



Employee Benefits Guide

Plan year

September 1, 2024 – August 31, 2025

MHMR has played an important role in Tarrant and surrounding counties for more than 50 years. Our goal is to change lives by addressing unique health care needs, such as substance abuse, mental illness, developmental disabilities, and delays in your children through a person-centered approach with a culture of caring.

MHMR is an equal opportunity employer that provides a quality work environment. We recognize the importance of having employees who enjoy where they work, feel they belong and whose main goal is to help change lives of the people we serve. Eligible employees will receive the following competitive benefits outlined in this information packet.

Disclaimer: Plan Document supersedes any applicable rules should any information in this guide be unintentionally noted. Not all data is covered in this guide.

This guide provides a summary on benefits for MHMR employees.

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Insurance Benefits Eligibility

Manage Benefit coverage in UKG
Pro>Benefits>Manage My Benefits

- Full time employees are offered coverage on the 1st of the month following last day of hire (see deadline dates on the following page). Online deadline will display as the end of the month but it's best not to wait until the final day.
- Specific job titles are offered coverage immediately first day of work and have 30 days to make elections from the date of hire (listed below).
- Part time market employees in specific job classes (market driven) are also eligible (refer to the page related to part time benefits)
- Regular Part time employees are only eligible for the medical plan and the Part time PTO schedule (not holidays).
- Spouses are not eligible under MHMR medical plan if they have eligible coverage through their employer. Please visit MHMR intranet or your human resources department for additional information. Spouses can join dental, vision and other optional benefits.
- Refer online Benefits Website for dependent detail eligibility. Full Plan documents prevail over all items listed in this guide. **You can find all plan documents on the Benefits Portal.**

Full time and Part time job titles that are considered "market driven" are offered insurance immediately:

Behavioral Health Services Disability Services Child and Family Services

- Advance Practice Nurse
- Psychiatrist
- Physician Assistant
- All Clinician Registered Nurses
- Dietitian
- Licensed Therapist Supervisor
- Licensed Therapist
- Licensed Chemical Dependency Counselor
- Licensed Chemical Dependency Counselor Supervisor
- Board Certified Behavior Analyst
- Infant Mental Health Specialist
- Occupational Therapist (including ECI Pgrm Mgr. - OT)
- Occupational Therapist Asst.
- Trauma Therapist (fully licensed)
- Board Certified Behavior Analyst
- Director Sr. Clinical (Psychologist)
- Licensed Psychologist
- Occupational Therapist
- Licensed Psychological Assoc. (Assessment Specialist)
- All Clinician Registered Nurses
- Physical Therapist - (including ECI Pgrm Mgr. - PT)
- Physical Therapist Asst.
- Speech Language Pathologist (including ECI Pgrm Mgr. - SLP)
- Speech Language Pathologist CFY
- Licensed Family Support Coach
- All Clinician Registered Nurses
- Mental Health Consultant L (fully licensed)
- Licensed Therapist (Youth)

Mandatory Dependent Verification – Online under My Documents

If you plan to add any dependents to your Medical, Dental and/or Vision insurance, MHMR does mandate to have dependent verification on file. For example: If you would like to add your child to your insurance, you will need to submit a birth certificate or legal documentation listing you as the guardian (a full list of acceptable documents can be found on our Info Depot Benefit pages under "Life event acceptable documents"). You will have a "To Do" task in UKG Pro indicating the deadline for these documents. **Should you not complete this portion and fail to turn in dependent verification supporting document(s), you will not receive coverage for that dependent requested.** All documentation must be submitted up to 30 days from your hire date but will risk retro deductions if not turned in prior to your insurance effective date. Should you fail to submit documentation within the timeframe, your next opportunity to enroll or edit will be the following open enrollment period.

Annual Open Enrollment

Anyone who is eligible but has not enrolled themselves during their initial hiring period or their dependents may request enrollment in the health plan(s) during open enrollment. Dependent verification still applies. Some benefit changes during open enrollment still require a medical/health questionnaire and it is the responsibility of the employee requested coverage or changes to submit the questionnaire to the applicable insurance provider. Mid-year changes occur if you have one of the life changing events as stated below and qualify for "Special Enrollment" as stated under the Plan event page. We highly encourage you to review your benefits each year by the open enrollment deadlines as items can change and you can find yourself without coverage or with coverage you did not want selected.

Open Enrollment does not waive the waiting period. If you are a new employee and are still within the required waiting period, your coverage will not become effective until you have completed said waiting period.

HIPAA Special Enrollment - This Plan complies with the Health Insurance Portability & Accountability Act (HIPAA) of 1996. For more information regarding your rights under HIPAA, you may want to contact the nearest Department of Labor. An initial notice of your rights under COBRA will be sent to any employee who elects medical, dental, and/or vision.

Special Enrollment Events If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if you have a qualifying event such as you get married, have a baby, adopt a child, you or your dependents lose eligibility for other coverage, or you or your dependents meet a lifetime limit on all benefits on other coverage, or the employer stops contributing towards you or your dependents' other coverage, provided that you request enrollment for this plan within 31 days from the effective date of one of these events. Note on the medical plan if spouse becomes eligible and is approved for coverage, a spouse "carve out form" is required during the 30 days of eligible enrollment. Refer to the Plan Document on MHMR intranet or online Benefits Website for all eligible qualifying events.

Effective Dates of Coverage

1st of month following last hire date.

Employees in "market driven" positions, listed on previous page begin coverage immediately following hire date

Month Hired or transferred to job with benefits	Make final selections*online UKG Pro Benefits Portal will indicate your applicable deadline. Final changes must be made within the 30 days of your Hire Date - including uploading documents.	The effective date of insurance is the 1 st of this month. Insurance deductions start on the first check date in this month
January	Within 30 days of your last hire date	February 1
February		March 1
March		April 1
April		May 1
May		June 1
June		July 1
July		August 1
August		September 1
September		October 1
October		November 1
November		December 1
December		January 1

*If your benefits are effective immediately (market driven), the above chart **does not** apply to you. You have 30 days from your hire date to make your elections. *If hired/transferred on the actual 1st of any month, the effective dates may vary, consult the HR Department.*

*If benefit selections are completed online close to your deadline you may incur retroactive deductions. Additionally, you could experience a delay in getting your insurance cards by your effective date. All benefits selected are still effective on your initial effective date listed above and not at the time you select the coverage online.

Insurance Plan Event Changes

An employee has the right to make changes to their insurance benefits anytime during the plan year if they have a qualifying **Event Change**. The employee has **31 days** to complete request online Benefits Website of such change from the event effective change date to add or drop coverage with MHMR. With each event change the employee must submit supporting documentation (upload on Benefits Website) of recently lost coverage or newly added coverage with another insurance company. **Additional information is also available on Info Depot under HR and online Benefits Website. The deadline to upload information is also within the 31-day period.**

Keep in mind that you only have 31 days from the Event Change to add or drop coverage. If your dependent has recently lost coverage through "CHIPS" you will have 60 days from the effective date or termination date to add or drop coverage with MHMR.

Event Change

The following are **some** examples of Qualifying Event Changes:

- ▶ Loss of coverage or recently enrolled into a new plan
- ▶ Marriage
- ▶ Divorce
- ▶ Adoption
- ▶ Birth
- ▶ Legal separation
- ▶ Death
- ▶ Termination
- ▶ Reduction of hours
- ▶ Dependent becomes ineligible

Please note that the specific insurance change requests must be consistent with the event change.

31 Days - Online changes must be completed within 31 days of the qualifying event.

Example: If you lose coverage on Jan. 31 and submit your documentation on Feb. 28, we will add your coverage with MHMR on Feb. 1, since there cannot be a lapse in coverage. Since two paydays in February have already been paid, we will need to catch up your deductions. In this example, you will still have to be charged for the whole month of February. The next check you receive will have to be charged retroactively. Your next check will have to be adjusted with a One-Time make up deduction for the month of February plus the deduction for the first check in March.

4 Possible Actions Needed in Benefits Portal

- | | |
|---|--|
| 1. Edit requested plan change. | 3. If adding dependent (verification of dependent) |
| 2. Upload documentation of reason for change (To Do task) | 4. If adding a spouse that is eligible, spouse carve out form is an additional document. |

If the event is not completed online, then the change cannot be accepted/processed. Contact the Benefits@mhmtc.org if you would like telephonic assistance with making changes.

Insurance Benefits that can be changed* during the year with an applicable event are but not limited to: Medical, dental, vision, supplemental life, accident, critical insurance and disability plans and Flexible Spending accounts - medical reimbursement/dependent care reimbursement. *Restrictions apply.

Medical Benefits

Claims administration provided by Boon-Chapman

Your health benefits are provided under a self-insured plan managed by Boon-Chapman. You may choose between the following two PPO plans: PPO Plan with an HRA feature and a Basic Plan. The 3rd plan is a Qualified High Deductible Health Plan (QHDHP) with a Health Savings Account (HSA) feature.

A Spotlight - Review the **full plan document** located in the Online Benefits Portal for specific coverage amounts, limits and eligibility for all other services.

Manage Benefit coverage in UKG
Pro>Benefits>Manage My Benefits

Manage Benefit coverage in UKG
Pro>Benefits>Manage My Benefits

- Hearing Aids – No Deductible up to \$4000 per ear – Must use “In-Network” providers.
- Infertility Treatment coverage after 2 years of current employment - Limited to: \$10,000 per Plan Participant per Lifetime
- Bariatric Surgery after 2 years of current employment
- Additional medical billing support for non-selected providers
- The health plan will cover a colonoscopy as preventative or diagnostic each plan year
- Preventative Immunizations are covered at 100% - deductible waived

Boon-Chapman’s utilization management system is designed to be your partner in **controlling healthcare costs** while promoting **high quality appropriate care**. Now, with one phone call, you or your doctor can contact Boon-Chapman and obtain verification of benefits and case management services.

- Cigna Network provides pre-certification for medical necessary procedures. Ensure your doctor provides all necessary paperwork for Cigna to review the procedure you may have meets medical necessity requirements. Should you receive a denial letter, contact your doctor’s office to ensure all documents were adequately submitted.
 - ✓ The utilization management program incorporates the managed care activities but not limited to:
 - Hospital admission review, Concurrent hospital review, Discharge planning, Surgical procedure review
 - All admissions and outpatient surgical procedures, chemo, radiation, dialysis, infusion therapies and inpatient rehab require that you notify Boon-Chapman within two (2) business days in advance of a scheduled date of service. A telephone call is required to initiate the review process. A registered nurse will contact your physician to determine the medical necessity of your admission and coordinate the length of hospital stay. Surgical procedures will be reviewed to identify the medical necessity.
 - For your provider to properly bill for services rendered ensure you provide your insurance card. The card states to file claims with Cigna (Cigna is not your insurance coverage – that is the network we use for your doctors to be in network). Your medical card will be mailed to you after 2 weeks when you finalize your enrollments. Your e-card can be found by logging in [here](#).
 - You will need to sign up and create an account once your data has been submitted to Boon Chapman. A glossary of terms (deductible, co-insurance, in and out of network etc. can be found [here](#).

Ensure you check your explanation of benefits (EOB) after each service with a provider to ensure accuracy.

Provider Listing A PPO provider network listing (doctor listing) is available online at www.cigna.com. Click on “Find a Doctor.” Of note: “PPO, Choice Fund PPO”

Note: Employees who get Employer-sponsored insurance through a family member’s work (i.e through MHMR) may qualify to have your insurance premiums reimbursed through the Texas Health Insurance Premium Payment (HIPP) program if a member of the family is enrolled in Medicaid. (www.hhs.texas.gov)

Pharmacy/Prescriptions

Your Prescription Drug Card provider is Caremark. Their network includes major U.S. pharmacy chains and most of the regional pharmacy chains and independent pharmacies including CVS, Eckerd, K-Mart, Kroger, Wal-Mart, Walgreens, Tom Thumb, and Sam’s Pharmacy. Contact Caremark’s “Help Desk” at **866-475-0056**. Please present your new Caremark Prescription Drug card/ID card to your local pharmacist when you get a prescription filled.

Mail Order

1. Complete a Caremark Direct Enrollment form and mail or fax to Caremark Direct along with your Prescription from your Doctor and a co-pay amount.
2. Contact Caremark’s “Quick Start” program by phone: **800-346-9113** have your prescription information ready, name of medication and dosage, and the names and phone number of the prescribing Physician. Caremark will contact your Physician to obtain a copy of the prescription.

Prescription Savings Program - This program works with employees, your doctors and your pharmacy to save you and the Health Plan money. This program does not change your current pharmacy benefits offered by MHMR of Tarrant County and administered by CVS Caremark, or the pharmacy you use to fill your prescription(s). Prescription Care Management (PCM) educates employees about opportunities to switch from higher cost drugs to lower cost drugs -- thereby potentially lowering your out-of-pocket expenses and saving money for the health plan. No action is required unless PCM contacts you. If contacted, it's your sole decision whether you want to learn more and participate in this program. PCM will answer all your questions and take care of the work. It's simple and easy for you. Should you receive a call from PCM, we encourage you to take advantage of these savings. After being contacted by PCM, call their Pharmacy Engagement Team at 1-800-281-7050 with any questions or concerns. Prescription Care Management (PCM) is a leading provider of pharmacy engagement programs. For more information, visit PCM's website www.pcmsavings.com

Spouse Acknowledgement

MHMR's policy restricts spouses to be covered under the medical insurance plan if they are offered working coverage (coverage through their employer). If you add your spouse to the medical insurance, you must acknowledge online that they are not offered working coverage as well as complete the Spouse Carve Out Form attached at the end of this Guide. **Upload the spouse carve out form into the document center online before your deadline to enroll.**

Medical Rates * Rates are semi-monthly.

