



2021

NEW HIRE BENEFITS

This packet contains benefits information necessary for new hires, rehires, and other eligible employees of Houston Independent School District who are or become benefits-eligible.



This guide provides an overview of your benefits options. Benefits are subject to change without notice. The complete provisions of the plans, including legislated benefits, exclusions and limitations, are set forth in the plan documents or insurance contracts. The insurance contracts are available for your review in the Benefits Department. If the information in this guide is not consistent with the plan documents or insurance contracts or state and federal regulations, the plan documents, insurance contracts and state and federal regulations will prevail. This guide is not intended as a contract of employment or a guarantee of current or future employment.



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The HISD Benefit Programs

HISD provides eligible employees with a full range of benefits to support overall health, wellness, and financial security. The following programs are available to eligible HISD employees:

- Medical, pharmacy, dental, and vision plans
- HISD Employee Health and Wellness Centers
- Wellness programs designed to maximize your overall health and well-being
- Employee assistance program (EAP)
- Life and accidental death and dismemberment (AD&D)
- Cancer, hospital indemnity, and critical illness supplemental coverage
- Disability insurance
- Personal legal plan
- Flexible spending accounts (FSAs) for health care and dependent care
- Accident insurance
- Long-term care offered through Genworth Life Insurance
- Livongo, a program to help with Diabetes
- 403(b) and 457(b) Retirement and Savings Plans

SUMMARY OF BENEFITS COVERAGE (SBC). The Summary of Benefits and Coverage (SBC) summarizes important information about any health coverage option in a standard format to help you compare options. The SBC is available online at www.HISDBenefits.org. Select Resources from the top menu bar and then select Plan and Legal Documents. A paper copy is also available free of charge by calling the HISD Benefits Office at 713-556-6655.

BENEFITS INFORMATION AT YOUR FINGERTIPS

TO LEARN MORE ABOUT YOUR BENEFITS, VISIT www.HISDBenefits.org.



Benefits Eligibility

You can participate in the benefits plans if you are a regular employee (active or on a paid leave approved by the district) and you are an active, contributing member of Teacher Retirement System (TRS). You may also participate if you are retired from TRS and rehired by the district into a benefits-eligible position. If you qualify as a full-time employee as defined under Section 4980H(c)(4) of the Internal Revenue Code, you will be treated as being in an eligible class for purposes of the benefits plan under the Affordable Care Act.

Eligible dependents may participate in some of the benefits plans. Eligible dependents include:

- Your legal spouse
- Your dependent children

Eligible dependent children under 26 years of age include:

- Your biological children
- Your stepchildren
- Your legally adopted children
- Your foster children, including any children placed with you for adoption
- Your child who qualifies as your dependent under the terms of a qualified medical child support order (QMSCO)
- Eligible dependent grandchildren under the age of 25.

Your child (age 26 or over) who otherwise meets the requirements above may be eligible for dependent coverage, provided the child is either mentally or physically incapacitated to such an extent to be dependent on you on a regular basis. Other requirements may apply. The employee must contact the HISD Benefits Dept. at 713-556-6655. To avoid any gap in coverage, the forms must be submitted and approved prior the end of the month the child turns 26.

You are required to provide documentation, such as a birth certificate, marriage license or federal tax return, to support the eligibility status of each of your dependents. If you do not, your dependents lose their coverage and cannot be added back until you show proof of their eligibility during the next enrollment period or qualifying life event. For questions, please contact the HISD Benefits Service Center at 1-877-780-4473.



How to Enroll

As a benefits eligible employee, your invitation to enroll will be sent to your HISD email. You can enroll online by visiting www.HISDBenefits.org. To access the site, enter through the HISD Employee portal as outlined below.

Your benefits will be effective the first of the month following 30 days after your hire date. For example: If your hire date is March 3, your benefits will begin May 1. However, if your hire date is March 1 or 2, your benefits will begin April 1.

Have you been rehired?

- If you are rehired within 30 days of termination, all benefits are bridged.
- If you are rehired outside of 30 days of termination, you will be given an opportunity to enroll.
- If the Affordable Care Act applies, returning employees still in a stability period will continue their current benefits they had prior to leaving the district.

If you do not receive your e-mail invitation to enroll **within 10 working days after your first day of work**, call the HISD Benefits Service Center at **1-877-780-HISD (4473)**. English and Spanish-speaking representatives are available weekdays from 7 a.m. to 7 p.m. except on federally approved holidays.

How to enroll in your benefits:

After you've reviewed your choices and determined your benefits options, you're ready to enroll.

