE EVENTS

If you experience a Qualifying Life Event (for instance: getting married or having a baby), please contact **Employee Benefits Support Services at ext 4020**; **proof of the Qualifying Life Event** must be submitted to **Employee Benefits Support Services within 31 days** in order **to change current benefit election**.

- A change in the number of dependents (birth, adoption, death, guardianship);
- A change in marital status (marriage, divorce, death, legal separation);
- A dependent's loss of eligibility (attainment of limiting age or change in student status);
- A change in associate's, spouse's, or dependents' work hours;
- A termination or commencement of employment of associate's spouse or eligible dependent with coverage;
- Other events as the administrator determines to be permitted or any other applicable guidelines issued by the Internal Revenue Service.

MEDICAL

Kempton

The medical program, administered by Kempton, provides the framework for your health and well-being. To better meet the varying needs of our employees, San Felipe Del Rio CISD offers the following medical plan.

Benefits (per calendar year)	**Medical Plan**
Deductible	
In-Network (Individual/Family)	$750/$1,500
Out-of-Network (Individual/Family)	$750/$1,500
Out-of-Pocket Maximum	
In-Network (Individual/Family)	$5,000/$10,000
Out-of-Network (Individual/Family)	$5,000/$10,000
Annual Maximum	Unlimited
Coinsurance (participant pays)	
In-Network	20%
Out-of-Network	20%
Primary Care Office Visit	$30 copay
Specialist Office Visit	$50 copay
Urgent Care	$50 copay
Emergency Room	$400
Hospital Services In-Patient	20% after deductible
Outpatient Diagnostic X-Ray & Lab Services (in office - $0 Copay)	100% deductible waived
Major Lab - MRI, PET Scan, CAT Scan	20% after deductible
KPP Free Providers	100% deductible waived
Val Verde Regional Medical Center	100% deductible waived
Air EVAC	In the event that a member is transported by air, plan will pay up to $10,000.
Mental Health Office Visit (In-Network)	$30 copay
Prescription Drug	
Retail Order (30-day) / Mail Order (90-day)	
Generic	$0 / $0
1st Choice	$35 / $87.5
Standard	$50 / $125
Specialty	$200 / $500
Prescription Drug Out of Pocket Maximum	
Individual/Family	$1,450/$2,900 (If you have met your max out-of-pocket there is no copay)
Life Insurance	$10,000

*Effective July 1, 2023 the district's contribution for health coverage per employee per month has increased to $640.01.

***Alternate Plan:** For employees who do not elect health coverage plan

In-Hospital Cash Benefits	**Life Benefit**	**(Optional) Dental Care Benefit**	**Benefit Percentage Payable**
Benefits while confined to hospital: $200 per day (24hrs.) Maximum Stay: 365 days	Term Life Benefits: $15,000	Individual Deductible: $75 per calendar year	Preventive: 80% after deductible Basic: 80% after deductible Major: 50% after deductible

Medical Plan Monthly Deductions

Coverage Tier	**Medical Plan**
Employee	$0.00
Employee + Spouse	$580.00
Employee + Child(ren)	$295.00
Family	$885.00

NEW THIS YEAR

Effective January 1, 2024, the Kempton Group will have a dedicated phone number for San Felipe Del Rio CISD Members!

The new phone number will be: (888) 840-6836

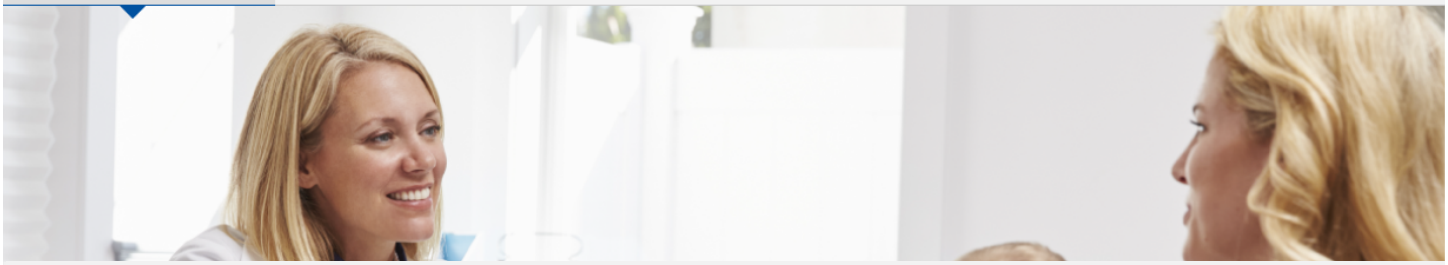
BUT DON'T WORRY!

The same phone number, (800) 324-9396, will still be available to you, before and after, January 1,2024.

THEKEMPTONGROUP

MEMBER PORTAL

HOME | MY BENEFITS | CLAIMS | KPP*FREE*



Welcome to Your 24/7 Online Benefits Connection!

- Review your personal details and health benefits from the privacy of your home or while on-the-go.
- View deductible and out-of-pocket balances. Download details into CSV file.
- View claims status, claim history, and Explanation of Benefits.
- Print a temporary ID card and request a new ID card.
- Ask questions, verify coverage, and more!
- View FAQs, flyers, plan details, benefits, and forms.

Creating Your Account is Simple!

1. Visit www.kemptongroup.com
2. Choose the “For Members” button, then "Secure Login."
3. Click “Create a New Login.”
4. Follow the simple steps on your screen. Use your member ID card to help you answer the questions.

Need help or have questions?

Call us at (888) 840-6836

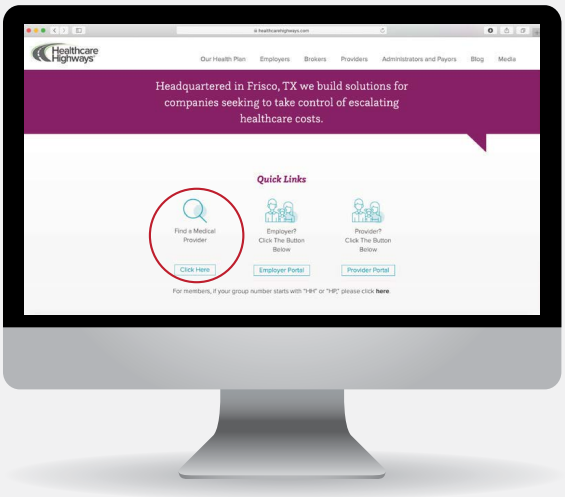
Healthcare Highways Network

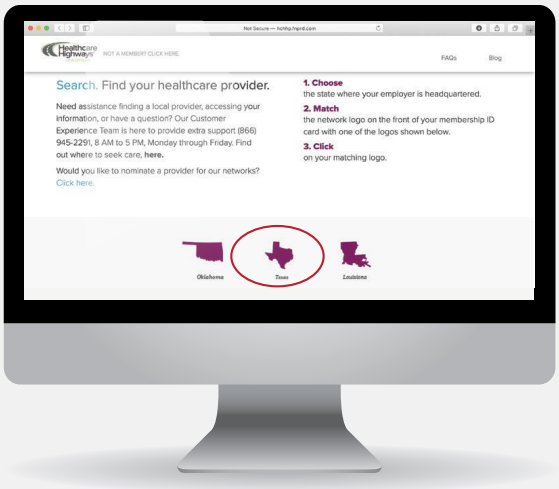
Finding an in-network provider

Welcome to Healthcare Highways! We're honored to be your healthcare partner. Let's help you find your in-network provider. You have two ways to search for a provider:

1 **Do it yourself.**
Go KemptonGroup.com and select the network shown on your ID Card.

2 **Let us help you.**
Call our customer experience team at 888-840-6836
We're available Monday through Friday, 8am to 5pm CST.