Medical Plan Rates per check (for full time employees)

For FTE.75 (30 hours or greater) Effective 9/1/2024 – 8/31/2024

Employee Pays / Per Check** (24 pay periods)	HRA Plan (\$1,500 plan year individual deductible)	HDHP - HSA Plan (\$1,600 plan year Employee Only Deductible)	Basic (Standard) Plan (\$1,750 plan year individual deductible)
Employee Only	\$19.00	\$35.00	\$38.00
Emp + Spouse	\$112.00	\$135.00	\$150.00
Emp + Child(ren)	\$47.00	\$71.50	\$80.00
Emp + Family	\$174.50	\$189.50	\$210.50

*Rounding may occur - Spouse**Not eligible if offered medical insurance through their group employer; restrictions apply.

When audits are conducted, any errors found will be corrected and retroactively reinstated or charged on any of the benefit plans. You can also view your current benefits on the UKG Self Service portal. If any benefits differ, please contact Benefits immediately. Note all rates noted in this guide may be slightly off due to rounding in systems.

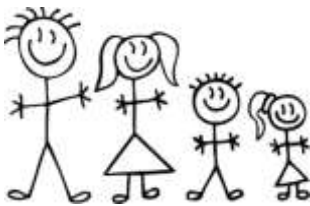
PPO Plans	Office Visit Copay	Individual Deductible (plan year) Separate from Out of Pocket Max	Family Deductible (plan year)	Co-insurance	Individual Out of Pocket Maximum (20% co-ins.) plan year Does not include deductible or copays	Family Out of Pocket Maximum (20% co-ins.) plan year	Urgent Care	Emergency Room	Hospital Inpatient	Prescription Copays Generic (#) Brand Non-Formulary (1) Specialty drugs (over \$1,000)
PPO Plan w/HRA* <i>(You can have an FSA account with the three PPO plans)</i>	TPA will be billed for negotiated rates. If there is still a deductible amount remaining after the HRA is exhausted, employees pay the balance owed.	\$1,500^	\$3,000	80/20**	\$5,500	\$11,000	TPA will be billed for negotiated rates. If there is still a deductible amount remaining after the HRA is exhausted, employees pay the balance owed. Co-insurance amounts apply after deductible is met.	\$150 copay with a max. of two visits per plan year per insured member. Additional visits go toward deductible.	TPA will be billed for negotiated rates. If there is still a deductible amount remaining after the HRA is exhausted, employees pay the balance owed. Co-insurance amounts apply after deductible is met.	\$10 \$35 \$55 \$100 (drugs over \$1,000) Cannot use HRA for copays on RX but can sign up for FSA
*HRA \$500 employee only coverage, \$1,000 employee + dependent, or \$1,500 for Employee + family coverage funded by Employer (Boon Chapman auto uses HRA dollars as claims are submitted by providers). A plan year maximum balance carryover of \$1,000 employee only and \$2,000 emp and dependents, \$3,000 Emp and family. Note: new employees enrolling in HRA will have HRA amount pro-rated based on effective date enrolled in thru 8-31 of each plan year. Full HRA amounts begin each September ^On HRA plan – The HRA amount used does reduce the deductible amount for the individual or family member who used the HRA.										
PPO Basic Plan	\$35	\$1,750	\$3,500	80/20**	\$4,000	\$8,000	\$50	Same as HRA	Deductible then Co-insurance Applies	Same as HRA
QHDHP w/HSA <i>This plan is not eligible to have an FSA</i>	After Deductible \$35	\$1,600	\$3,200 (if covering dependents must meet)	80/20**	\$5,700 (this maximum does include deductible and co-pays)	\$11,400 (this maximum does include deductible and co-pays)	After Deductible \$50	After Deductible same as HRA	Deductible then Co-insurance Applies	After deductible then Same as HRA
Note: Listed coverages are in-network – All plans cover preventative services at 100% including HSA plan. All Plans use the CIGNA provider network. **After the plan year deductible is met, employees and the health plan share additional expenses. Employees pay 20% and the plan pays 80% up to the out-of-pocket maximums. On HSA plan, member cannot have 1st level coverage until after the applicable deductible is met including any item that normally has a waived deductible. (1) Prescriptions submitted through Mail Order will experience a charge of 2 1/2 times the copay for a 3-month supply. (#) generic prescriptions that are considered preventative under the PPACA (Patient Protections and Affordable Care Act) and are received from an in-network pharmacy are covered at 100%, the generic copay is waived. Note - PPO plans are eligible to sign up and utilize a Medical FSA account.										

Health Savings Account (HSA) If you chose the HSA High Deductible Health Plan

- MHMR will provide a minimum of \$1 to your Health Savings Account if employees contribute a minimum of \$1 up to the max as shown in the chart below.
- MHMR match of 100% of the amount employee contributes up to the maximum listed in the chart below depending on your level of coverage.
- The IRS maximums for employee only coverage is \$4,150 and dependent coverage is \$8,300. An Additional \$1,000 can be contributed if you are age 55+. Employees can still contribute their portion up to the IRS maximum. Even though MHMR does not match up to the IRS limits, employees can contribute their portion up to the IRS limits.
- Maximum totals are both employee and employer contributions combined.
- Amounts that are unused continue to rollover in your account with no maximums.
- Employee pays their election amount per check and MHMR will now match their portion as the employee pays their portion. MHMR will no longer upfront the annual amounts for Employee and Employer match into the HSA account
- If an employee terminates early during the year, those contributions deposited on their behalf for the periods after termination will be considered taxable income. The taxable income will be included on your W-2 provided by MHMR.
- Other IRS limits apply including but not limited to stopping your HSA contributions prior to 6 months before you are eligible for Medicare. Ensure you check your HSA eligibility.



Employee Only Coverage		
<i>Employee Annual Contribution</i>	<i>Employer (MHMR) Annual Contribution</i>	Total in HSA account
\$1 to \$800	Match 100%	\$2 - \$1,600
\$1,351 to \$4,150*	\$800 maximum	\$1,601 - \$4,150



Dependent Coverage (Employee/Children and/or Spouse)		
<i>Employee Annual Contribution</i>	<i>Employer (MHMR) Annual Contribution</i>	Total in HSA account
\$1 to \$1,600	Match 100%	\$2 - \$3,200
\$1,601 to \$8,300*	\$1,600 maximum	\$3,201-\$8,300

*Additional \$1,000 can be contributed if employee age 55+

Surency - Health Savings Account Provider

Surency is your HSA money account provider. Once you are enrolled in the plan and MHMR has notified Surency, then you will need to register and access any HSA Account [Surency Flex Member Account](#) at Surency.com or the [Surency Flex mobile app](#) – or – call Surency Flex Customer Service at 866-818-

8805. **Note** – Surency accounts are NOT created and therefore usable until after your deadline to make changes in your enrollment window (30 days after your hire date).

Visit [Surency.com/forms](https://surency.com/forms) to access any forms and submit a Direct Deposit form to Surency.

Please note, if you submit your bank account information via the paper form, further action is required to successfully activate direct deposit with Surency Flex. After your completed form has been received by Surency Flex, you will be required to manually verify your bank account.

Why do I need to confirm my account? Surency Flex is complying with the *WEB Debit Account Validation Rule*. In summary, this rule dictates that we must use an approved account verification process to prevent fraud. PO BOX cannot be verified therefore, you may need to share with Surency an alternate address for validation. If you do not reply to their request for any verification requested, your account will not be set up and you will not be eligible for an HSA account under Surency. You will remain on the HSA medical plan without any contributions to the HSA account unless you have a qualifying event allowing such plan change and/or open enrollment change.

Have questions? Please contact us at 866-818-8805 with any questions you may have about your HSA account or at (316) 462-3316.

Working Part Time in Market driven positions

Refer to the table under eligibility for the market driven job titles eligible to have benefits if part time market.

The Benefit Package is slightly different if you are employed part-time market driven (less than 40 hours). Market driven positions are predefined by MHMR.

Differences from regular full-time benefits for the part-time benefits are:

- ▶ Separate health plan rates for FTE less than .75 (rates displayed below)
- ▶ Part Time Market Driven are not eligible for disability plans
- ▶ Must have an FTE of .38 (minimum of more than 15 hours a week) to be able to have life insurance.
- ▶ PTO hours are based on FTE (displayed below)
- ▶ Holiday hours paid are based on FTE (displayed below)

**Substitute positions (even if Market driven) do not qualify for benefits except mileage reimbursement.*

Medical Plan Rates per check (for part time employees)

For less than 30 hours (less than .75 FTE) –

Amounts may vary due to rounding.

Employee Pays / Per Check** (24 pay periods)	HRA Plan (\$1,500 plan year individual deductible)	HDHP - HSA Plan (\$1,600 plan year Employee Only Deductible)	Basic (Standard) Plan (\$1,750 plan year individual deductible)
Employee Only	72.31	160.75	178.59
Emp + Spouse	366.71	331.89	368.77
Emp + Child(ren)	295.68	265.76	295.18
Emp + Family	467.13	418.81	465.40

Market Part time Holiday Hours and PTO are based on the FTE assigned, not hours worked.

Contact Payroll department for PTO and Holiday pay questions. PTO is eligible for Regular Part time positions (not holidays and Diversity Day)

FTE Hours	Holiday Hours Received (Market only)	PTO Schedule – Market and Regular Part time Months Employed–Hours Received Bi-Weekly	PTO Maximum Balance and Payoff at Termination
.01 - .19 1 - 7	1	0 - 24 months .50 hours 25 - 60 months .75 hours 61 - 120 months .75 hours 121 - 180 months .75 hours 181+ months .75 hours	20.00 hrs. max 0.00% 25.00 hrs. max 50% 31.00 hrs. max 75% 34.00 hrs. max 85% 37.00 hrs. max 100%
.20 - .39 8 - 15	2.5	0 - 24 months 1.50 hours 25 - 60 months 2.00 hours 61 - 120 months 2.50 hours 121 - 180 months 2.50 hours 181+ months 2.50 hours	61.00 hrs. max 0.00% 76.00 hrs. max 50% 94.00 hrs. max 75% 103.00 hrs. max 85% 112.00 hrs. max 100%
.40 - .59 16 - 23	4	0 - 24 months 2.75 hours 25 - 60 months 3.25 hours 61 - 120 months 4.00 hours 121 - 180 months 4.00 hours 181+ months 4.00 hours	102.00 hrs. max 0.00% 126.00 hrs. max 50% 156.00 hrs. max 75% 171.00 hrs. max 85% 186.00 hrs. max 100%
.60 - .79 24 - 31	5.5	0 - 24 months 3.75 hours 25 - 60 months 4.50 hours 61 - 120 months 5.50 hours 121 - 180 months 5.50 hours 181+ months 5.50 hours	143.00 hrs. max 0.00% 176.00 hrs. max 50% 218.00 hrs. max 75% 239.00 hrs. max 85% 260.00 hrs. max 100%
.80 - .99 32 - 39	7	0 - 24 months 4.75 hours 25 - 60 months 5.75 hours 61 - 120 months 7.25 hours 121 - 180 months 7.25 hours 181+ months 7.25 hours	184.00 hrs. max 0.00% 227.00 hrs. max 50% 281.00 hrs. max 75% 308.00 hrs. max 85% 335.00 hrs. max 100%

Teladoc is automatically enrolled for employees and dependents enrolled in the medical plan with MHMR. Employees who do not choose one of the PPO medical plans can elect to purchase Teladoc Only. Regular Part time employees who do not choose the medical plan are not eligible for the Teladoc only benefit. **You must register each member See the flyer for instructions**

Teladoc



Brought to you by:
MHMR of Tarrant County



A welcome letter is being mailed to your home with instructions for setting up your Teladoc® account, completing your medical history and requesting a consult. Once you're set up, a Teladoc doctor is always just a call or click away.

MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Sinus problems
- Sore throat
- Respiratory infection
- Skin problems
- And more!

WHY TELADOC?

It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short term prescription refills

Talk to a doctor anytime for free!

Teladoc.com
1-800-Teladoc (835-2362)



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Teladoc Only Plan

Telehealth can be an important component of your health and wellness, and that of your family. Currently Teladoc is automatically available to employees who have MHMR medical insurance plans.

Note: Eligible employees who do not choose one of the PPO medical plans can elect to purchase Teladoc Only.

Teladoc is a doctor consultation by telephone or email on demand, 24/7. You can contact Teladoc to talk to a doctor for information, advice and treatment, including prescription medication when appropriate.

MHMR is now offering Teladoc to eligible employees who chose not to enroll in the MHMR medical insurance plan (waived coverage).

You will be able to enroll on this plan as a new hire or during open enrollment. Eligible employees and their eligible dependents can enroll for \$5.50 semi-monthly subject to change as rates are reviewed at renewal.

Employees who have an MHMR medical plan will continue to receive Teladoc within their MHMR medical plan at no additional charge.

You will see a deduction of \$5.50 on your pay check (semi-monthly) of the month for which you are enrolled.

You can cancel enrollment beginning the 1st of any month following the written request to cancel the Teladoc only benefit but will not be refunded any payment paid previously. You will need to wait for the following open enrollment if you wish to re-enroll. At employment end, the Teladoc coverage will end accordingly based on premiums paid.

This plan is only eligible for those employees that are normally eligible for MHMR medical plan AND who waived the medical plan. Teladoc is already included in the medical plan for participants who enroll in the medical plans.

Important Note: Employees cannot enroll just their dependents on this plan (must include the employee). Employees who are enrolled as employee only on the medical plan cannot enroll in this plan so that their dependents get access to the Teladoc benefit only.

Teladoc services are available to you (and your eligible dependents) from home, work or wherever you may be. The goal is not to replace every doctor's office visit but to assist you with immediate access to a physician 24/7 to provide advice or treatment (including some prescriptions) that allows avoidance of a more traditional and expensive clinical visit and/or to guide the patient down the best path for resolution of the medical complaint. **You must register each member See the flyer for instructions [here](#).**

Employees who have used it have reported they have used Teladoc in place of a higher-cost urgent care visit or waiting for a scheduled doctor's appointment.

For more information, visit the Benefits Website: click on Health Benefits, Medical, Teladoc.

If you have any questions, contact benefits.

For dependents to be covered, employees must be also enrolled in a plan. Dependents cannot be enrolled without the employee being covered.