1. Log on to myHISD.
2. Click the Benefits heart icon, which takes you to HISDBenefits.org.
3. Click Enrollment at the top of the page.
4. Click Enroll Now in the menu on the left and follow the instructions.
5. Click #4, which takes you to the Benefits Enrollment site.



When Benefits Begin

- If you are a new enrollee, your benefits coverage begins on your benefits effective date, which is the first of the month following 30 days after your hire date, as long as you select benefits prior to your benefits effective date.
- For benefits requiring evidence of insurability, coverage begins the first of the month following carrier approval of your application.
- For benefits selected during the annual benefits enrollment period, coverage begins January 1 of the following year.
- For reinstatement of benefits within 30 days or outside of 30 days, see "Have you been rehired" on page 4. For questions, please contact the HISD Benefits Service Center at 1-877-780-4473.



Making Benefit Changes

Important events in your life or work can impact your benefits. It is your responsibility to notify the district of a life event or family status change within 31 days of the event date by calling the HISD Benefits Service Center at 1-877-780-HISD (4473). In general, you can only change your benefits coverage during the year if you have a qualified life event or change in family status. **If you don't make changes within 31 days of the life event, you can't make changes to your district benefits until the benefits enrollment period for the next plan year.**

Certifying changes: If dependent eligibility, qualified life event or a family status change can't be verified upon request, the district will assume that you knowingly reported fraudulent or false information on an official district document. Any claims incurred under false pretenses will be assessed to the employee, and legal/disciplinary action may be taken.

Types of Changes

Qualified life events and changes in family status that permit coverage changes are:

- Employee gains a tax dependent, i.e., through birth, legal adoption or placement of a child for adoption
- Marriage
- Divorce or annulment
- Dependent reaches age 26, dependent grandchild reaches age 25
- Spouse gains or loses coverage due to gaining or losing employment/eligibility with current employer
- Death of spouse
- Death of dependent child
- Spouse/dependent becomes Medicare/Medicaid eligible or ineligible
- Spouse adds or drops coverage during a benefits enrollment period that is not concurrent with the district's benefits enrollment
- Court order (QMCSO)

You are required to provide documentation such as a birth certificate or marriage license to support the eligibility status of each of your dependents.

Learn more about making benefit changes: Information is available online at www.HISDBenefits.org under enrollment eligibility.

If you have questions about the type of benefits you may change, call the HISD Benefits Service Center at 1-877-780-HISD (4473) weekdays from 7 a.m. to 7 p.m. Central Time, except holidays.



Dependent Verification Services

Frequently Asked Questions

Q: Why is dependent verification being done?

A: At HISD, we are committed to providing affordable healthcare benefits for all employees and their eligible dependents. One way to ensure we effectively spend our benefits dollars and provide an equal level of benefit to all employees is to verify we are only paying the expenses of eligible dependents as specified in our healthcare plans.

Q: Who will be conducting the verification?

A: HISD has partnered with Automatic Data Processing, Inc. (ADP) to conduct Dependent Eligibility Verification.

Q: Who will be included in the verification?

A: All active employees who wish to enroll in a medical, dental and/or vision plan will be required to provide supporting documents to substantiate dependent eligibility.

Q: How do I know if my dependents are eligible?

A: The definition of eligible dependents is:

- Your legal spouse
- Your dependent children

Eligible dependent children under 26 years of age include:

- Your biological children
- Your stepchildren
- Your legally adopted children
- Your foster children, including any children placed with you for adoption
- Any children for whom you are responsible under a court order
- Your child who qualifies as your dependent under the terms of a qualified medical child support order (QMSCO)
- Eligible dependent grandchildren under the age of 25

You must verify your dependents. Dependent verification is a way of showing proof that any dependent you would like to enroll for benefits coverage meets our plan guidelines for eligibility. It's a very simple, very important process. You only need to do it once. You will be required to show documentation that your dependents meet the HISD plan guidelines. Employees and their dependents may lose or have their benefits eligibility suspended if they are found to have dependents on the plan who are not eligible.

For a child, one of these documents verifies eligibility:

- Adoption certificate
- Birth certificate with parent's name listed
- Documentation of legal guardianship
- Qualified medical child support order
- Adoption placement agreement
- Documentation of legal custody



- Hospital birth record (within 90 days of birth)

For a spouse, one of these documents verifies eligibility:

- Declaration of informal marriage
- Marriage licenses or certificate

If your dependent is a stepchild, you must also provide a copy of a marriage certificate to substantiate the child's relationship to the employee or spouse. If you have any questions, please call the HISD Benefits Service Center at 877-780-HISD (4473)

Q: What types of documentation do I need to provide to satisfy the verification requirements?

A: There are multiple forms of documentation that will be accepted for your dependents.