THE KEMPTON GROUP ADMINISTRATORS, INC.

EASY AS 1-2-FREE!

You can receive medical services for FREE when you choose KPP*Free*™!

Your health plan waives your deductible and coinsurance for medical services performed through the KPP*Free*™ program.

Step 1

If your physician determines you need a medical service, let them know you have an enhanced benefit through KPP*Free*™.

Following your doctor's diagnosis, call our Kempton Care Advocates at (888) 840-6836 to discuss your available options.

Our Kempton Care Advocates offer full concierge service and will walk you through the process.

Step 2

Once you decide to use KPP*Free*™ and schedule your appointment, we will send you a KPP*Free*™ Voucher.

Give the KPP*Free*™ Voucher to your provider when you arrive at your appointment. This ensures that the provider files the claim through KPP*Free*™ and is free to you!

Free!

Well done! Your medical services were FREE, and your choice also saved money for your health plan!

Services Available

Thousands of medical services are offered through the KPP*Free*™ program, including:

- General Surgeries
- Diagnostic Imaging
- Orthopedics
- Gastrointestinal
- Ear, Nose, & Throat
- Cardiac
- Oncology
- Gynecological
- Opthalmologic/Ocular
- Kidney
- Sleep Disorders
- Diabetic Medical Supplies
- Durable Medical Equipment

Don't forget your Preventive Services!
Many of your preventive screenings can be done through the KPP*Free*™ program. If a diagnosis is found, you can be confident that you won't receive surprise bills, and you may be able to get treatment from the same high-value provider.

Don't have a KPP*Free*™ option near you or want to use your current medical provider? Ask us about how any provider can "price match" and be reimbursed at 100% with a Cash Price Agreement!

To Learn More:

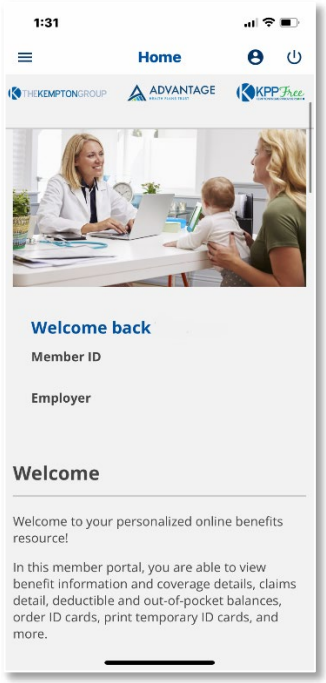
Call (888) 840-6836

Our Kempton Care Advocate team is available Monday - Friday, 8:00 a.m. - 5:00 p.m. C.S.T.

KPPFree.com

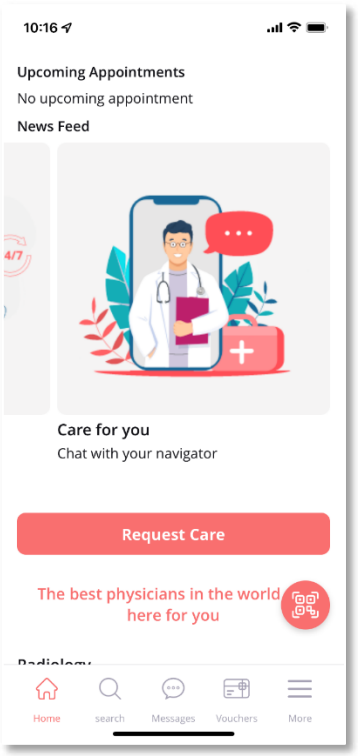
**KPP*Free*™ is only available for covered services. Please refer to your Summary Plan Description for a list of covered services. This Consumer Driven Option is subject to Plan exclusions, limitations, or other restrictions listed in the Plan which may apply. Under IRS guidelines, excepting ACA mandated Preventive Services, participants enrolled in a Qualified High Deductible Health Plan must meet their deductible before receiving a 100% benefit.*

MOBILE APPS



KEMPTON*NOW* APP

Mobile version of the member portal
Access your benefits and claims 24/7
View and download a virtual ID card
Send messages to your Kempton Care Advocates



KPP*FREE*™ APP

Manage KPP*Free*™ services 24/7
Get your KPP*Free*™ voucher virtually
Chat with your Kempton Care Advocate about KPP*Free*™

The KemptonNow and KPP*Free*™ mobile apps are available at Google Play and iOS App Store.

Download on the App Store

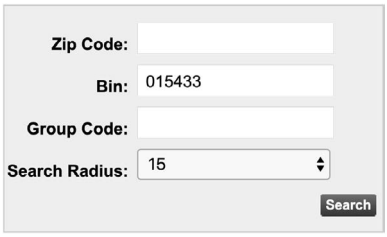
ANDROID APP ON Google play

Network Pharmacy Locator

Liviniti.com/members

Utilize the Network Pharmacy Locator Tool

Members will need to enter the following information:



1. Enter your ZIP code
2. The Southern Scripts Bin Number is **015433**
3. Enter your Group Code found on your insurance/prescription card
4. Select your search radius based on your ZIP code

firstchoice southernscripts

The pharmacy network consists of independent and chain pharmacies. Members of Liviniti have access to reduced prescription costs at participating FirstChoice™ pharmacies. The network is noted with the FirstChoice™ logo on the Pharmacy Locator page.

To maximize savings and reduce your Rx costs, inquire about generic medications to your doctor and pharmacist.

Pharmacy is contracted for specialty medications

Pharmacy is contracted for vaccines

(800) 710-9341 | support@southernscripts.net | Liviniti.com

southernscripts
A new kind of PBM
PHARMACY BENEFIT MANAGEMENT

PREMIER DRUG TIER

Your health plan offers medications at a 100% benefit!

Drugs included in the Premier Drug Tier are available at no cost to you! The next time you visit your doctor ask switching to a drug on this list is right for you.

HOW IT WORKS

- Fish Oil
- Methotrexate
- Sulfasalazine
- Fluticasone / Salmeterol
- Oxybutynin
- Refresh Tears
- MiraLAX
- Systane
- Polyethylene glycol
- Ketotifen
- Flonase
- Zantac 75, Ranitidine
- Tagamet HB, Cimetidine
- Axid AR
- Pepcid AC, Famotidine
- Prilosec
- Nexium 24 Hour
- Prevacid, Lansoprazole
- Claritin, Loratadine
- Claritin-D, Loratadine-D.
- Alavert
- Zyrtec-D, Certirizine-D
- Allegra, Fexofenadine
- Allegra-D, Fexofenadine-D
- Zegerid, Omepra/Bicar
- Zyrtec, Cetirizine

1. Tell your doctor that your prescription drug plan covers listed medications at ZERO cost to you.
2. Obtain a written prescription from your doctor.
   Some Premier Tier Drugs are available over-the-counter, but your doctor must write you a prescription for the pharmacy to process it through your plan.
3. Take the prescription to a pharmacy to have it filled at ZERO cost!
   For over-the-counter drugs, tell the pharmacist your plan offers coverage for the drugs on this list and to use the prescription to process it through your plan.

LEARN MORE

Download the Southern Scripts/Liviniti Mobile App!

- Find a pharmacy
- View your RX history
- Search the formulary
- And more!

(888) 840-6836 | KemptonGroup.com

GET HELP

If you need assistance, have questions, or would like to learn how to get your best benefit, call your dedicated Kempton Care Advocates (KCAs).