MHMR mandates to have dependent verification on file for each dependent. If you would like to add your child(ren) or Spouse to Teladoc only benefit, you will need upload proof of each dependent into the Benefits Website. If you have previously uploaded dependent verification data for dental, vision or if you had MHMR's medical plan in the past, then you do not have to re-load any documents. Validate the existence of your documents by reviewing the Document center to find your previously uploaded documents.

A full list of acceptable documents dependent verification documents can be found on our benefits website under "Quick Links".

Should you fail to complete this portion of the enrollment process and fail to upload eligible dependent verification documents for the dependents you wish to enroll, you will not receive the benefit for the specific dependent(s) requested.

Additional disclaimers:

Participation in this benefit does not satisfy the requirement of the Patient Protection and Affordable Care Act (PPACA) to maintain medical coverage.

1. Teladoc doctors do not issue prescriptions for controlled substances, non-therapeutic drugs, and certain other drugs.
2. This benefit is not intended to replace any existing health insurance coverage.
3. This is a voluntary supplemental benefit offering, not a medical plan.
4. This is the same criteria eligibility for dependents as the medical plan (up to age 26 and other applicable criteria).
5. This plan is only eligible for those employees that are normally eligible for MHMR medical plan AND who waived the medical plan. Teladoc is already included in the medical plan for participants. Employees cannot enroll just their dependents on this plan (must include the employee). Employees who are enrolled as employee only on the medical plan cannot enroll in this plan so that their dependents get access to the Teladoc benefit only.
6. This offering is not a qualifying event to add or remove any other benefit - this benefit is not COBRA eligible.
7. This is an after-tax deduction from paychecks.
8. Enrollment period deadlines apply, I will have to wait until Open Enrollment and new applicable rates may apply.
9. If you have other coverage under a HDHP with an HSA, confirm with that plan's administrator for additional guidance.

Frequently Asked Questions

Q1 – If I decline the agency medical plan can I choose to elect to just participate in Teladoc only.

A1- Yes, you can choose to enroll in Teladoc only if you don't have the medical plan.

Q2 – If I decline the agency medical plan, can I choose to enroll only my dependents in the Teladoc only plan?

A2 – No, eligible employees must also sign up for this benefit if they are interested in adding their dependent.

Q3 – I am enrolled in the medical plan, but I want to have Teladoc. Can I enroll in the Teladoc only plan?

A3 - Teladoc is included for all the members on the medical plan when you elect one of the medical plan options including those who enroll as part time employees.

Q4 – I am enrolled in the medical plan but my dependents are not. Can I enroll in the Teladoc only plan for my dependents only?

A4 – No, the Teladoc only plan must include the employees. You cannot enroll only dependents in the Teladoc Only plan.

Dental

Provided by UnitedHealthcare

Apply for this coverage online in UKG Pro-Benefits

Option 1 DHMO which offers benefits through a network of Plan Dentists

- Group plan (TX DHMO Select - Dallas) number:754425
- No Deductibles, No Claim Forms to file for Plan Dentist and Plan Specialty Dentist
- Referrals required for Specialty Dentist Services
- No Annual Maximum for Plan Dentist and Plan Specialty Dentist Services
- Varied co-pays for services ranging from \$5-\$65 for preventative services, crowns \$250 plus fees for noble.

Dentist: You **MUST** select a dentist provider for this plan that is in the UHC network while enrolling at www.myuhc.com. You will need the “Prac ID” number of the dentist you choose. You will be defaulted to a dentist if you don’t select one. You will not be able to use your dental coverage on this plan until you select a dentist in advance with UHC. There are a limited number of pediatric dentists in network on this plan.

Sampling of covered codes included but not limited to this list:

	ADA	DESCRIPTION	MEMBER PAYS
PREVENTIVE SERVICES			
D1110*		PROPHYLAXIS - ADULT	\$0
D1110*		- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	\$25
D1120*		PROPHYLAXIS - CHILD	\$0
D1120*		- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6 MONTHS	\$25
D1206		TOPICAL FLUORIDE VARNISH	\$0
D1208		TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	\$0
D1310		NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D1320		TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
D1330		ORAL HYGIENE INSTRUCTIONS	\$0
D1351		SEALANT - PER TOOTH	\$8
D1352		PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT - PERM TOOTH	\$10
D1353		SEALANT REPAIR - PER TOOTH	\$5
D1355		CARIES PREVENTIVE MEDICAMENT APPLICATION - PER TOOTH	\$0
D1516		SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25
D1517		SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25
D1520		SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$40
D1526		SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$40
D1527		SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$40
D1551		RECEM/REBOND BILATERAL SPACE MAINTAINER - MAXIL	\$15
D1552		RECEM/REBOND BILATERAL SPACE MAINTAINER - MANDIB	\$15
D1553		RECEM/REBOND UNILATERAL SPACE MAINTAINER/QUAD	\$15
D1556		REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER/QUAD	\$15
D1557		REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	\$15
D1558		REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	\$15
D1575		DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL/QUAD	\$25
D1999		UNSPECIFIED PREVENTIVE PROCEDURE, BY REPORT	\$0
RESTORATIVE SERVICES			
D2140		AMALGAM - ONE SURFACE PRIMARY/PERMANENT	\$0
D2150		AMALGAM - TWO SURFACES PRIMARY/PERMANENT	\$0
D2160		AMALGAM - 3 SURFACES PRIMARY/PERMANENT	\$0
D2161		AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	\$0
D2330		RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0
D2331		RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0
D2332		RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0
D2335		RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0
D2390		RESIN COMPOSITE CROWN ANTERIOR	\$40
D2391		RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$40
D2392		RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$45
D2393		RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$75
D2394		RESIN COMPOSITE - 4/MORE SURFACES POST	\$75

Option 2 PPO (Options PPO 30) which gives you the freedom to choose any Dentist/Specialist

- Freedom to Choose any Dentist, including Specialist – Better benefit value in Network
- Deductibles apply and Coinsurance amounts
- No referrals required, you or your dentist can file your claims

UnitedHealthcare Insurance Company (30100) [®]			Dental Plan	
Contributory Options PPO 30 / covered dental services			New Standard/20H50/U60	
	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	\$50	\$50	\$0	\$0
Family Annual Deductible	\$150	\$150	\$0	\$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)	\$1,500 per person per Calendar Year	\$1,500 per person per Calendar Year	\$3,000 per person per Lifetime	\$3,000 per person per Lifetime
New enrollee's waiting period	None			
Annual deductible and annual maximum benefit applies to preventive and diagnostic	No			
Annual Deductible Applies to Orthodontic Services	No			
Orthodontic Eligibility Requirement	Child Only (Up to Age 19)			
CMM-Annual Roll-Over	Yes			
COVERED SERVICES *	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES	
DIAGNOSTIC SERVICES				
Periodic Oral Evaluation	100%	100%	See Exclusions and Limitations section for benefit guidelines.	
Radiographs	100%	100%		
Lab and Other Diagnostic Tests	100%	100%		
PREVENTIVE SERVICES				
Prophylaxis (Cleaning)	100%	100%	See Exclusions and Limitations section for benefit guidelines.	
Fluoride Treatment (Preventive)	100%	100%		
Sealants	100%	100%		
Space Maintainers	100%	100%		
BASIC SERVICES				
Restorations (Amalgams or Composite)	90%	90%	See Exclusions and Limitations section for benefit guidelines.	
Emergency Treatment/General Services	90%	90%		
Simple Extractions	90%	90%		
Oral Surgery (incl. surgical extractions)	90%	90%		
Periodontics	90%	90%		
Endodontics	90%	90%		
MAJOR SERVICES				
Inlays/Onlays/Crowns	60%	60%	See Exclusions and Limitations section for benefit guidelines.	
Dentures and Removable Prosthetics	60%	60%		
Fixed Partial Dentures (Bridges)	60%	60%		
Implants	60%	60%		
ORTHODONTIC SERVICES				
Diagnose or correct misalignment of the teeth or bite	50%	50%		

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over \$500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.

***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage. Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

Dental Rates

EMPLOYEE PAYS / SEMI-Monthly	DHMO	PPO Dental
Employee Only	\$2.78	\$17.34
Employee + Children*	\$9.08	\$44.61
Employee + Spouse*	\$5.92	\$38.05
Employee + Family*	\$11.06	\$50.87

*Must complete dependent verification of dependents by uploading required documents online for dependents to be eligible for coverage

Vision

Apply for this coverage online in UKG Pro-Benefits

Provided by UnitedHealthcare

In-network, covered-in-full benefits (after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating¹ and the frame, or contact lenses in lieu of eye glasses. Below is a summary of the vision benefit:

Exam with Materials	
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 12 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	\$ 15.00
Materials	\$ 30.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the coverage)¹	
Private Practice Provider	\$175.00 retail frame allowance
Retail Chain Provider	\$175.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating, Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full. Other optional lens upgrades may be offered at a discount. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details. The Lens Options list can be found at myuhcvision.com.	
Contact Lens Benefit² (Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Non-Formulary. A copy of the list can be found at myuhcvision.com).	
Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay (if applicable).	If you choose disposable contacts, up to 8 boxes are included when obtained from an in-network provider.
Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. Material copay (if applicable) is waived.	\$200.00
Necessary contact lenses³	Covered in full after copay (if applicable).
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to \$40.00
Frames	Up to \$45.00
Single Vision Lenses	Up to \$40.00
Lined Bifocal Lenses	Up to \$60.00
Lined Trifocal Lenses	Up to \$80.00
Lenticular Lenses	Up to \$80.00
Elective Contacts in Lieu of Eyeglasses ²	Up to \$200.00
Necessary Contacts in Lieu of Eyeglasses ³	Up to \$210.00

Laser vision

UnitedHealthcare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction services. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at \$945 per eye for Traditional LASIK and \$1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com.

EMPLOYEE PAYS / Semi-Monthly		VISION PLAN	
Employee Only	\$2.76	Employee + Spouse*	\$5.34
Employee + Children*	\$5.58	Employee + Family*	\$8.81

*Must complete dependent verification of dependents by uploading required documents online for dependents to be eligible for coverage.

Flexible Benefit Plan

Provided by Boon-Chapman

Medical Reimbursement Account

You use the account to pay for eligible health care expenses that your health plan does not cover, such as: Deductibles, co-pays, coinsurance, dental services, contact lenses, eyeglasses and eye exams, prescription drugs

In general, health care expenses are eligible for reimbursement if they are incurred during the Plan Year and are considered tax-deductible by the IRS.

For a detailed list of eligible and ineligible expenses, review MHMR Intranet or online Benefits Website

You will receive a Flex Debit Card which will be loaded with your annual elected amount. You will use this card for all eligible medical expenses. The amount of the purchase will be deducted from the card balance.

Keep your receipts for all your Flex Card transactions when it is requested by administrator or for an audit.

Use It or Lose It – You MUST use all of the money in your accounts during the Plan Year except for a rollover amount of \$640. You will lose any remaining balance in the account at the end of the Plan Year. Money in your accounts may be used only for reimbursement of expenses you have incurred during the Plan Year. Claims for expenses you incur during the Plan Year must be submitted for reimbursement within 90 days after the Plan Year ends each 8/31. **Employees who choose the HDHP/w/HSA account are not eligible for MHMR's Medical Reimbursement Flexible Spending account.**

Dependent Day-care Reimbursement Account

Generally, you may use the money in the Dependent Day-care Account to care for your children under age 13 whom you claim as dependents for tax purposes for day care expenses. The **IRS requires** that you, the employee, must meet qualifications below to participate in this plan:

- If married, your spouse must be working, permanently disabled, or a full-time student. Or you may be a single parent.
- Day care expenses are being incurred *for you to work* or be gainfully employed.
- Your child is age 12 or under.

Submitting claims/using funds: See IRS eligible types of expenses/eligible receipts.

- **Online Access:**

- Eligible employees who have a Flexible Spending Account should login and create an account
- Additional login data is on page 2 of the Quick Start Guide and can also be found on Boon Chapman's online portal [Quick Start Guide](#). [new online portal](#)
- Download the [Boon Flex Mobile App](#) (BC Flex) – [new mobile app](#).
- New members will be issued a debit card for FSA eligible expenses. The debit cards will be issued by Boon Chapman and should be received at your home address no later than 14 days of effective date of the plan beginning or re-enrolling each year. (each Sept 1)
- **Filing Manual claims - Eligible** receipts can be submitted online Boon Chapman's Portal
 - [Homepage | UnbrandedForHomePage \(wealthcareportal.com\)](#)
 - [Complete a Reimbursement Form](#) and submit by [email](#).

Flexible Benefit Plan – A Tax Savings Program

Your Benefit Choices

Premium (Deductions) Account (Administered by your Employer)	Medical Reimbursement Flexible Spending Account (FSA)	Dependent/ <u>Child Care</u> Flexible Spending Account
<p>Insurance Premiums are deducted pretax and therefore under Section 125 of the IRS rules, enrollments and changes must comply with a qualifying event rule that limit changes within 30 days for most benefits but not limited to:</p> <ul style="list-style-type: none"> ▶ Medical Premiums ▶ Dental Premiums ▶ Vision Premiums ▶ FSA/HSA Premiums 	<ul style="list-style-type: none"> ▶ Deductibles ▶ Co-payments ▶ Non-covered Medical Expenses ▶ Dental Expenses ▶ Vision Expenses ▶ Prescriptions ▶ Prescribed Over-the-Counter Medications ▶ Visit the https://FSAsstore.com for more eligible items 	<ul style="list-style-type: none"> ▶ Day Care Providers for children under the age of 13.
Description of Accounts		
<p>Premiums deducted from your paycheck are paid tax-free through this account.</p>	<p>Allows you to set aside money tax-free to cover out-of-pocket health-related expenses for you and your family members.</p>	<p>Allows you to set aside money tax-free to cover childcare expenses that are incurred while you are at work.</p>
Annual Deposits Allowed by IRS		
<p>Medical, Dental Premiums</p>	<p>Minimum: \$130 annual Maximum: \$3,200</p>	<p>Minimum: \$0 *2024 Maximum: \$5,000 per family unit; \$2,500 if married and filing separately</p>
Employee Paid FSA Rollover		
<p>At the end of the plan year (Aug. 31), participants can rollover up to \$640 of unused FSA balance.</p>		
<p>Dependent Day Care Reimbursement</p> <ul style="list-style-type: none"> ➤ The IRS annual maximum amount for 2024 Calendar Year- Day Care FSA is \$5,000. ➤ <i>For MHMR plan year maximums are applied during open enrollment for Sept 1 plan start.</i> <p>In 2024 - \$5,000 a year for individuals or married couples filing jointly, or \$2,500 for a married person filing separately. New year maximums are applied at start of the benefit year (Sept 1).</p>		

Documentation you will need to include when submitting a claim against your FSA.