LIST OF ACCEPTABLE DOCUMENTS

Dependent Group Name Please Submit One Item From

Spouse	› Declaration of Informal Marriage › Marriage License/Certificate	
Child*	› Adoption Certificate › Adoption Placement Agreement › Birth Certificate with Parent's Name Listed › Documentation of Legal Custody	› Documentation of Legal Guardianship › Hospital Birth Record (within 90 Days of Birth) › Qualified Medical Child Support Order

*Please note: If the dependent is a stepchild, you must also provide a copy of a marriage certificate or current tax return to substantiate the child's relationship to the Employee or Spouse.

Important Tips When Submitting Documents

- Do not send original documents because they will not be returned.
- Birth certificates must list the parent(s) name.
- Marriage Licenses or Certificates must be the final document that includes the date of the marriage.

Q: What do I need to do at this time?

A: You should refer to the letter you receive from ADP and collect the documents that you are required to provide for the verification to be approved. They should be submitted as soon as you have the available documents but no later than the deadline provided in your letter and emails.

All you need to do is complete these three simple steps:

1. Review the Cover Sheet and confirm that each dependent is eligible for coverage.
2. Obtain the required documentation for each dependent listed on the Cover Sheet.
3. Upload, fax or mail the completed Cover Sheet, along with the required documentation, by the deadline in your letter.

SECURE UPLOAD: adpdvs.com

REGISTRATION CODE: n3wTqDDQ (sample)

Note: To upload scanned images of your documentation, please log onto adpdvs.com. If this is your first time using the site, you will need a registration code like the one listed above, along with additional requirements that will be listed on the website. Click on the First Time Registration link and follow the instructions on your screen. The website allows you to view the required documents, view a copy of this letter, submit documents and check



SECURE FAX:

ADP Dependent Verification
Services

866-400-1686

MAIL: ADP Dependent Verification Services

ADP-DVS PO Box 2338
Alpharetta, GA 30023-2338

Note: Do not mail original documents; they will not be returned. ADP is committed to protecting employee privacy and can assure you that all documentation will be treated confidentially. You will receive a confirmation letter from ADP Dependent Verification Services after your documentation has been processed.

If you have questions or need additional information regarding the necessary documentation, call:

HISD Benefits Service Center
877-780-HISD (4473)

Representatives are available 7:00 a.m. - 7:00 p.m. CT
Monday-Friday (except holidays) to assist you.

In some situations, you may need to contact a state or local agency. You can access cdc.gov/nchs/w2w.htm for information on where to obtain the necessary documents.

Q: Can I bring my documents to HR instead of sending them to ADP?

A: No. The HISD HR department will not accept your documents; you must provide your documents to ADP. ADP will send you a letter and email directly that will provide the submission instructions.

Q: How will I know if my dependents pass the verification?

A: Once your documentation has been processed, you will receive a letter and email informing you that your dependents have been approved. However, if the documentation provided was insufficient, you will be notified by letter and email what information is still required.

Q: Will my private information be protected?

A: Yes. The information that is needed for the dependent verification is your name, address and dependent information. You can remove or black out any information that pertains to your Social Security Number, account information, account numbers and financial information.

Q: How can I provide my documentation?

A: The letter and email sent from ADP outline three options for providing your documentation. You can scan it and upload it to a secure website, fax your documentation, or mail it to the Dependent Verification Services mail box.

Q: What will happen if I don't respond to the verification letter?

A: Any dependent not verified by document submission by the verification deadline date will be removed from HISD medical, dental and vision benefits. Any necessary rate change due to the removal of the dependents will be reflected on your paycheck following the verification deadline.

Q: Who should I contact for more information?

A: The HISD Benefits Service Center will be available to you during the verification process to answer any questions that you have. You can contact the Service Center by calling 877-780-HISD (4473) and representatives are available 7:00 a.m. to 7:00 p.m. CT, Monday-Friday (except holidays) to assist you.



HISD Employee HEALTH & WELLNESS CENTERS by nextlevel

HISD Health and Wellness Centers are now operated by Next Level Urgent Care.

These convenient clinics make it easy for benefits-eligible employees and covered dependents to receive urgent care close to where they work. Walk-in patients are welcome, but we recommend booking an appointment on the Next Level app or by calling 281-869-3630.

CONVENIENT MEDICAL CARE FOR EMPLOYEES AND COVERED DEPENDENTS

- URGENT CARE
- SPORTS PHYSICALS
- HEADACHES
- RASHES
- SPRAINS & STRAINS
- LACERATIONS
- URINARY TRACT INFECTIONS
- LABS
- FLU SHOTS
- WELLNESS PHYSICALS
- PRIMARY CARE

PERSONAL, HIGH-QUALITY MEDICAL CARE

HISD Employee Health & Wellness Centers are here for most of your day-to-day health care and wellness exams. Even better, if you're enrolled in an HISD medical plan, you can use these services at no cost to you. That also includes care for your covered dependents, age 5 and older.