Your KCAs can assist you with things like:

- KPP*Free*™ services and Cash Price Agreements
- KPP*Free*™ travel
- Benefit and coverage questions
- How to save money by using your best benefit
- Claims and out-of-pocket questions
- Connecting to Zelis for pre-service or post-service advocacy
- Questions about our website, portal, or mobile apps

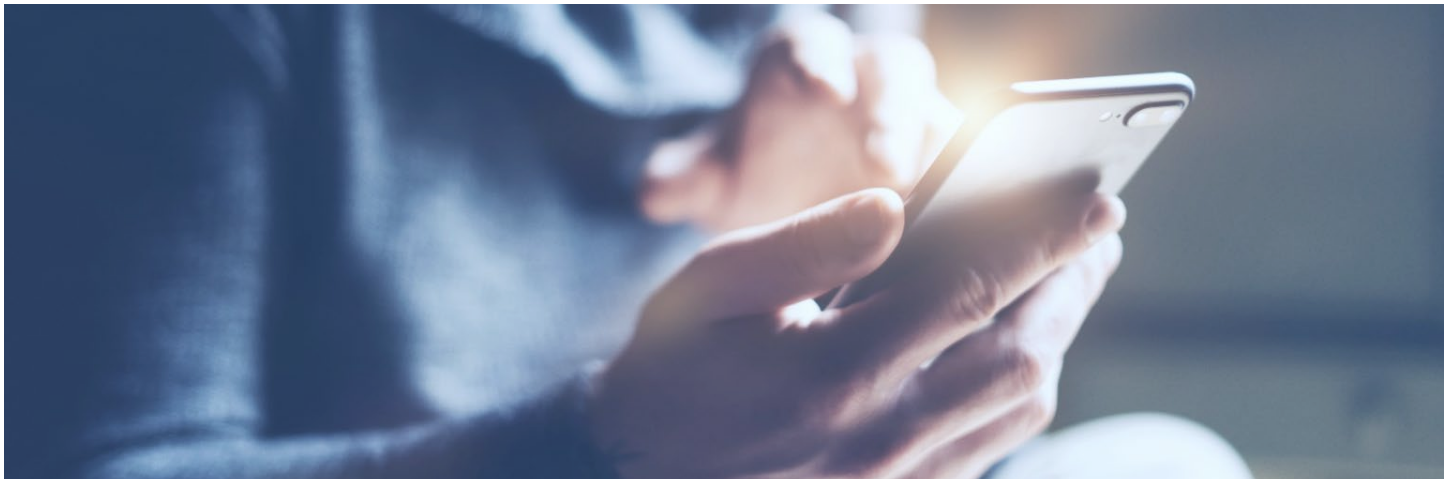
Your KCAs are available Monday - Friday 8:00 a.m. - 5:00 p.m. CST.

Call directly to KCAs | (888) 840-6836

Call our operator | (800) 324-9396

Send us an email | CustomerService@KemptonGroup.com

Visit our website | KemptonGroup.com



RediMD™
Leading Telemedicine

GETTING STARTED WITH REDIMD

PRIORITIZE YOUR HEALTH!

RediMD gives you and your family access to primary care 7 days a week at a time convenient to you. Set up your account today for easy access to care when you need it. RediMD is just a click away!

GET STARTED TODAY

- Enter your registration code
- Create a user and password
- Validate your account
- Complete profile and insurance
- Request a visit when needed

MORE INFORMATION

866-989-CURE

www.redimd.com

RediMD™ Leading Telemedicine

GET STARTED WITH REDIMD

Getting started with RediMD is quick and simple. Go online to redimd.com, click "First Time User" and follow the quick steps.

Enter your registration code

Employer codes are available from your HR/Benefits Department or by sending a "Contact Us" form on redimd.com. If not registering through an employer, use code REDIMD.

Create a user and password

You have the option of creating an account name using your e-mail or cell phone number.

Validate your account

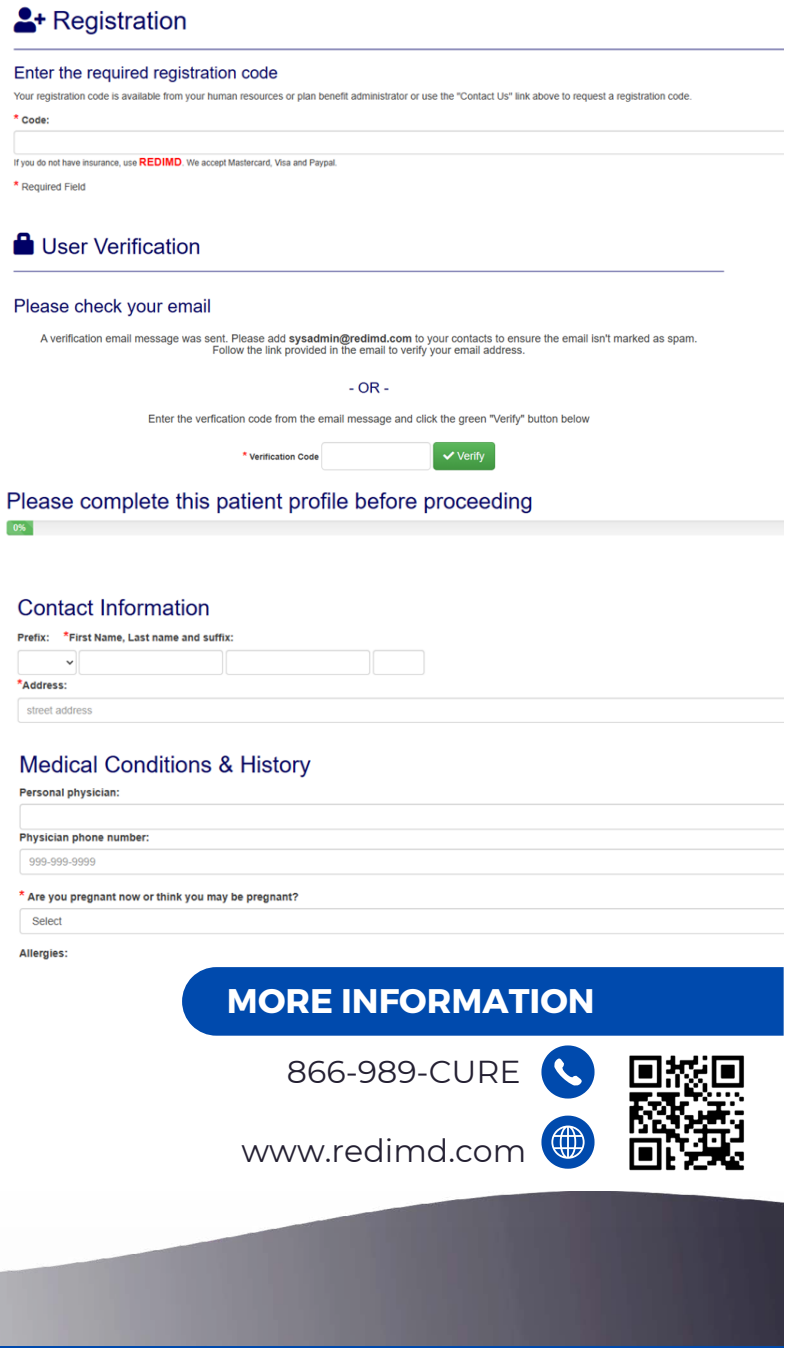
To protect the safety and security of your account, you will be asked to validate your account via e-mail or text message.

Complete profile and insurance

Profiles are quick to complete and asks for your contact information, pharmacy and medical history. You will also select your insurance and type the ID number listed on your insurance card.

Request a visit when needed

Schedule visits when you need them. All you need is your phone or computer with webcam and you are all set!