Medical Expenses
Covered Under a Plan

Copy of EOB

Over-the-Counter (OTC)
Medications

Copy of Prescription

Expenses NOT Covered
by ANY Benefit Plan

Itemized Bill with
Details of Service

[Watch Video to Learn More](#)

If you have insurance, you must first file your claim with your insurance plan or carrier.

*EOB – your insurance plan will send you an Explanation of Benefits (EOB) stating what portion of the incurred healthcare expenses **YOU are responsible for paying** out of pocket. Attach a copy of the EOB to a Flexible Spending Account Withdrawal Request Claim Form.

Boon-Chapman mailing address:

Flex Department
P.O. Box 9201
Austin, Texas 78766

Contact:

Boon Chapman, Plan Administrator
Office hours:
Monday through Friday – 8am to 5pm
Flex Department
1-800-252-9653 Opt. 6

Medical - Flexible Spending Account – Worksheet

Medical	
Physicals	\$
Pap Smear	
Doctor Office Visit	
Well-Baby Care	
Lab Work	
Immunizations	
Prescription Drugs	
Other	
Subtotal:	

Dental	
Exams	\$
X-rays	
Fillings	
Dentures/Partials	
Crowns	
Root Canal	
Orthodontia	
Other	
Subtotal:	

Vision	
Exams	\$
Lenses	
Frames	
Contacts & Solutions	
Other	
Subtotal:	

Other (see medical list)	
	\$
Subtotal:	

Hearing	
Exams	\$
Hearing Aid	
Other	
Subtotal:	

Subtotal of All Above:	\$
Less Any Insurance Reimbursement of the Above:	-
TOTAL:	\$
Maximum:	Refer to IRS maximum or this document for more information

TO CALCULATE YOUR DEDUCTION FOR YOUR ELECTION FORM:

Note - Election is mandated each plan year beginning 9/1

1. For coverage beginning Sept 1 - Divide the **TOTAL** by **24** paydays = *DEDUCTIONS/DEPOSIT: \$ _____
2. For coverage beginning during the plan year – divide the total by the # of paychecks (by Payday) left through 8/31.

*This amount will be payroll-deducted **each pay period** and deposited to your account **each pay period** beginning of each Plan Year September 1.

Dependent/Child Care Flexible Spending Account – Worksheet

The IRS requires that you, the employee, must meet all the following *qualifications* to participate in this Plan:

1. If married, your **spouse must be working, permanently disabled, or a full-time student**. Or you may be a single parent.
2. Day care expenses are being incurred **for you to work** or be gainfully employed.
3. Your child is age 12 or under.

List **childcare expenses** you will incur each month from **Sept. 1 through Aug. 31**.

Remember, adjust your expenses for certain times of the year and when childcare is ineligible.

January	
February	
March (<i>spring break</i>)	
April	
May	
June (<i>summer</i>)	
July (<i>summer</i>)	
August (<i>summer</i>)	
September (<i>school starts</i>)	
October	
November (<i>Thanksgiving</i>)	
December (<i>holidays</i>)	
SUBTOTAL	\$
LESS: Vacation (no payment to provider)	-
LESS: Sick days at home	-
TOTAL	\$
Maximum*	\$5,000

**Maximum to \$5,000 per family unit; \$2,500 if married filing separate*

TO CALCULATE YOUR DEDUCTION FOR YOUR ELECTION:

Note – Annual Election is mandated each plan year beginning 9/1 during open enrollment

1. For coverage beginning Sept 1 - Divide the **TOTAL** by **24** paydays = *DEDUCTIONS/DEPOSIT: \$ _____
2. For coverage beginning during the plan year – divide the total by the # of paychecks (by Payday) left through 8/31.

Flexible Spending Account Benefit Plan – IRS Rules

1. Open **enrollment is held annually** for you to elect the benefits you wish to participate in during the Plan Year (Sept 1 – Aug 31). Current participants must re-enroll each Plan Year during open enrollment.
2. After the Plan Year starts, **you cannot change your elections** unless you experience a "Event change." With an event change you may only make a change in your Dependent/Child Care Flexible Spending Account. You will have **31 days** from the date of the qualified event in which to complete a new enrollment form.
3. An **"Event change"** is defined as:
 - ▶ Marriage, divorce or legal separation
 - ▶ Birth or adoption of a child
 - ▶ Death of a dependent or spouse
 - ▶ Change (loss or gain) in employment status of yourself or your spouse
4. The **expenses** you elect to pre-tax through your Flexible Spending Account **must be "incurred"** (the services rendered) **during the Plan Year**.
5. The **expenses** you elect to pre-tax through your Flexible Spending Account **cannot be reimbursed by any other source** (i.e., paid by your Insurance Company or Plan).
6. The **expenses** you elect to pre-tax through your Flexible Spending Account **cannot also be deducted** on your personal income tax return.
7. **Maximum dependent day care** expenses allowed for the Plan Year are **\$5,000 per family unit; \$2,500 if married and filing separate. These maximums change regularly.**
8. **Maximum healthcare(medical)** expenses allowed for the Plan Year is **\$3200. These maximums change regularly (annual basis). Due to MHMR's plan being on a fiscal year, the maximum increases are applied during Open enrollment for Sept 1 start date of the plan.**
9. If you have insurance, an Explanation of Benefit (EOB) statement is required to document your claim if it is requested by the plan administrator.
10. If you are participating in the Dependent/Child Care Flexible Spending Account, the IRS requires a Form 2441 be attached to your personal income tax return.
11. Debit cards can be deactivated if proper documentation is not submitted when requested and your funds are not reimbursed to you until the proper documentation is received and authorized by the plan administrator. Note – if you cannot find that specific receipt you can submit an alternate receipt (that has not been reimbursed for the amount needed to cover the expense that you already received).

Basic Life, Accidental Death, and Dismemberment (AD&D) and Voluntary Supplemental Life Insurance

Apply for Voluntary Supplemental Life coverage online Benefit Focus

Provided by MetLife

Coverage (Basic and AD&D) – MHMR’s customer number is 105959

This benefit pays the designated beneficiary twice the amount of the employee's annual salary for both Basic Life and AD&D (Accidental Death and Dismemberment). Maximum of \$1,300,000. This coverage is automatically added for those employees who are eligible.

Part time Market-Driven Positions must work a minimum of 15 hours (FTE .38) to be eligible for Life Insurance.

Age Reduction:

Age of Employee	Percentage
70 but less than 75	45%
75 but less than 80	30%
80 or older	20%

Cost

Basic and AD&D coverage is free to all eligible employees.

Additional voluntary supplemental life insurance

You may also buy up additional life insurance for yourself, spouse or children/disabled child (maximums apply)

- ▶ Designation of beneficiary needs to be selected in Benefits Website.
- ▶ Enrollment selection must be completed in Benefits Website (The online system will automatically display the amounts of coverage you are eligible for without a health questionnaire (EOI). If you select coverage that requires a questionnaire, then only the coverage you are eligible immediately for will be deducted from your paycheck). The questionnaires must be submitted **by you** directly to the insurance company for consideration of the additional amount requested. After 90 days has elapsed from the request of the life or additional life coverage, and the coverage displays are pending EOI, the coverage will be declined as “not approved by carrier”. Employees can request additional coverage at the following open enrollment period and provide an updated EOI form as applicable.
- ▶ Employee rate sheet for your extra life insurance (provided on subsequent page)
- ▶ Spouse rate sheet for extra life insurance (maximums apply, the online enrollment system will automatically display the amounts your spouse is eligible) and if an EOI is required.
 - Child(ren) rate is listed at the bottom of the spouse rate sheet. Coverage is for \$10,000 each enrolled child. To cover children or spouse on Life Insurance, the employee must be approved for the minimum Supplemental Life Insurance. Dependents must be verifiable dependents
- ▶ For those that enroll in the Supplemental Life insurance, MetLife offers a **FREE** Digital Estate Planning (Will Preparation Service). If you are unable to access the legalplans.com/estateplanning website, you can find a network attorney by calling MetLife Legal Plans at 1 800 821 6400, Monday through Friday, 8am 8pm EST. You will need to provide your company name, customer number, and the last four digits of the policyholder’s Social Security number. Our company plan number is 105959. The representative will ask you to verify some personal information to determine if you currently have the supplemental life insurance plan. www.legalplans.com/estateplanning

Note: Detailed plan documents are available to all employees on the Benefits Website communication portal.

Supplemental Life Insurance Rates

Note – Employee Life rates will display on your online benefit enrollment portal – Rates may vary due to rounding.

MHMR of Tarrant County Optional Life Insurance												
Employee Semi-Monthly Payroll Deduction - Employee Coverage Rates												
Age Brackets	Monthly Rates Per 1000	Semi Monthly Rate per 1000										
			\$ 10,000	\$ 20,000	\$ 30,000	\$ 40,000	\$ 50,000	\$ 60,000	\$ 70,000	\$ 80,000	\$ 90,000	\$ 100,000
Under 25	\$ 0.04	0.0200000	\$ 0.20	\$ 0.40	\$ 0.60	\$ 0.80	\$ 1.00	\$ 1.20	\$ 1.40	\$ 1.60	\$ 1.80	\$ 2.00
25 to 29	\$ 0.04	0.0200000	\$ 0.20	\$ 0.40	\$ 0.60	\$ 0.80	\$ 1.00	\$ 1.20	\$ 1.40	\$ 1.60	\$ 1.80	\$ 2.00
30 to 34	\$ 0.05	0.0250000	\$ 0.25	\$ 0.50	\$ 0.75	\$ 1.00	\$ 1.25	\$ 1.50	\$ 1.75	\$ 2.00	\$ 2.25	\$ 2.50
35 to 39	\$ 0.07	0.0350000	\$ 0.35	\$ 0.70	\$ 1.05	\$ 1.40	\$ 1.75	\$ 2.10	\$ 2.45	\$ 2.80	\$ 3.15	\$ 3.50
40 to 44	\$ 0.08	0.0400000	\$ 0.40	\$ 0.80	\$ 1.20	\$ 1.60	\$ 2.00	\$ 2.40	\$ 2.80	\$ 3.20	\$ 3.60	\$ 4.00
45 to 49	\$ 0.12	0.0600000	\$ 0.60	\$ 1.20	\$ 1.80	\$ 2.40	\$ 3.00	\$ 3.60	\$ 4.20	\$ 4.80	\$ 5.40	\$ 6.00
50 to 54	\$ 0.19	0.0950000	\$ 0.95	\$ 1.90	\$ 2.85	\$ 3.80	\$ 4.75	\$ 5.70	\$ 6.65	\$ 7.60	\$ 8.55	\$ 9.50
55 to 59	\$ 0.31	0.1550000	\$ 1.55	\$ 3.10	\$ 4.65	\$ 6.20	\$ 7.75	\$ 9.30	\$ 10.85	\$ 12.40	\$ 13.95	\$ 15.50
60 to 64	\$ 0.54	0.2700000	\$ 2.70	\$ 5.40	\$ 8.10	\$ 10.80	\$ 13.50	\$ 16.20	\$ 18.90	\$ 21.60	\$ 24.30	\$ 27.00
65 to 69	\$ 1.02	0.5100000	\$ 5.10	\$ 10.20	\$ 15.30	\$ 20.40	\$ 25.50	\$ 30.60	\$ 35.70	\$ 40.80	\$ 45.90	\$ 51.00
70 & over	\$ 1.65	0.8250000	\$ 8.25	\$ 16.50	\$ 24.75	\$ 33.00	\$ 41.25	\$ 49.50	\$ 57.75	\$ 66.00	\$ 74.25	\$ 82.50
	Rates Per 1000	\$ 1,000	\$ 110,000	\$ 120,000	\$ 130,000	\$ 140,000	\$ 150,000	\$ 160,000	\$ 170,000	\$ 180,000	\$ 190,000	\$ 200,000
Under 25	\$ 0.04	0.0200000	\$ 2.20	\$ 2.40	\$ 2.60	\$ 2.80	\$ 3.00	\$ 3.20	\$ 3.40	\$ 3.60	\$ 3.80	\$ 4.00
25 to 29	\$ 0.04	0.0200000	\$ 2.20	\$ 2.40	\$ 2.60	\$ 2.80	\$ 3.00	\$ 3.20	\$ 3.40	\$ 3.60	\$ 3.80	\$ 4.00
30 to 34	\$ 0.05	0.0250000	\$ 2.75	\$ 3.00	\$ 3.25	\$ 3.50	\$ 3.75	\$ 4.00	\$ 4.25	\$ 4.50	\$ 4.75	\$ 5.00
35 to 39	\$ 0.07	0.0350000	\$ 3.85	\$ 4.20	\$ 4.55	\$ 4.90	\$ 5.25	\$ 5.60	\$ 5.95	\$ 6.30	\$ 6.65	\$ 7.00
40 to 44	\$ 0.08	0.0400000	\$ 4.40	\$ 4.80	\$ 5.20	\$ 5.60	\$ 6.00	\$ 6.40	\$ 6.80	\$ 7.20	\$ 7.60	\$ 8.00
45 to 49	\$ 0.12	0.0600000	\$ 6.60	\$ 7.20	\$ 7.80	\$ 8.40	\$ 9.00	\$ 9.60	\$ 10.20	\$ 10.80	\$ 11.40	\$ 12.00
50 to 54	\$ 0.19	0.0950000	\$ 10.45	\$ 11.40	\$ 12.35	\$ 13.30	\$ 14.25	\$ 15.20	\$ 16.15	\$ 17.10	\$ 18.05	\$ 19.00
55 to 59	\$ 0.31	0.1550000	\$ 17.05	\$ 18.60	\$ 20.15	\$ 21.70	\$ 23.25	\$ 24.80	\$ 26.35	\$ 27.90	\$ 29.45	\$ 31.00
60 to 64	\$ 0.54	0.2700000	\$ 29.70	\$ 32.40	\$ 35.10	\$ 37.80	\$ 40.50	\$ 43.20	\$ 45.90	\$ 48.60	\$ 51.30	\$ 54.00
65 to 69	\$ 1.02	0.5100000	\$ 56.10	\$ 61.20	\$ 66.30	\$ 71.40	\$ 76.50	\$ 81.60	\$ 86.70	\$ 91.80	\$ 96.90	\$ 102.00
70 & over	\$ 1.65	0.8250000	\$ 90.75	\$ 99.00	\$ 107.25	\$ 115.50	\$ 123.75	\$ 132.00	\$ 140.25	\$ 148.50	\$ 156.75	\$ 165.00
	Rates Per 1000	\$ 1,000	\$ 210,000	\$ 220,000	\$ 230,000	\$ 240,000	\$ 250,000	\$ 260,000	\$ 270,000	\$ 280,000	\$ 290,000	\$ 300,000
Under 25	\$ 0.04	0.0200000	\$ 4.20	\$ 4.40	\$ 4.60	\$ 4.80	\$ 5.00	\$ 5.20	\$ 5.40	\$ 5.60	\$ 5.80	\$ 6.00
25 to 29	\$ 0.04	0.0200000	\$ 4.20	\$ 4.40	\$ 4.60	\$ 4.80	\$ 5.00	\$ 5.20	\$ 5.40	\$ 5.60	\$ 5.80	\$ 6.00
30 to 34	\$ 0.05	0.0250000	\$ 5.25	\$ 5.50	\$ 5.75	\$ 6.00	\$ 6.25	\$ 6.50	\$ 6.75	\$ 7.00	\$ 7.25	\$ 7.50
35 to 39	\$ 0.07	0.0350000	\$ 7.35	\$ 7.70	\$ 8.05	\$ 8.40	\$ 8.75	\$ 9.10	\$ 9.45	\$ 9.80	\$ 10.15	\$ 10.50
40 to 44	\$ 0.08	0.0400000	\$ 8.40	\$ 8.80	\$ 9.20	\$ 9.60	\$ 10.00	\$ 10.40	\$ 10.80	\$ 11.20	\$ 11.60	\$ 12.00
45 to 49	\$ 0.12	0.0600000	\$ 12.60	\$ 13.20	\$ 13.80	\$ 14.40	\$ 15.00	\$ 15.60	\$ 16.20	\$ 16.80	\$ 17.40	\$ 18.00
50 to 54	\$ 0.19	0.0950000	\$ 19.95	\$ 20.90	\$ 21.85	\$ 22.80	\$ 23.75	\$ 24.70	\$ 25.65	\$ 26.60	\$ 27.55	\$ 28.50
55 to 59	\$ 0.31	0.1550000	\$ 32.55	\$ 34.10	\$ 35.65	\$ 37.20	\$ 38.75	\$ 40.30	\$ 41.85	\$ 43.40	\$ 44.95	\$ 46.50
60 to 64	\$ 0.54	0.2700000	\$ 56.70	\$ 59.40	\$ 62.10	\$ 64.80	\$ 67.50	\$ 70.20	\$ 72.90	\$ 75.60	\$ 78.30	\$ 81.00
65 to 69	\$ 1.02	0.5100000	\$ 107.10	\$ 112.20	\$ 117.30	\$ 122.40	\$ 127.50	\$ 132.60	\$ 137.70	\$ 142.80	\$ 147.90	\$ 153.00
70 & over	\$ 1.65	0.8250000	\$ 173.25	\$ 181.50	\$ 189.75	\$ 198.00	\$ 206.25	\$ 214.50	\$ 222.75	\$ 231.00	\$ 239.25	\$ 247.50