If you're eligible for HISD health care benefits but not enrolled in the HISD medical plan, you can still use the centers for just \$65-\$125 per visit, plus any additional lab fees.

NOTE: THE CENTERS DO NOT TREAT WORKERS' COMPENSATION INJURIES.

TO MAKE AN APPOINTMENT ONLINE:

GET THE NEXT LEVEL APP

- CLICK THE MENU IN UPPER LEFT CORNER
- CLICK "SCHEDULE APPOINTMENT"
- SELECT HISD CLINIC AND FOLLOW INSTRUCTIONS



HATTIE MAE WHITE EDUCATIONAL SUPPORT CENTER

4400 West 18th Street, Houston, Texas 77092
281-869-3630

Monday: 7 a.m. to 4 p.m.

Tuesday-Thursday: 9 a.m. to 6 p.m.

Friday: 7 a.m. to 4 p.m.

Saturday: 8 a.m. to 12 p.m.

ATTUCKS MIDDLE SCHOOL

4330 Bellfort Street, Houston, Texas 77051
(located off Ferdinand —SW side of campus)
281-869-3630

Monday: 7 a.m. to 4 p.m.

Tuesday-Wednesday: 9 a.m. to 6 p.m.

Thursday: 9 a.m. to 1 p.m.

Friday: 7 a.m. to 4 p.m.

BOTH CENTERS CLOSE DAILY FROM 1 TO 2 P.M.

NEXTLEVELURGENTCARE.COM/HISD



Insurance | Risk Management | Consulting



2021 Annual Enrollment Notices & Disclosures

Houston Independent School District
January 1, 2021

Arthur J. Gallagher & Co.
www.ajg.com



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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 the plan. Therefore, the following deductibles and coinsurance can be found in the Summary of Benefits Coverage at www.hisdbenefits.org.

If you would like more information on WHCRA benefits, please call your Aetna Plan Administrator at 877-224-6857 or visit www.Aetna.com

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 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).



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 www.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 www.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 www.askebsa.dol.gov or call **1-866-444-EBSA (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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	FLORIDA – Medicaid



<p>The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</p>	<p>Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268</p>
ARKANSAS – Medicaid	GEORGIA – Medicaid
<p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p>Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131</p>
CALIFORNIA – Medicaid	INDIANA – Medicaid
<p>Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_c ont.aspx Phone: 916-440-5676</p>	<p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
<p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563</p>	<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
KANSAS – Medicaid	NEBRASKA – Medicaid
<p>Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
KENTUCKY – Medicaid	NEVADA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p>Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900</p>
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP



<p>Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
<p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
<p>Website: https://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</p>	<p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>
OREGON – Medicaid	VERMONT – Medicaid
<p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>	<p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462</p>	<p>Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282</p>
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
<p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>	<p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
<p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
SOUTH DAKOTA – Medicaid	WISCONSIN – Medicaid and CHIP
<p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>
TEXAS – Medicaid	WYOMING – Medicaid



ANNUAL ENROLLMENT | NOVEMBER 2020

Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
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To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, 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 1/31/2023)

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights

Houston Independent School District is committed to the privacy of your health information. The administrators of the Houston ISD Health Plans (the "Plan") medical, dental, and vision use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting the HISD Benefits Service Center 877-780-HISD (4473) or benefitsoffice@houstonisd.org

HIPAA SPECIAL ENROLLMENT RIGHTS

Houston ISD Health Plans Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Houston ISD Health Plans (to actually participate, you must complete an enrollment – by phone or online -- and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program).

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new



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Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the HISD Benefits Service Center at 877-780-4473 or via email to benefitsoffice@houstonisd.org

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.



NOTICE OF CREDITABLE COVERAGE

Important Notice from Houston Independent School District

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 Houston Independent School District 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:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Houston Independent School District has determined that the prescription drug coverage offered by the medical 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 Houston Independent School District coverage will not be affected. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current Houston Independent



School District coverage, be aware that you and your dependents will not be able to get this coverage back until annual enrollment.

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 Houston Independent School District, 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.

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

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

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

Date: January 1, 2021

Name of Entity/Sender: HoustonISD

Contact—Position/Office: The Benefits Department

Office Address: 4400 West 18th Street Houston, TX

77092 Phone Number: 713-556-6655



COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights (For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:



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

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

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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. You must provide this notice to: The Benefits Office (HISD) 713-556-6655 or benefitsoffice@houstonisd.org

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:



Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.