MORE INFORMATION

866-989-CURE

www.redimd.com

Endocrinologist-Led Telemedicine Diabetes Program

One-of-a-kind program that has demonstrated

- >50% diabetic complication risk reduction
- 0 hospitalizations for diabetic complications
- 100% patient satisfaction with virtual care
- Convenient and direct access to a board-certified endocrinologist

Where you are now

No access to diabetes experts

- Patients must travel to San Antonio & take time off work to see endocrinology
- Unable to schedule appointment due to phone hold times >1h **if** answered at all
- Waiting list >3 months to be seen
- Seen by specialist 1x/year, other visits with midlevel non-specialist
- Waiting room times > 2h
- No lifestyle and nutrition coaching
- Dissatisfaction and worsening health
- **5 minute visit** with MD or midlevel

Where we will take you

Direct telemedicine access to board-certified endocrinologists with proven outcomes

- No travel
- No time off work
- No lost time waiting on hold
- No waiting lists or waiting rooms
- No midlevels
- Healthier and happier employees
- **1 full hour** visit with an endocrinologist physician

Biweekly support from our health and nutrition coaches

Our fully integrated team takes patients from confusion to confidence with diabetes

Meet your ★★★★★ endocrinologists

Vidhya Illuri, MD

Dr. Illuri is committed to fostering a strong patient-physician relationship. She is so passionate about using nutrition that she has done healthy cooking demos on KSAT Live and at her local children's museum. Her training is from Northwestern University and Loyola University.

Arti Thangudu, MD

Dr. Thangudu provides high-level, well-rounded, lifestyle-focused endocrinology and diabetes care. Her training is from Northwestern University, UT Health Science Center in San Antonio. Baylor College of Medicine, Tulane University, and the University of Pittsburgh Medical Center.

COMPLETE MEDICINE

hello@sacomplete.com

www.sacomplete.com

Save with a FSA

PROFICIENT™ BENEFIT SOLUTIONS

What if you could save 30% on your healthcare expenses?

Health FSA

No matter what health plan option you choose, chances are you and your family will incur out-of-pocket costs this plan year – in the form of deductibles, copays, coinsurance, etc. Health FSA dollars can be used to pay for these expenses for you, your spouse and children (up to the age of 27). You can choose to contribute up to the maximum of $3,200.00 per plan year and it is all tax-sheltered dollars. The best part is – up to $640 rolls over to the new plan year if you don't use it. And because the Health FSA is pre-funded, your entire annual election is available for use on the first day of your plan year.

Helpful Tips:

- **Know your coverage.** Every health plan will have out-of-pocket costs in the form of deductibles, copays, and coinsurance.
- **Consider your budget and financial goals.** Ensure your contributions fit into your overall personal finances. Ask yourself how many office visits, prescriptions, specialists, labs, and other procedures you or your family is likely to need.
- **Factor in major purchases.** Look up average costs for any major planned treatments or procedures.
- **Look back at prior years.** Your prior year spending may give you a hint as to how much you are likely to spend this year.

It's time to make those decisions again:

- Regardless of which health insurance plan you choose, you are likely to incur out-of-pocket costs. An FSA allows you to stretch your healthcare dollars an average of 30% by using pre-tax funds.
- Put the 'right' amount of money into your account. Consider your financial goals, your likely spending needs, and your budget constraints.

Dependent Care FSA

The most you can set aside is $ 5,000 single or married and filing jointly or $2,500 if married and filing separately. The person whose expenses you are claiming must be

- your qualifying child under the age of 13, who shares the same residence with you; or
- your spouse or qualifying child or qualifying relative who is physically or mentally unable to care for him/herself who shares the same residence with you and has income less than the Federal exemption amount.

You must make a new election each year!

210-659-8100 • ask@proficientbenefits.com • www.proficientbenefits.com

PROFICIENT™
BENEFIT SOLUTIONS

Manage your account on-the-go!

PROFICIENT™
connect

Register Today!

Visit www.proficientbenefits.com
Click on *Login*
Select *Proficient Connect*
Click on *Register*

- **Step One**- Complete the registration form
  - Choose a username & password
  - Enter your demographic information
  - Use Employer ID: SASSFDR when prompted for Registration ID
  - Your Employee ID is your SSN without dashes or spaces
- **Step Two**- Select 4 security questions
- **Step Three**- Confirm email address
- **Step Four**- Review and confirm registration information and security questions. *You may want to print your security questions for future reference.*

Features

A single digital experience – optimal viewing experience across all browsers and devices, including touchscreens

Personalized content – resources and messages are tailored to your individual preferences and account settings

Full account details at your fingertips – intuitive online access to plan details, account balances, and transaction history (including prior years)

Self-service convenience – check balances, submit claims and receipt documentation, pay bills, manage investments, and more

Comprehensive decision support tools – educational and interactive tools to help you make critical spending and saving decisions throughout the plan year

Communication when you need it – manage your preferences, with access to more than 25 alerts to keep you connected to your account

Value-add services and offers – to help you get the most value from your healthcare dollars

The Proficient Connect mobile app provides ultimate convenience and 24/7 access directly from your tablet or mobile device.

Register Today!

Download and open the Proficient Connect app

Click on *Register*

- **Step One**- Complete the registration form
  - Select a username
  - Create and confirm password
  - Use Employer ID: SASSFDR when prompted for Registration ID
  - Your Employee ID is your SSN without dashes or spaces
- **Step Two**- Select 4 security questions
- **Step Three**- Confirm email address
- **Step Four**- Review and confirm registration information and security questions.

Note: If your device uses touch or face recognition access technology , you can choose to enable them to access Proficient Connect Mobile(Touch ID and Face ID for Apple devices, or Fingerprint Access for Android devices). These options can be changed and disabled at any time via the 'Settings' screen.

Features

Ask Emma – the industry's first voice-activated intelligent assistant that provides answers to questions you may have about your benefit account

Access accounts – check balances, view transaction history, and more

Manage claims – submit new claims, upload receipts, and check claims status

Eligibility Scanner – check the eligibility of an item

Access cards – manage card details, access your PIN, and initiate card replacement for lost or stolen cards

Receive alerts – view important account messages

Update your profile – update personal information, including your email and mobile phone

PO Box 380678, San Antonio TX 78268 • 210-659-8100 • ask@proficientbenefits.com • www.proficientbenefits.com

DENTAL

Carrier - MetLife

MetLife gives you the freedom to choose whether you would like to visit a participating dentist or an out-of-network dentist. There are considerable cost savings when using a dentist who is in network. The following is a brief summary of the major plan provisions.

Dependent Age Limits: To age 26 | **Waiting Periods:** None

Benefit	Dental Plan	
	In-Network	Out-of-Network
Deductible (aggregate) Period Waived for	**$50 Individual / $150 Family** Calendar Year Preventive	
Annual Maximum (applies to A, B, C services)	$1,000 per person	
Reimbursement	Negotiated Fee Schedule	90th R&C
Type A - Preventative Services Oral Examinations (once/6 months) Cleanings (once/6 months) Sealants (to age 15, 1/ molar in lifetime) Bitewing X-Rays (to age 19, twice/1 year) Fluoride (to age 16, once/1 year) Space Maintainers (to age 15, 1/ lifetime) Lab & Other Tests	100%	100%
Type B - Basic Services Amalgam Fillings (1 replacement/surface in 24 months) X-Rays (once/5 years) Oral Surgery (simple extractions) Periodontics Non Surgical (once/quadrant, 24 months) General Anesthesia Recementations (once/12 months) Harmful Habits Appliances	80%	80%
Type C - Major Services Surgical Extractions Crown Buildups/Post Core (1/tooth in 84 months) Implants (1/tooth position in 84 months) Bridges & Dentures Crown, Denture, and Bridge Repair (once/12 months) Crowns, Inlays, Onlays (once/84 months) Periodontal Surgery (once/quadrant, 36 months)	50%	50%
Orthodontia	50% Lifetime Maximum: $1,000 per person	

Dental Plan Deductions	
Coverage Tier	Monthly
Employee Only	$27.33
Employee + Spouse	$56.16
Employee + Child(ren)	$63.61
Family	$92.78

MetLife

www.metlife.com/mybenefits

How to Register on MyBenefits

MyBenefits provides you with a personalized, integrated and secure view of your MetLife-delivered benefits. You can take advantage of a number of self-service capabilities as well as a wealth of easy to access information. MetLife is able to deliver services that empower you to manage your benefits. As a first time user, you will need to register on MyBenefits. To register, follow the steps outlined below.