MHMR of Tarrant County Optional Life Insurance – Continued Employee Only rates

MHMR of Tarrant County Optional Life Insurance												
Employee Semi-Monthly Payroll Deduction - Employee Coverage Rates												
Age Brackets	Monthly Rates Per 1000	Semi Monthly Rate per 1000	\$ 310,000	\$ 320,000	\$ 330,000	\$ 340,000	\$ 350,000	\$ 360,000	\$ 370,000	\$ 380,000	\$ 390,000	\$ 400,000
Under 25	\$ 0.04	0.0200000	\$ 6.20	\$ 6.40	\$ 6.60	\$ 6.80	\$ 7.00	\$ 7.20	\$ 7.40	\$ 7.60	\$ 7.80	\$ 8.00
25 to 29	\$ 0.04	0.0200000	\$ 6.20	\$ 6.40	\$ 6.60	\$ 6.80	\$ 7.00	\$ 7.20	\$ 7.40	\$ 7.60	\$ 7.80	\$ 8.00
30 to 34	\$ 0.05	0.0250000	\$ 7.75	\$ 8.00	\$ 8.25	\$ 8.50	\$ 8.75	\$ 9.00	\$ 9.25	\$ 9.50	\$ 9.75	\$ 10.00
35 to 39	\$ 0.07	0.0350000	\$ 10.85	\$ 11.20	\$ 11.55	\$ 11.90	\$ 12.25	\$ 12.60	\$ 12.95	\$ 13.30	\$ 13.65	\$ 14.00
40 to 44	\$ 0.08	0.0400000	\$ 12.40	\$ 12.80	\$ 13.20	\$ 13.60	\$ 14.00	\$ 14.40	\$ 14.80	\$ 15.20	\$ 15.60	\$ 16.00
45 to 49	\$ 0.12	0.0600000	\$ 18.60	\$ 19.20	\$ 19.80	\$ 20.40	\$ 21.00	\$ 21.60	\$ 22.20	\$ 22.80	\$ 23.40	\$ 24.00
50 to 54	\$ 0.19	0.0950000	\$ 29.45	\$ 30.40	\$ 31.35	\$ 32.30	\$ 33.25	\$ 34.20	\$ 35.15	\$ 36.10	\$ 37.05	\$ 38.00
55 to 59	\$ 0.31	0.1550000	\$ 48.05	\$ 49.60	\$ 51.15	\$ 52.70	\$ 54.25	\$ 55.80	\$ 57.35	\$ 58.90	\$ 60.45	\$ 62.00
60 to 64	\$ 0.54	0.2700000	\$ 83.70	\$ 86.40	\$ 89.10	\$ 91.80	\$ 94.50	\$ 97.20	\$ 99.90	\$ 102.60	\$ 105.30	\$ 108.00
65 to 69	\$ 1.02	0.5100000	\$ 158.10	\$ 163.20	\$ 168.30	\$ 173.40	\$ 178.50	\$ 183.60	\$ 188.70	\$ 193.80	\$ 198.90	\$ 204.00
70 & over	\$ 1.65	0.8250000	\$ 255.75	\$ 264.00	\$ 272.25	\$ 280.50	\$ 288.75	\$ 297.00	\$ 305.25	\$ 313.50	\$ 321.75	\$ 330.00
	Rates Per 1000	\$ 1,000	\$ 410,000	\$ 420,000	\$ 430,000	\$ 440,000	\$ 450,000	\$ 460,000	\$ 470,000	\$ 480,000	\$ 490,000	\$ 500,000
Under 25	\$ 0.04	0.0216666	\$ 8.88	\$ 9.10	\$ 9.32	\$ 9.53	\$ 9.75	\$ 9.97	\$ 10.18	\$ 10.40	\$ 10.62	\$ 10.83
25 to 29	\$ 0.04	0.0216666	\$ 8.88	\$ 9.10	\$ 9.32	\$ 9.53	\$ 9.75	\$ 9.97	\$ 10.18	\$ 10.40	\$ 10.62	\$ 10.83
30 to 34	\$ 0.05	0.0270833	\$ 11.10	\$ 11.37	\$ 11.65	\$ 11.92	\$ 12.19	\$ 12.46	\$ 12.73	\$ 13.00	\$ 13.27	\$ 13.54
35 to 39	\$ 0.07	0.0379167	\$ 15.55	\$ 15.93	\$ 16.30	\$ 16.68	\$ 17.06	\$ 17.44	\$ 17.82	\$ 18.20	\$ 18.58	\$ 18.96
40 to 44	\$ 0.08	0.0433334	\$ 17.77	\$ 18.20	\$ 18.63	\$ 19.07	\$ 19.50	\$ 19.93	\$ 20.37	\$ 20.80	\$ 21.23	\$ 21.67
45 to 49	\$ 0.12	0.0650000	\$ 26.65	\$ 27.30	\$ 27.95	\$ 28.60	\$ 29.25	\$ 29.90	\$ 30.55	\$ 31.20	\$ 31.85	\$ 32.50
50 to 54	\$ 0.19	0.1029167	\$ 42.20	\$ 43.22	\$ 44.25	\$ 45.28	\$ 46.31	\$ 47.34	\$ 48.37	\$ 49.40	\$ 50.43	\$ 51.46
55 to 59	\$ 0.31	0.1679166	\$ 68.85	\$ 70.52	\$ 72.20	\$ 73.88	\$ 75.56	\$ 77.24	\$ 78.92	\$ 80.60	\$ 82.28	\$ 83.96
60 to 64	\$ 0.54	0.2700000	\$ 110.70	\$ 113.40	\$ 116.10	\$ 118.80	\$ 121.50	\$ 124.20	\$ 126.90	\$ 129.60	\$ 132.30	\$ 135.00
65 to 69	\$ 1.02	0.5100000	\$ 209.10	\$ 214.20	\$ 219.30	\$ 224.40	\$ 229.50	\$ 234.60	\$ 239.70	\$ 244.80	\$ 249.90	\$ 255.00
70 & over	\$ 1.65	0.8250000	\$ 338.25	\$ 346.50	\$ 354.75	\$ 363.00	\$ 371.25	\$ 379.50	\$ 387.75	\$ 396.00	\$ 404.25	\$ 412.50

Coverage is provided under a group insurance policy (Policy Form G.2130-S OR Policy Form GPN-P99) issued to your employer by MetLife. Optional Life coverage terminates when your employment ceases, when your Optional Life contributions cease, or upon termination of the group contract by your employer upon prior written notice to MetLife. Optional Life Insurance does not provide payments of benefits for death caused by suicide within the first two years (one year in North Dakota) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within two years (one year in North Dakota) of an increase in coverage (except in Missouri and Washington). This coverage may also be discontinued by MetLife for non-payment of premium if participation requirements are not met.

Spouse and Children Rates

MHMR of Tarrant County Dependent Life

Employee Semi-Monthly Payroll Deduction - SPOUSE RATES

Rates may vary due to rounding

Spouse Age Brackets	\$ 5,000.00	\$ 10,000.00	\$ 15,000.00	\$ 20,000.00	\$ 25,000.00	\$ 30,000.00	\$ 35,000.00	\$ 40,000.00	\$ 45,000.00	\$ 50,000.00
15 to 19	0.15	0.30	0.46	0.61	0.76	0.91	1.06	1.21	1.37	1.52
20 to 24	0.13	0.26	0.39	0.52	0.65	0.78	0.91	1.04	1.17	1.30
25 to 29	0.15	0.30	0.46	0.61	0.76	0.91	1.06	1.21	1.37	1.52
30 to 34	0.20	0.39	0.59	0.78	0.98	1.17	1.37	1.56	1.76	1.95
35 to 39	0.23	0.46	0.68	0.91	1.14	1.37	1.59	1.82	2.05	2.28
40 to 44	0.27	0.54	0.81	1.08	1.35	1.63	1.90	2.17	2.44	2.71
45 to 49	0.42	0.85	1.27	1.69	2.11	2.54	2.96	3.38	3.80	4.23
50 to 54	0.80	1.60	2.41	3.21	4.01	4.81	5.61	6.41	7.22	8.02
55 to 59	1.28	2.56	3.84	5.11	6.39	7.67	8.95	10.23	11.51	12.78
60 to 64	2.33	4.66	6.99	9.32	11.65	13.98	16.30	18.63	20.96	23.29
65 to 69	4.00	8.00	11.99	15.99	19.99	23.99	27.98	31.98	35.98	39.98
70 & Over	6.08	12.16	18.23	24.31	30.39	36.47	42.54	48.62	54.70	60.78

Spouse Age Brackets	\$ 55,000.00	\$ 60,000.00	\$ 65,000.00	\$ 70,000.00	\$ 75,000.00	\$ 80,000.00	\$ 85,000.00	\$ 90,000.00	\$ 95,000.00	\$ 100,000.00
15 to 19	1.67	1.82	1.97	2.12	2.28	2.43	2.58	2.73	2.88	3.03
20 to 24	1.43	1.56	1.69	1.82	1.95	2.08	2.21	2.34	2.47	2.60
25 to 29	1.67	1.82	1.97	2.12	2.28	2.43	2.58	2.73	2.88	3.03
30 to 34	2.15	2.34	2.54	2.73	2.93	3.12	3.32	3.51	3.71	3.90
35 to 39	2.50	2.73	2.96	3.19	3.41	3.64	3.87	4.10	4.32	4.55
40 to 44	2.98	3.25	3.52	3.79	4.06	4.33	4.60	4.88	5.15	5.42
45 to 49	4.65	5.07	5.49	5.92	6.34	6.76	7.18	7.61	8.03	8.45
50 to 54	8.82	9.62	10.42	11.22	12.03	12.83	13.63	14.43	15.23	16.03
55 to 59	14.06	15.34	16.62	17.90	19.18	20.45	21.73	23.01	24.29	25.57
60 to 64	25.62	27.95	30.28	32.61	34.94	37.27	39.60	41.93	44.25	46.58
65 to 69	43.97	47.97	51.97	55.97	59.96	63.96	67.96	71.96	75.95	79.95
70 & Over	66.85	72.93	79.01	85.09	91.16	97.24	103.32	109.40	115.47	121.55

Spouses can have up to 100% of the Employee's amount or \$100,000; whichever is the lesser. * Guaranteed issue amount (without health questionnaire) is \$25,000.