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coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Benefits Office (HISD) 713-556-6655 or benefitsoffice@houstonisd.org



MARKETPLACE NOTICE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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.²

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.

² 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.



How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Benefits Office (HISD) 713-556-6655 or benefitsoffice@houstonisd.org.

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

PART B: Information about Health Coverage Offered by Your Employer

This section contains information about 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. www.healthcare.gov

3. Employer name Houston Independent School District		4. Employer Identification Number (EIN) 74-6001255	
5. Employer address 4400 W 18 th Street		6. Employer phone number 713-556-6655	
7. City Houston	8. State TX		9. ZIP code 77092
10. Who can we contact about employee health coverage at this job? Benefits Office			
11. Phone number (if different from above) 713-556-6655		12. Email address Benefitsoffice@houstonisd.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:

1. Regular part-time or full-time employee as defined by HISD and a contributing member of the Teachers Retirement System (TRS)
2. Retired from TRS and rehired into a position that is eligible for benefits.
3. You qualify as a full-time employee as defined under Section 4980H(c)(4) of the Internal Revenue Code

•With respect to dependents:

☐ We do offer coverage. Eligible dependents are:

1. Your legal spouse
2. Your dependent children



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Eligible dependent children under 26 years of age include:

1. Your biological children
2. Your stepchildren
3. Your legally adopted children
4. Your foster children, including any children placed with you for adoption
5. Your child who qualifies as your dependent under the terms of a qualified medical child support order (QMSCO)

Your child (age 26 or over) that otherwise meets the requirements above may be eligible for dependent coverage, provided the child is either mentally or physically incapacitated to such an extent to be dependent on you on a regular basis as determined by HISD Benefits Office medical partners and meets other requirements as determined. To avoid any gap in coverage, the forms must be submitted and approved prior to the end of the month the child turns 26. Contact HISD Benefits Office at 713-556-6655 for assistance completing the Disabled Dependent application.

Eligible dependent grandchildren under the age of 25 may be covered if you provide required documentation.

- ✓ ☐ 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

-
13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?** For questions 13- 16, these answers would be specific to each employee on a case by case basis. HISD would complete the form if the employee needed it for the Marketplace.

- ☐ **Yes (Continue)**
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
- ☐ **No**



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14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest cost plan that meets the minimum value standard³ offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan?

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

PLEASE RETAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

DHCS 9121 (Rev. 06/19)

* 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.



Gallagher

Insurance | Risk Management | Consulting



HISD Benefits Department
Benefits Support Retirement Storefront
Ph: 713-695-5561
Fax: 713-695-5723

Overview

Benefits Support administers several unique programs within the HISD Office of Benefits. Benefits Support was first created to provide local service to HISD employees on their Teacher Retirement System of Texas (TRS) benefits. The office is also known as the Retirement Storefront and has saved retiring employees countless hours and miles traveling to Austin.

Mission Statement: Our mission is to provide exceptional service to HISD employees by being accessible and clearly explaining benefit options, thereby allowing employees to focus on the overall strategic mission of the district.

Using a direct-contact customer service model for one-on-one counseling sessions, telephone counseling, and seminars, employees receive personalized service and a clear unbiased perspective on their retirement income and TRS-Care healthcare benefits. Appointments are recommended and walk-ins are serviced as time permits. Benefits Support administers benefit programs for the district including:

403(b) & 457 Voluntary Retirement Savings Programs
Teachers Retirement System of Texas (TRS) Counseling
Supplemental Sick Leave Bank (SSLB)
Drug-Free Workplace

The 403(b) and 457 retirement plans give employees the opportunity to voluntarily save money for retirement. The 403b plan accepts both tax deferred (pre-tax) and Roth (after-tax) contributions, while the 457 plan offers pre-tax only. Employees are in control of their retirement contributions with 24-hour online access to the Retirement Manager website at www.myretirementmanager.com and can change contributions, select a vendor, and request loan and hardship distribution certificates.

The **Drug-Free Workplace** program administers the district's drug and alcohol testing requirements. HISD is legally required to maintain a fully compliant (49 CFR parts 40 and 382) U.S. Department of Transportation (DOT)/Federal Highway Administration (FHWA) drug and alcohol testing program that includes, but is not limited to, employees required to have a Commercial Drivers License (CDL).

The **Supplemental Sick Leave Bank** (SSLB) is a pool of local sick leave days voluntarily contributed to the bank by HISD employees to be used by contributing members for additional sick leave days once a member has exhausted all personal time off and experiences a catastrophic illness as defined by the plan. As an SSLB member, an employee may receive a benefit up to 30 paid days during the program plan year.