Registration Process for MyBenefits

Provide Your Group Name

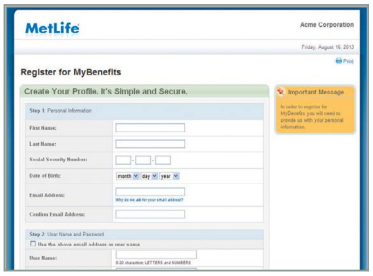
Access MyBenefits at www.metlife.com/mybenefits and enter your group name and click **'Submit.'**

The Login Screen

On the Home Page, you can access general information. To begin accessing personal plan information, click on **'Register Now'** and perform the one-time registration process. Going forward, you will be able to log-in directly.

Step 1: Enter Personal Information

Enter your first and last name, identifying data and e-mail address.



Step 2: Create a User Name and Password

Then you will need to create a unique user name and password for future access to MyBenefits.

The User Name and Password requirements may vary by company setup. General setup includes a User Name between 8-20 characters, containing at least one letter and one number, and a password between 6-20 characters, containing at least one letter and one number.

Step 3: Security Verification Questions

Now, you will need to choose and answer three identity verification questions to be utilized in the event you forget your password.

Step 4: Terms of Use

Finally, you will be asked to read and agree to the website's Terms of Use.

Step 5: Process Complete

Now you will be brought to the "Thank You" page.

Lastly, a confirmation of your registration will be sent to the email address you provided during registration.

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166
www.metlife.com

VISION

Carrier - Eyetopia

Eyetopia is pleased to present to you vision benefits designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health.

Dependent Age Limits: To age 26 | **Waiting Periods:** None

Benefit	Vision Plan - 180/300H (once every calendar year)
Benefit One (choose either one of the following 2 options every 12 months) Refractive Exam- One refraction or one Routine Vision Exam Medical co-pays or any material or service of an equal or lesser value	 $5 copay[1] $65 allowance
Benefit Two (choose only one of the following Vision Correction Options) Eyetopia Vision Care Provides you with three (3) options for correcting your vision	
Lenses and/or frame [2,3] Single Vision Bifocal Trifocal PAL lenses (include a Basic anti-Reflective Coat - covered 100%)	 copay not applicable copay not applicable copay not applicable $120 allowance
Frames The member may select any frame on display, allowance will be applied toward the frame selected. The member pays any amount exceeding the allowance.	$180 allowance
Contact Lenses Elective[6] Medically Necessary[7]	 $300 allowance to be applied towards lenses, fitting fee, and any other charges $250 evaluation allowance and $400 contact lens allowance
Refractive Surgery Option[6] (You may select refractive surgery instead of spectacles or contact lenses during each plan period) LASIK, ASA, ICL or RLE	In-Network: $500 per eye allowance Out-of-Network: $150 per eye allowance

Vision Plan Monthly Deductions	
Coverage Tier	**Vision Plan - 180/300H**
Employee Only	$20.00
Employee + One	$39.00
Family	$54.00

1 The co-pay must be paid to the Participating Provider at the time of service.
2 Special Lens Materials: The member may select special lens materials (transition, ultra light, premium PALs, etc.) provided they pay any amount exceeding the participating provider's U&C fees for the covered lenses.
3 Non-covered items: Any items not specifically mentioned above, including but not exclusive to rush service, service agreements, special lens materials, oversize and other extras are paid for by the patient at the time of service. Standard Progressive Lenses are defined as any brand of PAL offered by the Participating Provider with a retail value of $120.00 or less.
4 If the contact lens exam or "fitting" is performed and the patient decides against getting contact lenses, the patient is responsible for the cost of the contact lens fitting fee.
5 Total maximum benefit allowance is $650.00. The Participating Provider must pre-authorize medical necessity.
6 If the contact lens evaluation, fitting or dispensing service is performed and the Member decides to use their benefit toward an alternative vision correction option, the Member must pay the cost of the contact lens evaluation, fitting or dispensing service before another vision correction benefit option can be used.
7 Total maximum benefit allowance is $650.00. The Participating Provider must pre-authorize medical necessity.

VISION CONT.

Carrier - Eyetopia

Dependent Age Limits: To age 26 | **Waiting Periods:** None

Benefit	Vision Plan - 120/145 (once every calendar year)
Benefit One[2] (choose either one of the following 2 options every 12 months) Refractive Exam- One refraction or one Routine Vision Exam Medical co-pays or any material or service of an equal or lesser value	 $10 copay[1] $45 allowance
Benefit Two (choose only one of the following Vision Correction Options) Eyetopia Vision Care Provides you with three (3) options for correcting your vision	
Lenses and/or frame [3] Single Vision[4] Bifocal[4] Trifocal[4] PAL lenses[4]	 $20 copay[1] $20 copay[1] $20 copay[1] $120 allowance
Frames The member may select any frame on display, allowance will be applied toward the frame selected. The member pays any amount exceeding the allowance.	$120 allowance
Contact Lenses Elective [6] Medically Necessary[7]	$145 allowance after $20 co-pay to be applied toward lenses, fitting fee, and any other charges $145 evaluation allowance and $400 contact lens allowance
Refractive Surgery Option[7] (You may select refractive surgery instead of spectacles or contact lenses during each plan period) LASIK, ASA, ICL or RLE	 In-Network: $350 per eye allowance Out-of-Network: $75 per eye allowance

Vision Plan Monthly Deductions Coverage Tier	Vision Plan - 120/145
Employee Only	$8.00
Employee + One	$15.00
Family	$22.00

1 The co-pay must be paid to the Participating Provider at the time of service.
2 When Health Insurance Carriers offer an annual wellness eye exam it creates an overlap in benefits for Eyetopia Members. If this occurs, the Member may choose another option under Benefit One as described, a $10.00 co-pay is still required to exercise these other options.
3 Special Lens Materials and Non-covered Items: Transition, ultra light, premium PALs, rush service, service agreements, other special lens materials, oversize, other extras and any items not specifically mentioned above may be substituted provided the Member pays any amount exceeding the price of the covered benefit and the Participating Provider's usual and customary fees for the upgrade at the time of service.
4 Standard Progressive Lenses are defined as any brand of PAL offered by the Participating Provider with up to a $120.00 retail value.
5 If the contact lens exam or "fitting" is performed and the patient decides against getting contact lenses, the patient is responsible for the cost of the contact lens fitting fee.
6 If the contact lens evaluation, fitting or dispensing service is performed and the Member decides to use their benefit toward an alternative vision correction option, the Member must pay the cost of the contact lens evaluation, fitting or dispensing service before another vision correction benefit option can be used.
7 The Participating Provider must pre-authorize medical necessity.
8 This allowance can be applied toward the contact lens fitting fee and all other charges including follow-up visits and contact lenses.

LIFE AND AD&D

Carrier - The Standard

BASIC TERM LIFE AND AD&D

The company provides you with a maximum amount of $10,000 of Basic Life and Accidental Death and Dismemberment (AD&D) Insurance coverage through The Standard. San Felipe Del Rio CISD provides a guaranteed issue amount of Basic Life insurance at ***no cost to you during your employment***. Please ***call*** the Benefits Service Center ***to designate or update beneficiary information***.