Dependent Life coverage terminates when Dependent Life contributions cease, upon the death of the employee, when a dependent no longer qualifies as a dependent, when a dependent reaches age 80, or upon termination of the group contract by your employer upon prior written notice to MetLife. This coverage may also be discontinued by MetLife for non-payment of premium or if participation requirements are not met. Dependent Life insurance does not provide payment of increased benefits for death caused by suicide within the first two years (one year in North Dakota) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within the first two years (one year in North Dakota) of an increase in coverage (except in Missouri, Washington and Massachusetts). Spouse coverage cannot exceed employee coverage. Note – Employees cannot cover the same dependent on each of their life insurance plans.

Child(ren) coverage cannot exceed \$10,000 per eligible child. [For employees residing in Texas, dependent coverage cannot exceed employee coverage.

Child(ren) coverage: \$10,000 - The cost of child(ren) term life coverage is 1.02 per month or .51 semi-monthly (15 days to 19, after 19 to 25 if full time student unless the child is disabled). One rate for all covered children. Employees must notify the Employee Benefits Office, when dependent ceases to be eligible for child(ren) life coverage. Employee must have coverage to have child (ren) coverage.

Disability Insurance Plans

Provided by NYLGBS

Long-Term Disability (LTD) Insurance Coverage

Paid by MHMR

If eligible, you will automatically be enrolled in this coverage.

Eligibility

This benefit is provided to active, full-time MHMR employees regularly working a minimum of 40 hours per week. Anyone designated Part time are not eligible.

Monthly Benefit

This plan pays a benefit of up to 60% of your monthly covered earnings up to a maximum of \$6,000 per month. Benefit can be reduced due to other earnings.

Definition of Disability

Disability means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to earn 80% or more of your indexed earnings from working in your regular occupation. After benefits have been payable for 24 months, you are considered disabled if solely due to your injury or sickness, you are unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience, and you are unable to earn 60% or more of your indexed earnings. We will require proof of earnings and continued disability.

Elimination Period

You must be disabled for 90 days whichever is greater, before benefits may be payable.

Benefit Duration

Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit period shown below, or until you no longer qualify for benefits, whichever occurs first.

Your benefit period begins on the first day after you complete your elimination period. And, should you remain disabled, your benefits continue according to the following schedule, depending on your age at the time you become disabled.

Age at Disability	62 or Younger	63	64	65	66	67	68	69+
Duration of Payments (months)	To SSNRA or the date the 42 nd monthly benefit is payable, if later	36	30	24	21	18	15	12

78% Americans live paycheck-to-paycheck.

CareerBuilder, January 11, 2019

60 percent of Americans do not have a “rainy day” fund to cover three months of unanticipated financial emergencies.

FINRA Foundation State-by-State Financial Capability Survey, 2011

Cost: Free. The cost of this insurance program is paid by MHMR

Additional Plan Details

Earnings While Disabled

During the first 24 months that benefits are payable, benefits will be reduced if benefits plus income from employment exceeds 100% of pre-disability covered earnings. After that, benefits will be reduced by 50% of earnings from employment.

Pre-Existing Conditions

Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures,) or for which a reasonable person would have consulted a physician during the 3 months just prior to the most recent effective date of insurance.

Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been in active service for a time of 3 consecutive months when you received no medical treatment, care, or services after you have been under this plan for at least 12 months after your most recent effective date of insurance.

Limited Benefit Period

Disabilities caused by or contributed to by any one or more of the following conditions are subject to a lifetime limit of 24 months for outpatient treatment: Anxiety-disorders, delusional (paranoid) or depressive disorders, eating disorders, mental illness, somatoform disorders.

Benefits are payable during periods of hospital confinement for these conditions for hospitalizations lasting more than 14 consecutive days that occur before the 24- month lifetime outpatient limit is exhausted. Disabilities caused by or contributed to by any one or more of the following conditions are subject to a lifetime limit of 24 months for outpatient treatment: Alcoholism, drug addiction or abuse.

Family Survivor Benefit

If you die while receiving disability benefits, we will pay a survivor benefit based on 100% of the total of your last month's benefit plus the amount of any disability earnings by which this benefit had been reduced for that month. This plan pays a single lump sum equal to 3 months of benefits. We pay this benefit directly to your lawful spouse, or to your children in equal shares, if there is no lawful spouse. If you have no lawful spouse or children, we pay this benefit to your estate.

Programs Included at No Additional Cost

Cigna's Online Will and Health-related Legal Document and Funeral Preparation Program offers you and your covered spouse access to a website that helps you build state-specific customized wills and other legal documents as well as create an end-of-life plan that spells out the handling of your estate and funeral arrangements. Visit www.Cignawillcenter.com.

Cigna's Identity Theft Program

The program provides access to personal case managers who give step-by-step assistance and guidance if you have had your identity stolen. Call 888.724.2262, Monday – Friday from 9:00 am to 11:00 pm EST to speak with an MSA representative. All you'll need to give is your name, city, state, zip code and the name of your employer or plan sponsor. You can also visit cigna.mysecureadvantage.com for more information, or to register and access online tools and educational resources and create legal documents.

This information is a brief description of the important features of the plan. It is not a contract. Terms and conditions of life insurance coverage are set forth in Group Policy No.LK-963401, issued in TX to MHMR. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut Street, Philadelphia, PA. As used in this brochure, the term Cigna and Cigna Group Insurance are registered service marks of Life Insurance Company of North America, a CIGNA company, which is the insurer of the Group Policy. Insurance products and services are provided by the individual CIGNA companies and not by the Corporation itself. © Cigna 2011

Voluntary Short-Term Disability (STD) Insurance Coverage

Provided by NYLGBS

Employee Paid

Eligibility

This benefit is provided to active, full-time MHMR employees regularly working a minimum of 40 hours per week. Anyone designated Part time are not eligible.

Monthly Benefit

This plan pays a benefit of up to 60% of your monthly covered earnings up to a maximum of \$1,100 per week. Benefit can be reduced due to other earnings.

Definition of Disability

Disability means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to earn 80% or more of your covered earnings from working in your regular occupation. We will require proof of earnings and continued disability.

Elimination Period

You must be disabled for 14 days from either accident or sickness.

Benefit Duration

Once you qualify for benefits under this plan, you continue to receive them until the end of the 11-week benefit period, or until you no longer qualify for benefits, whichever occurs first.

Cost

The cost of this insurance program is paid by you. The cost of this coverage is \$0.40 per \$10 of weekly covered benefits.

Full-Time Employee Deductions

Basic Weekly earnings (hourly rate x 40) x \$.024 =

*Monthly Deduction x 12 divided by 24 = per paycheck deduction

Example: \$300 per week x \$.024 = \$7.20

*monthly deduction x 12 divided by 24 =

\$3.60 deducted 2x per month (semi-monthly)

78% Americans live paycheck-to-paycheck.

CareerBuilder, January 11, 2019

60% of Americans do not have a "rainy day" fund to cover three months of unanticipated financial emergencies.

FINRA Foundation State-by-State Financial Capability Survey, 2011

Additional Plan Details

This information is a brief description of the important features of the plan. It is not a contract. Terms and conditions of life insurance coverage are set forth in Group

Earnings While Disabled

Benefits will be reduced for any week that benefits plus income from employment exceeds 100% of weekly covered earnings.

If you're not actively at work on the date your coverage would otherwise take effect, you'll be covered on the date you return to work.

Termination of Disability Benefits

Disabilities caused by or contributed to by any one or more of the following conditions are subject to a lifetime limit of 12 months for outpatient treatment: Alcoholism, drug addiction or abuse.

Your benefits will terminate when your disability ceases, when your benefit duration period is exceeded, or on the following events: (1) the date you earn from any occupation more than 80% of your covered earnings, (refer to your plan's definition of disability); (2) the date you fail to cooperate with us in a rehabilitation plan, transitional work arrangement, or the administration of the claim.

When Coverage Takes Effect

Your coverage takes effect on the later of the program's effective date, the date you become eligible, the date we receive your completed enrollment form, or the date you authorize any necessary payroll deductions.

If you have to submit evidence of good health, your coverage takes effect on the date we agree, in writing, to cover you.

Programs Included at No Additional Cost

Cigna's Online Will and Health-related Legal Document and Funeral Preparation Program offers you and your covered spouse access to a website that helps you build state-specific customized wills and other legal documents. Visit www.Cignawillcenter.com or call 800.901.7534.

Cigna's Identity Theft Program

The program provides access to personal case managers who give step-by-step assistance and guidance if you have had your identity stolen.

Policy No. VDT- 961201, issued in TX to MHMR. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut Street, Philadelphia, PA. As used in this brochure, the term Cigna and Cigna Group Insurance are registered service marks of Life Insurance Company of North America, a CIGNA company, which is the insurer of the Group Policy. Insurance products and services are provided by the individual CIGNA companies and not by the Corporation itself. © Cigna 2011

Family Medical Leave Act (FMLA)



MHMR wants to ensure that all employees are made aware of their rights and responsibilities under the Family and Medical Leave Act.

FMLA provides employees with up to 12 weeks of unpaid, job protected leave. FMLA is designed to help employees balance their work and family responsibilities by allowing reasonable unpaid leave for certain family and medical reasons.

On the following pages you will find information issued by the Department of Labor regarding MHMR rights and responsibilities and those of the employees.

To Request Leave: Login into UKG “Workforce Management” > Select 3 dashes top left corner.



Select “My Information” > Click On “My Calendar”>Click On “Request”> “Leave of absence” > Select applicable items. For questions, contact MHMR Disability Coordinators.

Personal Leave and Parental Leave

Personal Leave and Parental Leave is available for employees not eligible for protected FMLA leave. For more information contact the leaves team.

Americans with Disability Act (ADA)

MHMR, after being placed on appropriate notice, provides reasonable accommodation to qualified job applicants/employees with disabilities, unless to do so would cause undue hardship. MHMR is committed to compliance with the Americans with Disabilities Act [“ADA”] and other applicable laws pertaining to individuals with disabilities. For “reasonable accommodation requests” please contact the Leave Coordinator in Human Resources

Workers Compensation

For all work-related injuries, employees must immediately notify their supervisor and the leaves team. Employees may seek medical treatment for all work-related injuries and must complete a drug and alcohol screening within 12 hours of injury and complete appropriate documentation. Employees must select a Primary Care doctor participating in the Workers’ Compensation Alliance Network. **NOTE**– Doctors outside of the Alliance network will not be paid by the workers compensation insurance company and your health insurance is not required to pay workers compensation medical bills. For a list of primary providers in the Alliance network go to www.pswca.org or call **866-997-7922**.

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

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

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

Military Family Leave Entitlements

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

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

Benefits and Protections

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

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

Eligibility Requirements

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

Definition of Serious Health Condition

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

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

Use of Leave

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

Substitution of Paid Leave for Unpaid Leave

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

Employee Responsibilities

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

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

Employer Responsibilities

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

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

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- ▶ Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- ▶ Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

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

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

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures

HOSPITAL INDEMNITY INSURANCE BENEFITS – Watch [this video](#) and to learn more

Metlife’s support page <https://www.metlife.com/MHMRofTarrantCounty/>

With MetLife, you’ll have a choice of two comprehensive plans which provide payments in addition to any other insurance payments you may receive. Here are just some of the covered benefits/services, when an accident or illness puts you in the hospital.¹

Benefit Type ²	Low Plan MetLife Hospital Indemnity Insurance Pays YOU	High Plan MetLife Hospital Indemnity Insurance Pays YOU
Hospital Coverage (Accident)		
Admission - Non-ICU - ICU must occur within 180 days after the accident	\$500 per accident \$1,000 per accident	\$1,000 per accident \$2,000 per accident
Confinement - Non-ICU - ICU must occur within 180 days after the accident	\$100 a day, up to 365 days \$200 a day up 30 days	\$200 a day, up to 365 days \$400 a day up to 30 days
Inpatient Rehab stay must occur immediately following hospital confinement and occur within 365 days of accident	\$100 a day, up to 15 days per accident and 30 days per calendar year	\$200 a day, up to 15 days per accident and 30 days per calendar year
Hospital Coverage (Sickness)³		
Admission - Non-ICU - ICU <i>Payable 1x per calendar year</i>	\$500 \$1,000	\$1,000 \$2,000
Confinement - Non-ICU - ICU <i>Paid per sickness</i>	\$100 a day, up to 365 days \$200 a day up 30 days	\$200 a day, up to 365 days \$400 a day up to 30 days
Other Benefits		
Lodging ⁴ benefit provided for a companion accompanying a covered insured while hospitalized	\$100 a day up to 30 days per calendar year; lodging facility must be located at least 50 miles from covered person’s primary residence	\$200 a day up to 30 days per calendar year; lodging facility must be located at least 50 miles from covered person’s primary residence
Health Screening (Wellness) ⁵ benefit provided if the covered insured takes one of the covered screening/prevention tests <i>Payable 1x per calendar year</i>	\$50	\$100

Susan wakes up in the middle of the night experiencing chest pain. An ambulance takes her to the emergency room (ER) at a local hospital. Upon arrival, the ER doctor examines Susan and advises that she requires immediate admission to the Intensive Care Unit for further evaluation and treatment. After 1 day in the Intensive Care Unit, Susan moves to a standard room and spends 2 additional days recovering in the hospital. Susan was released to her primary care physician for follow-up treatment and observation. Her primary doctor is now keeping a close watch over Susan’s overall health. Depending on her health insurance, Susan’s out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. Hospital Indemnity Insurance payments can be used to help cover these unexpected costs or to cover other expenses.