<u>Questions about:</u>	<u>Best information source:</u>	<u>Phone Number:</u>
403b/457 Plans	HISD Retirement Storefront – BenefitsESS@houstonisd.org	713-695-5561
	Employee's 403b or 457 Provider – www.myretirementmanager.com	See Providers List
HISD Benefits	HISD Benefits Administration	713-556-6655
	HISD Benefits Service Center	877-780-4473
HISD Paycheck Issues	HISD Payroll	713-556-6440
HISD Policy/Contracts/Leave	HISD HR Customer Service	713-556-7383
Social Security & Medicare	Social Security Administration – www.ssa.gov	800-772-1213
Texas TRS Pension	HISD Retirement Storefront – RetirementStorefront@houstonisd.org	713-695-5561
	Teacher Retirement System of Texas (TRS) – www.trs.state.tx.us	800-223-8778



HISD Benefits - Benefits Support
Retirement Storefront
Phone: 713-695-5561
Fax: 713-695-5723
BenefitsESS@houstonisd.org

HISD 403b and 457 retirement plan comparison details:

The HISD 403b and 457 voluntary retirement plans have similarities and differences (see comparison table below). Employees are encouraged to speak with an agent or representative of their chosen 403b or 457 account provider for details on which plan might be better for their personal financial goals and circumstances. Plan features discussed below may not be offered by all provider contracts. Ask provider for available contract features and costs.

Plan Similarities:

1. All employees are eligible to voluntarily contribute to either plan, or both, with no minimum contribution requirements.
2. Both accept pre-tax contributions up to the maximum IRS limits of \$19,500 if under age 50, and up to \$26,000 at age 50 and over.
3. Both allow tax deferred growth providing more money to accumulate without paying taxes on the interest or growth each year.
4. Both plans offer loan and hardship distributions based on IRS rules.
5. Employees may withdraw all funds from both plans upon separation from employment and the distributions are subject to regular income taxes.
6. The after-tax Roth feature is offered in both the HISD 403b and 457 Plans. Roth contributions to the 403b or 457 are after-tax, and the interest & investment returns are tax free upon withdrawal when two conditions are met:
 - a. the participant is at least age 59 ½
 - b. the Roth has been open at least 5 years.

Plan Differences:

1. Employees may choose from thirty three (33) 403b providers and three (3) 457 plan providers.
2. Active HISD employees may withdraw money from the 403b at age 59 ½, but withdrawals from the 457 plan are not allowed for active employees until age 70 ½.
3. Withdrawals from the 403b by separated employees under age 59 ½ may be subject to an IRS 10% early withdrawal penalty*.
4. Regardless of age at distribution, separated employees may take 457 plan withdrawals without a 10% early withdrawal penalty.

*Participants separating from service in the year they turn age 55 or older may not be subject to an IRS 10% early withdrawal penalty on 403b distributions. Ask your tax or financial advisor for details.



HISD Voluntary Retirement Plan Comparison Table

	403(b)	457
Plan eligibility	All employees	All employees
Number of providers	33	3
Pre-tax contributions	Yes	Yes
Tax-deferred interest and earnings	Yes	Yes
After-tax Roth contributions	Yes	Yes
Contribution Limit* under age 50	\$19,500	\$19,500
Contribution Limit* age 50 and over	\$26,000	\$26,000
Loan availability	Yes	Yes
In-service distribution availability	Funeral/burial expenses Post-secondary education Prevent eviction or foreclosure Purchase principal residence Uninsured home repairs due to peril Unreimbursed medical expenses	Unforeseeable emergency causing severe financial hardship
IRS 10% Excise Tax (distribution prior to age 59.5)	Yes	No
Unrestricted in-service distribution age	59.5	70.5

*2021 Tax Year Limits



ANNUAL 403(b) PLAN NOTICES

The **HOUSTON INDEPENDENT SCHOOL DISTRICT 403(b) PLAN** ("Plan") has been adopted to help our employees save for retirement. As an employee, you may make Salary Deferrals if you are eligible to participate under the Plan. (Please refer to the other Plan information materials to determine whether you are eligible to participate in this Plan.) This Annual 403(b) Plan Notice provides important information relevant to your participation in the Plan.

Notice of Universal Availability

This **2021 Annual Notice of Universal Availability** describes your right to make Salary Deferrals (if you are eligible for the Plan), the procedures for electing to make Salary Deferrals Reduction Contributions and the tax advantages of making contributions to the Plan.