The AD&D insurance provides a monetary benefit to an employee or beneficiary when the employee experiences certain bodily injuries or death resulting from a covered accident while insured. The company provides a guaranteed issue amount equal to the basic life insurance amount.

Benefits Payable	
	Employee Benefits
Age Reduction	To 50% at age 70

VOLUNTARY TERM LIFE AND AD&D

In addition to the company paid life insurance, you have the opportunity to elect additional life insurance through The Standard. AD&D amount will reflect the Voluntary Life insurance amount.

Benefits	**Voluntary Term Life and AD&D**
Employee Benefit Benefit Amount Guarantee Age Reduction	 Each year at annual enrollment the employee can increase in increments of $10k with no EOI not to exceed GI of $200k.$XX Up to $200,000 To 50% at age 70
Spouse Benefit Benefit Amount Guarantee Age Reduction	 Each year at annual enrollment the employee can increase in increments of $5k with no EOI not to exceed GI of $50k. Up to $50,000 To 50% at age 70
Child Benefit Benefit Amount Guarantee Age Reduction	 For eligible children 14 days to 26 years (26 if full time student), you may choose to purchase benefits of $5,000 or $10,000 to $10,000 Up to $10,000 N/A

UNIVERSAL LIFE

Carrier - Trustmark

Trustmark's fully-portable Universal Life solutions address differing employee needs for permanent life insurance and peace of mind for a lifetime. These are available for employees and their spouses and their children in face amounts from $5,000 up to $300,000. The options include the industry's most comprehensive Living Benefits package.

Benefits	Plan
Universal Life Events®	LifeEvents pays a higher death benefit during the working years when expenses are high and families need maximum protection. At age 70, when financial needs are typically lower, the death benefit reduces to one third. However, higher Living Benefits do not reduce — they continue through retirement to match the greater need for Long Term Care (LTC).
Spouse/Domestic Partner	Inflation-fighting options for employees and spouses. Guaranteed increases to both living and death benefits without underwriting. Employees and spouses through age 60: additional premium of $1 per week on each of the first 10 anniversaries.
Terminal Illness Benefit	Acccelerates 75% of death benefit amount when life expectancy is 24 months or less, as compared with 50% and 6- or 12-month life expectancies commonly seen in the industry.
Accelerated Death Benefit for Criical Care (Built-in)	Designed to accelerate Death Benefit at 4% per month for up to 25 months to pay for long-term care in an assisted living or long-term care facility, or home health care and/or adult day care.

Please speak to a licensed Benefit Counselor(s) for personalized rates.

ACCIDENT

Carrier - Guardian

You do everything you can to keep your family safe, but accidents do happen. It's comforting to know you have help to manage the medical costs associated with accidental injuries, both on and off the job. Guardian's Accident insurance pays a scheduled cash benefit upon diagnosis of covered accident injuries. The Accident policy will pay a ***$50 wellness benefit*** once per calendar year, per person.

Benefit	Accident Plan	
	Plan 1	Plan 2
Accidental Death Benefit Employee Spouse Children	 $25,000 $12,500 $5,000	 $60,000 $20,000 $10,000
Common Carrier	200% of AD&D	200% of AD&D
Ambulance: Ground **Ambulance: Air**	$150 $1,000	$200 $1,500
Appliance	$125	$125
Lacerations	Up to $400	Up to $500
Second and Third Degree Burns	Up to $12,000	Up to $12,000
Therapy Services (up to 10 days)	$25 per day	$35 per day
Concussion	$75	$100
Dislocation	Up to $4,400	Up to $4,800
Emergency Dental Work	$300/Crown, $75/Extraction	$400/Crown, $100/Extraction
Epidural Pain Management (2 times per accident)	$100	$100
Coma	$10,000	$12,500
Eye Injury	$300	$300
Fractures	Up to $5,500	Up to $6,000
Surgery	Up to $1,250	Up to $1,500
Initial Physician's office/Urgent Care Facility Treatment	$75	$100
Hospital Admission	$1,000	$1,250
Hospital Confinement (per day up to 1yr)	$225 per day	$250 per day
Hospital ICU Admission	$2,000	$2,500
Hospital ICU Confinement (up to 15 days)	$450 per day	$500 per day

Accident Plan Deductions Coverage Tier	**Plan 1** Monthly	**Plan 2** Monthly
Employee Only	$17.78	$20.16
Employee + Spouse	$28.64	$31.78
Employee + Child(ren)	$29.57	$32.41
Family	$40.43	$44.03

CRITICAL ILLNESS

Carrier - Guardian

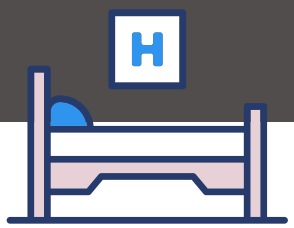
You have responsibilities - to yourself and to your family. Critical Illness Insurance protects you and your family in the event of a serious illness or other medical condition with coverage that is portable (meaning you can take it with you if you leave!) Payments are made directly to the employee and can be applied to claims, household bills, or other expenses as needed.

Benefit	Critical Illness
Coverage Amounts	
Employee (Guaranteed Issue - $20,000)[1] Spouse (Guaranteed Issue - $10,000)[1] Child (All child amounts are guaranteed)[2]	$5,000 to $20,000 $5,000 to $10,000 25% of employee amount
Benefit Reductions	50% at age 70
Benefit	
Heart Attack Stroke Heart Failure Organ Failure Kidney Failure Coma ALS (Lou Gehrig's Disease) Loss of Speech, Sight, or Hearing Severe Burns	100%
Coronary Arteriosclerosis Addison's Disease Huntington's Disease	30%
Wellness Benefit (Provides a per year benefit for completing certain routine wellness screenings or procedures)	
Employee Spouse Child	$50 $50 $50
Pre-Existing Condition Limitation	3-month look-back period, 6 months treatment-free /12 months after

1 Less than age 70
2 Dependent Age Limits - 0 days to 26 years (26 if full time student)

Child cost is included with employee election.

Critical Illness Plan Monthly Deductions - Employee							
Benefit Amounts		<30	30-39	40-49	50-59	60-69	70+
Non-Tobacco	$10,000	$3.24	$4.80	$8.20	$14.76	$24.20	$52.02
	$20,000	$6.48	$9.60	$16.40	$29.52	$48.40	$104.04
Tobacco	$10,000	$4.20	$6.72	$13.10	$23.32	$39.92	$85.84
	$20,000	$8.40	$13.44	$26.20	$46.64	$79.84	$171.68
Benefit Amount Up To 50% of Employee Amount to a Maximum of $10,000 - Spouse							
Benefit Amounts		<30	30-39	40-49	50-59	60-69	70+
Non-Tobacco	$5,000	$1.62	$2.40	$4.10	$7.38	$12.10	$26.01
	$10,000	$3.24	$4.80	$8.20	$14.76	$24.20	$52.02
Tobacco	$5,000	$2.10	$3.36	$6.55	$11.66	$19.96	$42.92
	$10,000	$4.20	$6.72	$13.10	$23.32	$39.92	$85.84



CANCER INSURANCE

Carrier - Guardian

While most people can appreciate the importance of having health and disability insurance, the costs of cancer can go well beyond what they cover. Cancer insurance is an affordable way to provide additional funds to help cover out-of pocket expenses.

The average out-of-pocket cost for patients with cancer is estimated to be $1,200 a month. Copays and deductibles, out-of-network and experimental treatments, home health care needs, and travel are just some of the costs a person could face if they are diagnosed with cancer. And that's on top of everyday bills such as groceries, utilities, car payments and others they need to keep up with. Cancer insurance is an affordable way for you to address rising medical costs while strengthening your employee benefit package.