BENEFIT PAYMENT EXAMPLE

Covered Benefit ²	Benefit Amount ⁶
Admission - Intensive Care Unit Coverage (Sickness)	\$2,000
Confinement for 1 day- Intensive Care Unit Coverage (Sickness)	\$400
Confinement for 2 days – Hospital Coverage (Sickness)	\$400
Benefits paid by Hospital Indemnity Insurance	\$2,800

EMPLOYEE PAYS / Semi Monthly – rates may vary due to rounding	LOW PLAN	HIGH PLAN
Employee Only	\$6.93	\$14.09
Employee + Children	\$11.46	\$22.85
Employee + Spouse	\$11.46	\$22.85
Employee + Family	\$16.66	\$32.95

CRITICAL ILLNESS INSURANCE PLAN SUMMARY

COVERAGE OPTIONS - This plan has a non-smoker and smoker rate based on the nicotine usage in the 1st nicotine questionnaire

Eligible Individual	Initial Benefit	Requirements
Employee	\$10,000, \$20,000 or \$30,000	Coverage is guaranteed provided you are actively at work. ²
Spouse	100% of the employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the spouse is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. ²
Dependent Child(ren) ^{1*}	100% of the employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. ²

BENEFIT PAYMENT: Your **Initial Benefit** provides a lump-sum payment upon the first diagnosis of a Covered Condition. Your plan pays a Recurrence Benefit³ equal to the Initial Benefit for the following Covered Conditions: Heart Attack, Stroke, Coronary Artery Bypass Graft, Full Benefit Cancer and Partial Benefit Cancer. A Recurrence Benefit is only available if an Initial Benefit has been paid for the Covered Condition. There is a Benefit Suspension Period between Recurrences. Initial Benefits and Recurrence Benefits will be paid until the Total Benefit Amount has been reached.

The maximum amount that you can receive through your Critical Illness Insurance plan is called the **Total Benefit** and is 3 times the amount of your Initial Benefit. This means that you can receive multiple Initial Benefit and Recurrence Benefit payments until you reach the maximum of 300% or \$30,000; \$60,000 or \$90,000.

Example of Initial & Recurrence Benefit Payments

Covered Conditions	Initial Benefit	Recurrence Benefit
Full Benefit Cancer ⁴	100% of Initial Benefit	100% of Initial Benefit
Partial Benefit Cancer ⁴	25% of Initial Benefit	25% of Initial Benefit
Heart Attack	100% of Initial Benefit	100% of Initial Benefit
Stroke ⁵	100% of Initial Benefit	100% of Initial Benefit
Coronary Artery Bypass Graft ⁶	100% of Initial Benefit	100% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not applicable
Alzheimer's Disease ⁷	100% of Initial Benefit	Not applicable
Major Organ Transplant Benefit	100% of Initial Benefit	Not applicable
22 Listed Conditions	25% of Initial Benefit	Not applicable

The example below illustrates an employee who elected an Initial Benefit of \$10,000 and has a Total Benefit of 3 times the Initial Benefit Amount or \$30,000.

Illness – Covered Condition	Payment	Total Benefit Remaining
Heart Attack – first diagnosis	Initial Benefit payment of \$10,000 or 100%.	\$20,000
Heart Attack – second diagnosis, two years later	Recurrence Benefit payment of \$10,000 or 100%	\$10,000
Kidney Failure – first diagnosis, three years later	Initial Benefit payment of \$10,000 or 100%	\$0

Critical Illness Rates

Monthly Premium/\$1,000 of Coverage: **Non – Smoker**

Monthly Premium/\$1,000 of Coverage: **Smoker**

Issue Age	Employee Only	Employee +Spouse	Employee +Children	Employee +Spouse/Children
<25	\$0.44	\$0.90	\$0.73	\$1.19
25–29	\$0.44	\$0.97	\$0.73	\$1.26
30–34	\$0.61	\$1.36	\$0.90	\$1.65
35–39	\$0.84	\$1.95	\$1.13	\$2.24
40–44	\$1.26	\$2.93	\$1.55	\$3.22
45–49	\$1.74	\$4.07	\$2.03	\$4.36
50–54	\$2.32	\$5.43	\$2.61	\$5.72
55–59	\$2.93	\$6.84	\$3.22	\$7.13
60–64	\$3.62	\$8.26	\$3.91	\$8.55
65–69	\$4.14	\$9.42	\$4.43	\$9.71
70+	\$5.07	\$11.53	\$5.36	\$11.82

Issue Age	Employee Only	Employee +Spouse	Employee +Children	Employee +Spouse/Children
<25	\$0.66	\$1.34	\$0.95	\$1.63
25–29	\$0.66	\$1.46	\$0.95	\$1.75
30–34	\$0.95	\$2.11	\$1.24	\$2.40
35–39	\$1.34	\$3.11	\$1.63	\$3.40
40–44	\$2.06	\$4.77	\$2.35	\$5.06
45–49	\$2.87	\$6.71	\$3.16	\$7.00
50–54	\$3.84	\$9.02	\$4.13	\$9.31
55–59	\$4.88	\$11.45	\$5.17	\$11.74
60–64	\$6.06	\$13.92	\$6.35	\$14.21
65–69	\$6.99	\$16.07	\$7.28	\$16.36
70+	\$8.68	\$19.93	\$8.97	\$20.22

With MetLife, you'll have a choice of two comprehensive plans which provide payments in addition to any other insurance payments you may receive. Here are just some of the covered events/services.

Benefit Type ¹	Low Plan MetLife Accident Insurance Pays YOU	High Plan MetLife Accident Insurance Pays YOU
Injuries		
Fractures ²	\$50 – \$3,000	\$100 – \$6,000
Dislocations ²	\$50 – \$3,000	\$100 – \$6,000
Second and Third Degree Burns	\$50 – \$5,000	\$100 – \$10,000
Concussions	\$200	\$400
Cuts/Lacerations	\$25 – \$200	\$50 – \$400
Eye Injuries	\$200	\$300
Medical Services & Treatment		
Ambulance	\$200 – \$750	\$300 – \$1,000
Emergency Care	\$25 – \$50	\$50 – \$100
Non-Emergency Care	\$25	\$50
Physician Follow-Up	\$50	\$75
Therapy Services (including physical therapy)	\$15	\$25
Medical Testing Benefit	\$100	\$200
Medical Appliances	\$50 – \$500	\$100 – \$1,000
Inpatient Surgery	\$100 – \$1,000	\$200 – \$2,000
Hospital ³ Coverage (Accident)		
Admission	\$500 – \$1,000 per accident	\$1,000 – \$2,000 per accident
Confinement (non-ICU confinement paid for up to 365 days. ICU confinement paid for 30 days)	\$100 (non-ICU) – \$200 (ICU) a day	\$200 (non-ICU) – \$400 (ICU) a day
Inpatient Rehab (paid per accident)	\$100 a day, up to 15 days	\$200 a day, up to 15 days
Benefit Type ¹	Low Plan Accident Insurance Pays YOU	High Plan Accident Insurance Pays YOU
Accidental Death		
Employee receives 100% of amount shown, spouse receives 50% and children receive 20% of amount shown.	\$25,000 \$75,000 for common carrier ⁵	\$50,000 \$150,000 for common carrier ⁴
Dismemberment, Loss & Paralysis		
Dismemberment, Loss & Paralysis	\$250 – \$10,000 per injury	\$500 - \$50,000 per injury
Other Benefits		
Lodging ⁵ - Pays for lodging for companion up to 30 nights per calendar year	\$100 per night, up to 30 nights; up to \$3,000 in total lodging benefits available per calendar year	\$200 per night, up to 30 nights; up to \$6,000 in total lodging benefits available per calendar year

Kathy's daughter, Molly, plays soccer on the varsity high school team. During a recent game, she collided with an opposing player, was knocked unconscious and taken to the local emergency room by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly's face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy's out-of-pocket costs could run into hundreds of dollars to cover expenses like co-payments and deductibles. Accident Insurance payments can be used to help cover these unexpected costs.

BENEFIT PAYMENT EXAMPLE

Covered Event ¹	Benefit Amount ⁷
Ambulance (ground)	\$300
Emergency Care	\$100
Physician Follow-Up (\$75 x 2)	\$150
Medical Testing	\$200
Concussion	\$400
Broken Tooth (repaired by crown)	\$200
Benefits paid by MetLife Group Accident Insurance	\$1,350

EMPLOYEE PAYS / Semi Monthly – Rates may vary due to rounding	LOW PLAN	HIGH PLAN
Employee Only	3.35	6.36
Employee + Children	6.07	11.28
Employee + Spouse	5.20	9.69
Employee + Family	8.08	14.92



Wellness Program Wellness.Works@mhmrtc.org

MHMR supports its employees to voluntarily participate in wellness initiatives to help foster healthy lifestyles and save the agency and its employee's health care costs over time. Onsite and online engagement is available. Announcements and communications are distributed year-round depending on the activities being promoted. Some activities include onsite Flu shots, mobile blood donations, mobile mammograms and more!

Wellness Works provides you additional resources, partnerships, and support in the following areas of overall health including but not limited to Emotional, Financial, Occupational, Social, Environmental, Intellectual, Physical and Spiritual Wellbeing.



To support these areas, the following resources are available at no additional fee:

- Retirement record-keeper – Beginning January 2023, Voya Financial is our retirement provider at VoyaRetirementPlans.com | (800)-584-6001 | Search **Voya Retire** mobile app on your favorite app store to download to your phone
- Hub International (aka Gus Bates - Retirement Consultant)
- Care.com is free to our employees - Use **Care.com/yourbenefits** to be connected to the MHMR's premium membership
- GoodRx –<http://www.goodrx.com>– Potential coupons on your prescriptions. This benefit should be used only if your insurance plan does not cover an item or if the cost under the insurance copay is higher.
- My Strength – www.mystrength.com – various overall health topics
- Employee Assistance Programs: Talkspace (<https://talkspace.com/MHMRTarrant>) and The [Wellness EAP FLYER](#) for work/life balance support or the Financial EAP Flyer for [Finance/Legal/Estate](#) support information.
- Teladoc – www.teladoc.com – Telehealth Medical assistance part of your medical plan you are enrolled in
- Boon Chapman – www.boonchapman.com Medical Case Management and Maternity Program
- Discounted/Gym opportunities – see below and InfoDepot Discount page to learn more

EAP Printable Flyer can be found on HR page of InfoDepot under Employee Resources -link [Wellness EAP FLYER](#).

Care.Com Premium Membership – Free to MHMR of Tarrant County Employees

Your MHMR Care benefits include unlimited, premium access to the world's leading network for finding and booking short- and long-term care for all you love - kids, seniors, pets, and more. Whether it's nannies, day cares, babysitters, pet sitters, senior caregivers, or housekeepers - it can all be found on our network. Easily search and filter, browse profiles, and check out reviews to find your perfect caregiver match - online or through the app. And with 100% background-checked caregivers, you can rest assured your loved ones are in good hands.



Care Membership

Care for all you love

Nanny quit? House a mess? Finding the right care for your family can be hard, especially when you're balancing the demands of work and life. We make it easier with unlimited access to the world's leading network for finding and managing care for kids, adults, pets, home, and more.



How It Works

- 1 Log in to your account online or through the app.
- 2 Search caregiver profiles, post a job, schedule interviews and request background checks.
- 3 Once you're ready to hire, easily schedule and pay your caregiver on Care.com.

“Care.com has given me the flexibility to find care providers to meet the unique needs of my family.”

— Care Membership User



100%
of caregivers complete
background check

Enroll or login to find care today
www.care.com/yourbenefits



Care.com premium membership has More!



LifeMart Discounts

Make everyday life more affordable

Get exclusive offers on childcare, education, nutrition services, and more through our members-only online discount program offering savings on major brands and everyday essentials. Access hundreds of online discounts to save money on everyday needs.



How It Works

- 1 Log in to your account on the Care website and select LifeMart discounts.
- 2 Search for discounts by category.
- 3 Select an offer to review the details and redemption instructions.

*“Love this benefit from my employer!!
Lots of savings and discounts!”*
— LifeMart Discounts User



\$6.4 MM saved
on child care in one year
(2020 member savings)

Enroll or login to start saving
www.care.com/yourbenefits



Wellness Works and Other Discounts

MHMR offers the following health, wellness programs and other discount programs to help you and your family stay healthy and get more out of life. Throughout the year, MHMR hosts blood drives as well as mobile mammograms and other preventative screenings including flu shot opportunities – all covered by your MHMR insurance. We remind you often of these benefits through Uconnect – our agency wide daily newsletter that arrive to your MHMR email.

- MHMR provides the premium membership to care.com to MHMR employees to support and alternatives to help them find the right care for their families. This membership offers discounts at daycares, other varied discounts offered and online platform with many providers offering daycare, family care, pet care and more! **Use [Care.com/yourbenefits](https://www.care.com/yourbenefits)** to be connected to the MHMR's premium membership.
- MHMR currently has agreements for [discounts](#) at various fitness facilities for all employees and their direct family members. Information can be found on the benefits website under the Wellness Resources tab.
- YMCA provides 30% discount to employees. Other restrictions apply, refer to the discount page on InfoDepot where you can find other gym discounts linked to Care.com (under LifeMart discounts).
- MHMR gives employees **free** access to [MyStrength.com](https://www.mystrength.com) at no cost to you. My Strength offers a mobile app that allows you to track your mental wellbeing by taking assessments, logging your mood and participating within the app to personalize the experience. Visit Benefits Website under the Wellness Resources tab for more information.
- [Stay Trauma Informed!](#) Your employee assistance program and work/life services program can help with a variety of personal and family problems and concerns. Examples include **free** stress, financial management, family/ friends and co-worker relationships, child and elder care, legal services, and emotional short-term counseling. Longer term counseling services is available through your MHMR medical plan selection.
- Potential Prescription discounts - Visit www.goodrx.com for coupons on your prescriptions. This benefit should be used only if your insurance plan does not cover an item or if the cost under the insurance copay is higher than what GoodRx may offer for your prescription. The prices listed on GoodRx are updated frequently and are generally very accurate, but if you have experienced an issue with a price at your pharmacy, please give us a call at 1-855-268-2822 (Monday-Sunday, between the hours of 8AM and 7PM CT). ** Our Rx Plan costs are separate from deductible and co-insurance maximums and do not apply**

Talkspace and Employee Assistance Program



MHMR is an advocate for mental health and well-being and through Talkspace offers convenient, personal, and professional mental health support for you. Talkspace is a **digital space** for counseling, therapy and medication services from licensed providers. Message (text, voice, video) your personal therapist -- anytime, anywhere -- or schedule a video appointment with a prescriber. Talkspace is confidential and secure.