Eligibility to Participate. The Plan is an Internal Revenue Code section 403(b) plan. A "403(b) Plan" is subject to the universal availability requirement which requires that all employees are eligible to make voluntary contributions to the Plan. These contributions are called Salary Deferrals. To make Salary Deferrals, you must complete a Salary Reduction Agreement designating the amount you want to have withheld from your paycheck and deposited into the Plan. You will also need to complete additional enrollment forms provided by the approved investment provider that you elect to have hold and invest your contributions. Please contact the Plan Administrator to request a copy of the Salary Reduction Agreement and/or to receive a list of approved investment arrangements.

Salary Deferral Limits. You may make Salary Deferrals up to \$19,500 in 2021 (unless otherwise limited under the Plan). This annual Salary Deferral limit is subject to change each year. In addition, this limit may be increased if you are eligible to make "catch-up" contributions under the Plan. Please see the other Plan information materials or contact your Plan Administrator for more information concerning the availability of catch-up contributions under the Plan.

Tax Advantages. If you elect to make Salary Deferrals to the Plan, you may make these contributions on a pre-tax basis, or if available under the Plan, on an after-tax basis (also referred to as Roth contributions).

- **Pre-tax contributions** – If you elect to make Salary Deferrals on a pre-tax basis, the amounts deferred (and any earnings on those amounts) generally will not be subject to income taxes until the amounts are distributed from the Plan. Upon distribution, such amounts are taxed as ordinary income.
- **Roth contributions** – You may also elect to make Salary Deferrals on an after-tax basis (i.e., such contributions are subject to income tax at the time contributed to the Plan) as Roth contributions. Such contributions (and earnings) will not be subject to income taxes when distributed from the Plan, if certain conditions are satisfied. Generally, the conditions are that at least five (5) years have passed since you began to make Roth contributions and the distribution is a "qualified distribution". For this purpose, a qualified distribution is a distribution made due to your attainment of age 59½, death or disability.

2020 – 2021 Notice of Required Contribution Aggregation If You Are “In Control” of Another Business

Under IRS rules, in certain situations, Plan participants must aggregate Salary Deferrals and other amounts contributed to this Plan and other “qualified retirement plans” to determine whether they are within the maximum annual contribution limits under the law. If you meet all of the conditions below, the Internal Revenue Service requires that you contact the Plan Administrator to review whether or not you have exceeded your maximum annual contribution limit. ***Failure to provide the Plan Administrator with certain necessary and correct information may result in adverse tax consequences, including your inability to exclude the amounts contributed to this Plan from your taxable income.***

You must notify the Plan Administrator if you meet all the following conditions:

- You make contributions to this Plan,
- You are “in control” of another company, and
- The other company maintains a “qualified retirement plan” and makes contributions to your account.

What does it mean to be “in control” of another company?

For you to be considered “in control” of another business, you generally must have a significant ownership interest in the other business. For example, you own 50% of a business that is separate from **HOUSTON INDEPENDENT SCHOOL DISTRICT**. Determining whether you are “in control” of another business is complicated. Your tax advisor can assist you in making this determination.

Example: You are a doctor or professor that participates in this Plan and you also own more than 50% of a private practice or consulting business. You are considered to be “in control” of the outside business.

What types of retirement plans fall within the meaning of a “qualified retirement plan”?

For this purpose, a “qualified retirement plan” includes certain defined contribution plans that receive special tax benefits under the Internal Revenue Code. These include defined contribution plans that qualify under Internal Revenue Code §401(a) (such as a profit sharing plan, 401(k) plan or money purchase pension plan), another 403(b) plan, or a simplified employee pension (SEP) plan.

What is the maximum annual contribution limit?

The maximum annual limits are below. This annual limit is subject to change each year. However, certain participants (such as those who are at least age 50) may have a higher limitation, if provided for under the 403(b) Plan.

2020 Plan Year - Limit \$57,000

2021 Plan Year - Limit \$58,000

What amounts are counted for purposes of determining whether you exceed the maximum annual contribution limit?

The following amounts are counted towards the maximum annual contribution limit:

- Employer contributions (including matching contributions and SEP contributions)
- Salary deferrals including Roth
- After-tax contributions
- Certain other amounts allocated to your account (this does not include earnings or rollover amounts)

Additional information. If you would like additional information regarding your right to make Salary Reduction



HISD Workers' Compensation Program

Effective 05/20/2013, Houston ISD implemented the HISD WC 504 Provider Panel as its workers' compensation health care provider panel.

The HISD WC 504 Provider Panel has been built to provide you with quality medical care and includes health care providers who are trained in treating work related injuries and getting people back to work safely. Who Handles Our 504 Provider Panel?