Benefit	Cancer	
	Plan 1	Plan 2
Initial Diagnosis Benefit Employee Spouse Child	 $1,500 $1,500 $1,500	 $1,500 $1,500 $1,500
Benefit Waiting Period	30 days	30 days
Cancer Screening	$50; $50 follow-up screening	$50; $50 follow-up screening
Radiation Therapy or Chemotherapy	Up to a maximum of $15,000 per benefit year	
Pre-Existing Condition Limitation	3-month look-back period; 12-month exclusion period	
Air Ambulance (limit 2 trips per confinement)	$1,500 per trip	$2,000 per trip
Ambulance (limit 2 trips per hospital confinement)	$200 per trip	$250 per trip
Anesthesia	25% of surgery benefit	
Anti-Nausea	$50/day up to $150 per month	$50/day up to $250 per month
Attending Physician (limit 75 visits)	$25/day while hospital confined	
Blood/Plasma/Platelets (per year)	$100/day up to $5,000	$200/day up to $10,000
Bone Marrow/Stem Cell	Bone Marrow: $7,500 Stem Cell: $1,500 50% benefit for 2nd transplant $1,000 benefit if a donor	Bone Marrow: $10,000 Stem Cell: $2,500 50% benefit for 2nd transplant $1,500 benefit if a donor
Experimental Treatment	$100/day up to $1,000/month	$200/day up to $2,400/month
Extended Care Facility/Skilled Nursing Care	$100/day up to 90 days per year	$150/day up to 90 days per year
Hospital Confinement	$300/day first 30 days $600/day for 31st day thereafter	$400/day first 30 days $800/day for 31st day thereafter
ICU Confinement	$400/day for first 30 days; $600/day for 31st day thereafter per confinement	$600/day for first 30 days; $800/day for 31st day thereafter per confinement
Skin Cancer	Biopsy Only: $100 Reconstructive Surgery: $250 Excision of a skin cancer: $375 Excision of a skin cancer with flap or graft: $600	

Cancer Plan Deductions Coverage Tier	**Plan 1** Monthly	**Plan 2** Monthly
Employee Only	$23.81	$28.55
Employee + Spouse	$44.89	$53.72
Employee + Child(ren)	$26.60	$31.61
Family	$47.68	$56.78

DISABILITY

Carrier - The Standard

We understand the unique needs of those who work in education, and we have Long-Term Disability insurance to meet those requirements. The Standard's Long-Term Disability insurance can replace a portion of your salary if you become ill or injured and can't work. It can help you cover your expenses and protect your finances at a time when you're not getting a paycheck and have extra medical bills.

LONG-TERM DISABILITY (LTD)

The Standard's Long-Term Disability Insurance provides income replacement benefits for you and your family in the unfortunate event you are unable to work due to injury or illness. As long as you remain disabled, you can receive payments for up to ***24 months***. This covers injuries and illnesses from both on- or off-the-job.

Highlights	Long-Term Disability
Employee Benefit	You may purchase a benefit in multiples of $100 units, starting at a minimum of $200, up to $7,500.
Maximum Monthly Benefit	The lesser of $7,500 or 66 2/3% of your pre-disability earnings rounded to the nearest $100.

Please speak to a licensed Benefits Counselor(s) for personalized rates.

Definition of Disability: During the first 24 months, Standard will define disability as follows:

You are unable to perform the material and substantial duties of your regular occupation due to sickness or injury; you have a 20% or more loss of indexed monthly earnings due to the same sickness or injury; and, during the elimination period, you are unable to perform any of the material and substantial duties of your regular occupation.

After benefits have been paid for 24 months, you are disabled when Standard determines that, due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

Why is LTD coverage so valuable?

- It's flexible. You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.
- It's affordable. Your cost is based on your age when you buy the insurance and will not increase when you move into the next age band.
- It's convenient. Your premiums are automatically deducted from your paycheck.

Emotional wellbeing and work-life balance resources to keep you at your best

SupportLinc offers expert guidance to help you and your family address and resolve everyday issues

In-the-moment support
Reach a licensed clinician by phone 24/7/365 for immediate assistance

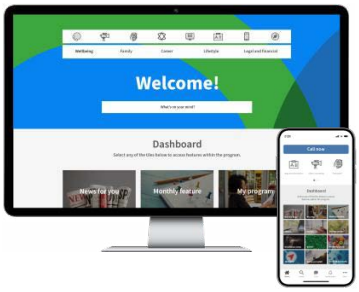
Financial expertise
Consultation and planning with a financial counselor

Legal consultation
By phone or in-person with a local attorney

Short-term counseling
Access up to **five (5) no-cost counseling sessions,** in-person or via video, to resolve stress, depression, anxiety, work-related pressures, relationship issues or substance abuse

Convenience resources
Referrals for child and elder care, home repair, housing needs, education, pet care and so much more

Confidentiality
Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law



Your web portal and mobile app
- The one-stop shop for program services, information and more
- Discover on-demand training to boost wellbeing and life balance
- Find search engines, financial calculators and career resources
- Explore thousands of articles, tip sheets, self-assessments and videos

Convenient, on-the-go support
- **Textcoach®**
  Personalized coaching with a licensed counselor on mobile or desktop
- **Animo**
  Self-guided resources to improve focus, wellbeing and emotional fitness
- **Virtual Support Connect**
  Moderated group support sessions on an anonymous, chat-based platform

Start with Navigator
Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator survey. You'll immediately receive personalized guidance to access support and resources.

supportlinc

Download the mobile app today!

1-888-881-5462

supportlinc.com:
sfdrcisd

HEALTH INSURANCE TERMS

In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, health plans, and health care providers.

- **Benefits -** The amount of money payable by an insurance company to a claimant under the insurance policy.
- **Claim -** A request by an individual (or his /her provider) for the insurance company to pay for services obtained.
- **Co-insurance -** The money that an individual is required to pay for services, after deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20% of the charges while the health plan pays 80%.
- **Co-payment -** An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered.
- **Deductible -** A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual or contract year basis.
- **Exclusions and Limitations -** Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).
- **Flexible Spending Account (FSA) -** An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.
- **High Deductible Health Plan (HDHP) -** A health plan that meets the requirements of being considered an HDHP. There are NO copayments on an HDHP. All medical and prescription drug expenses are applied towards the calendar year deductible first, then once a member has satisfied his/her deductible, the coinsurance will apply.
- **In-Network -** Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.
- **Medically Necessary -** A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.
- **Out-of-Network -** Typically refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.
- **Maximum Out-of-Pocket Maximum -** The total amount paid each year by the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that calendar year.
- **Pre-Existing Condition -** Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.
- **Preferred Provider Organizations (PPO) -** A type of managed care plan in which doctors and hospitals agree to provide discounted rates to plan members. Patients are typically reimbursed 80-100% for treatment received withing the network, versus 50-70% outside the network.
- **Primary Care Physician (PCP) -** A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP services as a gatekeeper for an individual's care, referring him or her to specialists and admitting him or her to hospitals when needed.
- **Reasonable and Customary Charges -** The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges then are the responsibility of the patient.
- **Explanation of Benefits (EOB)-** A summary of claims processed which will be provided to you after a claim is processed for you or for a dependent. This statement outlines year-to-date deductible and out-of-pocket amounts met during the year. This statement will be mailed unless it is turned off on the website.

FREQUENTLY ASKED Q&A

This document outlines important annual, required legal notices for San Felipe Del Rio CISD. If you have any questions about these notices, contact the Human Resources at **830-778-4100**.

GENERAL

If I am already enrolled and not making any changes, do I have to complete the Open Enrollment process?

Yes. It is important that you review any rate or plan changes to your current plan.

If I want to decline coverage, must I still complete the Open enrollment process?