- ☐ **Cannon Cochran Management Services, Inc. (CCMSI)** - is the district's claims administrator for workers' compensation claims.
- ☐ **Corporate Remedies, Inc.** - manages the physicians in the 504 Provider Panel.
- ☐ **Novare Nurse Case Management** – serves as pre-authorization administrator for medical referrals and nurse case management.

If you have an injury what should you do? Report your injury/illness to your Supervisor or Nurse immediately. You and your supervisor must complete an HISD Employee Injury and Treatment (EIT) Form.

• The injured employee's supervisor must fax the completed EIT form to (713) 556-9224 to report the incident

"Employees cannot report their own injury"

The injured employee's supervisor should provide the injured employee with a copy of the completed EIT form that will include the following:

- An identification card (located at the bottom of the EIT form)
- A pharmacy card (located at the bottom of the EIT form)

In Case of an Emergency

If you are injured on the job and it is an emergency, you should seek treatment at the nearest emergency facility or urgent care facility as soon as possible. This also applies if you are injured after normal business hours.

If the injured employee is taken via ambulance, please contact the HISD Workers' Compensation Department immediately at 713-556-9200 (during business hours) and 214-551-8831 (after hours) and provide the following:

- the injured employee's name;
- school or location where the injury occurred;
- where the employee is being transported

Choosing your Treating Doctor

If you are hurt at work, you **must** choose a treating doctor from the HISD WC 504 Provider Panel. This is required for you to receive coverage and cover the cost of care for your work related injury/illness.

To find the Physician Directory go to www.houstonisd.org, select "Departments", select "Workers' Compensation", choose "Find a Treating Doctor".

When you select a treating doctor from the panel, you **do not need approval** from HISD, Cannon Cochran Management Services (CCMSI), or Corporate Remedies, Inc. to get care.

Important Contacts	
HISD Workers' Compensation Department:Phone: (713) 556-9200	
Fax: (713) 556-9224	
Cannon Cochran Management Services, Inc.	Phone: (713) 314-1470
Corporate Remedies 504 Panel Administrator:	Email: support@corporateremedies.com
Novare Nurse Case Management	Phone: (713) 314-1492 (during business hours)
	Phone: (214) 551-8831 (after hours)

For more information about workers' compensation at HISD, please visit houstonisd.org/page/73125



**NOTICE TO EMPLOYEES CONCERNING WORKERS'
COMPENSATION IN TEXAS**

COVERAGE: Houston Independent School District has workers' compensation insurance coverage from Cannon Cochran Management Services, Inc. (CCMSI) in the event of work-related injury or occupational disease. This coverage is effective from 11/01/2014. Any injuries or occupational diseases which occur on or after that date will be handled by Cannon Cochran Management Services, Inc. (CCMSI). An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

Notice 6 (01/13)
OF WORKERS'
COMPENSATION

TEXAS DEPARTMENT OF INSURANCE, DIVISION
Rule 110.101(e)(1)



NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: 1-866-EZE-OIEC (1-866-393-6432). More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

WHAT IS AN OMBUDSMAN? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has a workers' compensation adjuster's license and has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation. Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.

28 TAC §276.5. Employer Notification of Ombudsman Program to Employees (Effective 9/1/13)

(a) All employers participating in the workers' compensation system shall post notice of the Office of Injured Employee Counsel's (OIEC) Ombudsman Program. This notice shall be posted in the personnel office, if the employer has a personnel office, and in the workplace where each employee is likely to see the notice on a regular basis.

(b) This notice of the Ombudsman Program shall be publicly posted in English, Spanish, and any other language that is common to the employer's employees. (c) This notice shall be the text provided by OIEC without any additional words or changes and may be obtained by:

(1) Downloading the form on OIEC's website at: www.oiec.texas.gov; or

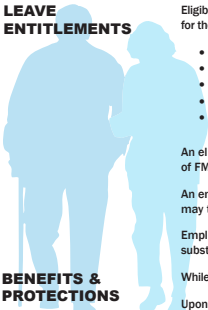
(2) Requesting the notice by calling OIEC's toll-free telephone number at: 1-866-EZE-OIEC (1-866-393-6432).



EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS



Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

REQUESTING LEAVE

EMPLOYER RESPONSIBILITIES

ENFORCEMENT



For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division





YOUR RIGHTS UNDER USERRA THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at <http://www.dol.gov/vets>. An interactive online USERRA Advisor can be viewed at <http://www.dol.gov/elaws/userra.htm>.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: <http://www.dol.gov/vets/programs/userra/poster.htm>. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.



U.S. Department of Labor
1-866-487-2365



U.S. Department of Justice



Office of Special Counsel



1-800-336-4590

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