Yes. It is important that Human Resources has a record of your decision. Please keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a special qualifying event such as a marriage, divorce, birth or adoption of a child, or loss of other coverage.

Can I enroll my spouse or dependent on one plan and myself on another?

No. All covered dependents, including spouse, must be on the same plan as the employee.

Can I drop or change plans during the plan year?

Changes can only be made if there has been a qualifying event or personal life change. Examples include marriage, divorce, birth of a child, or change in employment status.

What is the difference between a calendar year and a contract year?

A plan on a calendar year runs from January 1–December 31. Items like deductible, maximum out-of-pocket expense, etc. will reset every January 1. All Individual and Family plans are on a calendar year. A plan on a contract year (also called benefit year) runs for any 12-month period within the year. Items like deductible, maximum out-of-pocket expense, etc. will reset at the plan's renewal date. For example, ABC Company renews on July 1 every year. Your deductible would start July 1 and end on June 30. The deductible would reset every July 1 for ABC Company members.

What happens if I sign up for insurance but find later on in the year that I cannot afford the premiums?

If the reason for your change in affordability is due to a life-changing event such as the loss of a job, death of a spouse, or birth of a child, you would be eligible for special enrollment within 60 days of the event. If you do not enroll during this period, you will not be assured a health plan will cover you either through the Health Insurance Marketplace or in the private market. If you do not pay your premium, you could lose coverage and will not be able to enroll again until the next open enrollment period.

Benefit payments

For benefits received in the Network, you are responsible only for your co-payment, deductible and coinsurance amounts. Your provider will file the claim.

MEDICAL

Should I notify my pharmacy and physician of my benefits plan with Kempton?

Yes. On your next visit to the pharmacy or doctor, simply present your Kempton ID card. This will allow the provider to correctly bill UMR for the services you have received. It's important to inform your physician of the requirement to utilize an Kempton facility as a medical plan participant.

LEGAL NOTICES

Certificate of Creditable Coverage

You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA, when COBRA coverage ceases, if you request it before you lose coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage from the plan, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in other coverage if you are age 19 or older.

Health Insurance Portability and Accountability Act (HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. A copy of the Privacy Practices is available for medical, dental, vision, and healthcare Flexible Spending Accounts from Human Resources.

Newborns' and 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 of 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Act of 2008 general requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employers plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (830) 778-4100.

Women's Health and 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). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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.

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact HR at (830) 778-4100.

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

For additional information, contact your plan administrator at (830) 778-4100.

LEGAL NOTICES

An Important Notice from San Felipe Del Rio CISD 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 San Felipe Del Rio CISD 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 Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
San Felipe Del Rio CISD has determined that the prescription drug coverage offered by the San Felipe Del Rio CISD Welfare Benefit Plan is, on average for all plan participants, 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 and each year from October 15th to December 7th. 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.

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 San Felipe Del Rio CISD coverage will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current San Felipe Del Rio CISD coverage, be aware that you and your dependents will be able to get this coverage back.

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 San Felipe Del Rio CISD 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 that 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 October to join.

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

Name of Entity/Sender: San Felipe Del Rio CISD
Contact--Position/Office: Rachel Garcia, Employee Benefits Coordinator
Address: 315 Griner Road
Phone Number: (830) 778-4100
Email: Rachel.garcia@sfdr-cisd.org

LEGAL NOTICES

Patient Protection Rights under HealthCare Reform

HMO health plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, your HMO health plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your HMO health plan using the contact information provided in the Benefit Guide.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your HMO health plan 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 your HMO health plan using the contact information provided in the Benefit Guide.

LEGAL NOTICES

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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 2013 for coverage starting as early as January 1, 2014.

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 9.5% 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 Rachel Garcia rachel.garcia@sfdr-cisd.org

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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.

LEGAL NOTICES

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.

3. Employer name San Felipe Del Rio CISD		4. Employer Identification Number (EIN) 74-1694073
5. Employer address 315 Griner Rd.		6. Employer phone number 830-778-4100
7. City Del Rio	8. State TX	9. ZIP code 78840
10. Who can we contact about employee health coverage at this job? Rachel Garcia		
11. Phone number (if different from above)	12. Email address rachel.garcia@sfdr-cisd.org	

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Eligible employees working 30 hours or more per week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Eligible spouses and eligible children up to age 26.

☐ We do not offer coverage.

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

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

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

SAN FELIPE DEL RIO CONSOLIDATED SCHOOL DISTRICT

2023 - 2024 SCHOOL CALENDAR

July

(3-7) District Closed
4 Independence Day
31 New Teacher Orientation

August

(1-4) New Teacher Orientation
(7-10) Staff Development
11 Teacher Work Day
14 First Day of School/ Begin 1st Six Weeks

September

4 Labor Day / Holiday
22 End 1st Six Weeks
25 Begin 2nd Six Weeks

October

9 Indigenous People's Day / Holiday

November

3 End 2nd Six Weeks
6 Begin 3rd Six Weeks
10 Veteran's Day - Holiday
(20-24) Thanksgiving Break

December

(5-15) STAAR Testing
22 End 3rd Six Weeks
(25-29) Winter Break

January

(1-5) Winter Break
8 Teacher Work Day
9 Begin 4th Six Weeks
15 MLK Day / Holiday
15 Make-Up Day / If Applicable

February

23 End 4th Six Weeks
26 Begin 5th Six Weeks

March

(11-15) Spring Break
29 Good Friday / Holiday

April

1 Easter / Holiday
1 Make-Up Day / If Applicable
(2-5) STAAR Testing
8 Solar Fest Day / Holiday
19 End 5th Six Weeks
22 Begin 6th Six Weeks
30 STAAR Testing

May

(1-17) STAAR Testing
24 Last Day for Seniors
27 Memorial Day / Holiday
30 End 6th Six Weeks/Last Day Of School
31 Graduation
31 Teacher Work Day

June

3 HB3 Extended Year Begins
(18-28) STAAR Testing

July

(1-5) District Closed
4 Independence Day
12 Last Day of HB3 / Summer School

July 2023

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February 2024

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March 2024

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April 2024

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July 2024

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Together We Are Better

Legend

District Closed	Staff Development
New Teacher Orientation	Student/Staff Holiday
First/Last Day of School	+ + Make Up Day
STAAR Testing	G Graduation
« » Beginning/End of Six Weeks	^ ^ Last day for Seniors
HB3 Extended Year	Teacher Work Day

INSTRUCTIONAL DAYS		TEACHER WORKING DAYS	
1st Six Weeks	29	1st Six Weeks	34
2nd Six Weeks	29	2nd Six Weeks	29
3rd Six Weeks	29	3rd Six Weeks	29
4th Six Weeks	33	4th Six Weeks	34
5th Six Weeks	32	5th Six Weeks	32
6th Six Weeks	28	6th Six Weeks	29
TOTAL	180 Days	TOTAL	187 Days
SENIORS	177 Days		

	Instructional Mins.	Waiver Mins.	Total Mins.:	Excess Mins.:	Instructional Day:	Total Instructional Mins.
Irene Cardwell:	76500	0	76500	900	7:55AM - 3:00PM	425
Elementary:	78300	0	78300	2700	7:50AM-3:05PM	435
SFMMS/DRMS:	78300	0	78300	2700	8:15AM-3:30PM	435
DRHS/DRFS/ECHS /Blended:	80100	0	80100	4500	8:10AM-3:35PM	445
Seniors:	78765	0	78765	3165	8:10AM-3:35PM	445

Board Approved 03/27/2023

NOTES

2024 EMPLOYEE BENEFITS GUIDE

SPC Bldg.
315 Griner St. Del Rio, Texas 78840
Office: 830.778.4100 | www.sfdr-cisd.org

Brown & Brown INSURANCE®