There is no-cost access to Talkspace online therapy and psychiatry. There are no taxes or fees; it is a **free benefit** that MHMR of Tarrant County is providing **all active employees and their dependents**. Visit [MHMR's Intranet](#) (Sharepoint – InfoDepot) to locate the MHMR portal and access code (changes periodically) to begin your journey on Talkspace.

talkspace
Comprehensive mental health care

Talkspace is a virtual behavioral health platform designed to address a variety of needs. Available to all employees and dependents, Talkspace offers counseling, psychiatry, live classes, and self-guided programs from the convenience of a laptop or mobile device (iOS, Android, web).

Our managed network includes thousands of licensed, insured, and verified therapists and prescribers spanning 50 states and 150 areas of expertise. All clinicians hold at least a master's degree and are verified according to NCQA standards.

Counseling & Therapy

Personalized matching with a licensed provider based on evaluation of needs and preferences. 1:1 communication with therapists (via text, audio, or video) begins within days.

- Intake & assessment
- Unlimited messaging + 2 live video session per month
- Self-help exercises
- Sign up today at talkspace.com/mhmtarrant with Organization code: MHMR Tarrant Therapy

Psychiatry

Live video appointments with a licensed psychiatric provider. They'll determine the effective treatment option, prescribe medication if needed, and manage treatment via follow-up sessions.

- Assessment, evaluation, & diagnosis
- One 60-min evaluation + twelve 30-min follow-up sessions
- Medication prescription & management
- Sign up today at talkspace.com/mhmtarrant with Keyword: MHMR Tarrant Psychiatry

Self-Guided Therapy

Self-guided programs for individuals, couples, and parents. Build mental well-being through personalized courses, daily journaling, and weekly live classes with therapists.

- 70+ programs, 800+ sessions
- Assessments, exercises, journaling, reminders
- Address anxiety, stress, burnout, trust, & more
- 6+ therapist-led live group classes per week
- Sign up in the app store Organization code: MHMRTarrant

To learn more about your comprehensive mental health care services, contact your IIR representative or reach out to partners-support@talkspace.com for any questions in signing up



SCAN ME

Employee Assistance Program (EAP)- Provided by New York Life (NYL)



FREE Resource - EAP Printable Flyer can be found on HR page of InfoDepot under Employee Resources -link [here](#).

Along with Talkspace, all benefit eligible employees are automatically part of the EAP program. Just when you think you have it figured out, along comes a challenge.

But whether those challenges are big or small, your traditional Employee Assistance Program is available to help you and your family, find a solution and restore peace of mind.

Call any time, any day. We're just a phone call away whenever you need us – at no cost to you when you utilize the in-network program through ComPsych. All calls are answered by a Guidance Consultant, a master's or PhD-level counselor who will collect some general information about you and will talk with you about your needs.

An advocate is ready to help assess your needs and develop a solution to help resolve your concerns. He or she can also direct you to an array of resources in your community as well as online tools.

Visit a specialist. For face-to-face assistance, you have three (3) free sessions available to you and your household members. Call us to request a referral to ensure continuity of care through your medical plan (rates may apply). The 3 sessions renew each calendar year.

Life Assistance & Work/Life Support Program services are available 24 hours a day, seven days a week with confidential support, guidance, and resources.

Assistance for you or any household members. Household members must be at least sixteen years of age to refer themselves.

Three In-person sessions (calendar year) for short-term problem resolution.

Work/life services for assistance with:

feeling overwhelmed by the demands of balancing work and family

- experiencing stress, anxiety, or depression
- dealing with grief and loss
- child or elder care concerns
- legal or financial questions
- Substance abuse for yourself or a dependent

Guidance Resources

Online (www.guidanceresources.com) information, resources, tools, and other features on topics such as health and wellness, law and regulations, family and relationships, work and education, money and investments, consumer and leisure and home and auto. Includes articles, podcasts, videos, slideshows, on-demand trainings and “Ask the Expert” which are personal responses to questions.

Do you need Assistance? Please review the [Wellness EAP FLYER](#) for work/life balance support or the Financial EAP Flyer for [Finance/Legal/Estate](#) support information.

401a & 457 Retirement Accounts

(You will not be able to enroll in these accounts online Benefits Website, contact Voya or Hub International for enrollment information)

401a Important Notes

Voya will send you a packet in the 11 month after your hire date for all new hires. You must already be enrolled by your 12 month anniversary which is your deadline. If you don't receive your packet timely, contact Benefits@mhmrtc.org to help you enroll. Rehires – prior employment dates may apply - Contact Benefits Office immediately at rehire.

Plan details continued on next page:

- ▶ Full-time status employees
- ▶ Market part-time status employees
- ▶ Minimum age required for participation is 18 years old
- ▶ Your contributions will begin after you've been employed for 12 months; if you are rehired, you may be eligible immediately – contact your benefits Office immediately.
- ▶ **You must submit your completed online enrollment beginning at the 11th month and before your 12-month anniversary date (which is your deadline date), or you will no longer be eligible for the remainder of your employment or re-employment as described by the IRS code and plan restrictions.**
- ▶ **It is the responsibility of the employee to create multiple reminders to not miss the deadline to enroll.**
- ▶ Once enrolled, employees cannot stop or change contributions during employment; contributions will stop when employees are no longer eligible for the plan. Contributions will also re-start at rehire/eligibility. As described by the IRS code, enrolling, or not enrolling are a one-time irrevocable election.
- ▶ 1-time lump sum payments are not eligible to have employee or Employer contributions deducted.
- ▶ If your address changes, ensure you change online employee self-service MHMR system (UKG). Your demographic information is sent to Voya weekly.
- ▶ If you don't receive a Voya packet, do not wait on it, use Enrollment information listed on next page (401a Plan) during your enrollment window (at 11 months of completed employment).
- ▶ Rehires contact Benefits Office or Voya immediately to determine your eligibility.

457 Voluntary Account

- 457 Employee Account is a tax deferred account **not** matched by your employer.
- Employees can contribute up to the maximum allowed by the IRS in this plan per year, or 50% of yearly taxable includible salary, whichever is less.
- Deductions can stop and start at the beginning of following month after change is requested.
- If you are 50 years of age, you can tax defer an additional amount (catchup amount) . Maximums are set by the IRS. These amounts are separate enrollment requests online.
- Contact Voya if you are interested in enrollment. Enrollment is online through the retirement provider. Enrollment information is listed on the next page under (457(B) Plan).

Retirement record-keeper – Voya Financial is our retirement provider at enroll.voya.com - (800)-584-6001 - Search **Voya Retire** mobile app on your favorite app store to download to your phone.

**MHMR OF TARRANT COUNTY
401(A) PLAN**

ELIGIBILITY:	1 Year of Service as an Eligible Employee												
PLAN ENTRY:	DEADLINE is your ONE year anniversary. It is the employee responsibility to notate the deadline and ensure they are enrolled prior to the 12 month deadline. Refer to Benefits Guide for details. Contact Benefits Office before deadline for any concerns.												
CONTRIBUTIONS:	<p>EMPLOYEE DEFERRALS – Traditional (Pre-Tax) Contributions MUST contribute 5% or not at all (Lifetime Election). If no election is made before the anniversary deadline and a break in service occurs, then employee cannot enroll if even if rehired.</p> <p>EMPLOYER CONTRIBUTION – 8%; employee MUST contribute to receive the employer contribution</p>												
VESTING:	<p>EMPLOYEE DEFERRAL – 100% Immediate</p> <p>EMPLOYER MATCH – 5 Year Graded Vesting Schedule based on Years of Service</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th>YEAR</th> <th>1</th> <th>2</th> <th>3</th> <th>4</th> <th>5</th> </tr> </thead> <tbody> <tr> <td>%</td> <td>20%</td> <td>40%</td> <td>60%</td> <td>80%</td> <td>100%</td> </tr> </tbody> </table>	YEAR	1	2	3	4	5	%	20%	40%	60%	80%	100%
YEAR	1	2	3	4	5								
%	20%	40%	60%	80%	100%								
CHANGES TO ACCOUNT:	<p>DEFERRAL AMOUNTS – no changes allowed</p> <p>INVESTMENTS – Anytime, internet and phone access Voya Mobile App Available Enrollment: enroll.voya.com <i>Plan # 664693</i> <i>Verification # 158166</i> Website: www.voyaretirementplans.com 1-800-584-6001</p> <p>BENEFICIARY DESIGNATIONS – anytime, update online Voya portal</p>												
WITHDRAWALS:	<p>All accounts at termination of employment, disability, or death</p> <p>IN-SERVICE WITHDRAWALS – from fully vested balances upon attainment of age 70½, from Rollover Contributions at anytime.</p>												
LOANS:	<p>FIVE outstanding loans at a time – ONLY ONE NEW LOAN A CALENDAR YEAR</p> <p>Minimum loan \$1,000; Limited to the lesser of ½ vested interest or \$50,000; Repayment up to 5 year amortization schedule. Outstanding Loan Balance becomes due immediately OR taxable if you leave the company for any reason. Interest Rate = Prime Rate + .5%</p>												

MHMR OF TARRANT COUNTY 457(B) PLAN

ELIGIBILITY:	No eligibility requirement
PLAN ENTRY:	1 st of the month immediately following date of employment
CONTRIBUTIONS:	EMPLOYEE DEFERRALS ONLY – Traditional (Pre-Tax) Contributions Use IRS 457b Maximums – updated yearly. Catch Up Contribution – Age 50+
VESTING:	EMPLOYEE DEFERRAL – 100% Immediate
CHANGES TO ACCOUNT:	DEFERRAL AMOUNTS – beginning of any month. INVESTMENTS – Anytime, internet and phone access Voya 📱 Mobile App Available Enrollment: enroll.voya.com <i>Plan #664692</i> <i>Verification #158166</i> Website: www.voyaretirementplans.com 1-800-584-6001 BENEFICIARY DESIGNATIONS – anytime, update online Voya portal
WITHDRAWALS:	All accounts at termination of employment, disability, or death IN-SERVICE WITHDRAWALS – from fully vested balances upon attainment of age 70½, from Rollover Contributions at anytime

Apply for this thru MetLife directly
 – not payroll deducted.

Pet Insurance

Provided by MetLife – learn more at <https://www.metlife.com/MHMRofTarrantCounty/>.

Key Features

With **MetLife Pet Insurance**, pet parents have the **power of choice** to customize their pet insurance to meet their needs.



<ul style="list-style-type: none"> ✓ No breed exclusions ✓ No upper age limits ✓ No initial exam or previous vet records needed to enroll ✓ No per-incident or lifetime limits 	<ul style="list-style-type: none"> ✓ Group flexible coverage with up to 90% reimbursement* and the freedom to visit any U.S. licensed vet. ✓ Optional Preventive Care coverage† ✓ 24/7 access to Telehealth Concierge Services – because accidents and illnesses don't always wait for your vet to be open. ✓ Multi-channel support options with caring, knowledgeable representatives ✓ Discounts up to 30%‡ and additional offers on pet care, where available. ✓ MetLife Pet mobile app makes it easy to submit and track claims and manage your pet's health and wellness.
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 Pet Insurance © 2022 MetLife Services and Insurance, LLC

Plan Highlights

Flexibility to select various levels of coverage, including optional Preventive Care† coverage, while also providing among the shortest wait periods for accident and illness coverage‡.

\$500-unlimited	Levels of coverage‡
\$0-\$2,500	Deductible options†
50%-100%	Various reimbursement percentages§



 Pet Insurance © 2022 MetLife Services and Insurance, LLC

Enrollment **An Easy 3-Step Process** www.MetLifePetInsurance.com



Apply with Texas Legal directly – application below – not payroll deducted.



When You Need an Attorney, Texas Legal Has You Covered

Texas Legal, a nonprofit organization, founded by the State Bar and the Texas State Legislature, provides legal plans to Texans. Our legal plans cover the in-network Attorney's billable time, ensuring the resolution of personal legal matters is always affordable, accessible, and convenient.

Why You Should be a Member of Texas Legal

Always Have Legal Help When You Need It

Every year, 70 percent of people have a legal issue. But many Texans don't get the help they need because hiring an attorney is too expensive, time-consuming, or stressful. Texas Legal can help.

"Texas Legal has saved us thousands of dollars and provides peace of mind knowing we don't have to worry about legal issues."

- Gloria R., Texas Legal Member

Affordable Access to High-Quality Attorneys

Texas Legal has experienced and qualified attorneys to serve our members in multiple practice areas. We have the most comprehensive plans on the market covering:

- Wills & Trusts
- Divorce
- Criminal Defense
- ID Monitoring
- Consumer Protection
- And Much More

With a vast network of licensed attorneys across the State of Texas, our members have access to the best legal help without the high price tag.

Serving Texans – Not Profiting

As a nonprofit, our mission is to protect and serve Texans, not profit from them. Our goal is to make receiving comprehensive legal services from high-quality attorneys affordable and accessible for every Texan. Rest easy knowing Texas Legal has you and your family covered for the majority of life's personal legal needs.

Need a Will? We Have You Covered!

PROBLEM: You need a will, but you don't know an attorney and wills are expensive.

SOLUTION: A Texas Legal membership fully covers estate planning. You simply call one of our attorneys, and he or she takes you through the whole process.

\$1,600 - The average cost of a basic will and estate planning package

\$300 - The average yearly premium paid by Texas Legal Members

Process: Easy

Saved: \$1,300

Gained: Priceless Peace of Mind



Scan to join Texas Legal.

Please see the next page to learn about our legal plans.

Group Plan Coverage

Please note that while the vast majority of personal legal needs are covered, not all limitations or exclusions are listed below, especially for contested/complex matters. *

Select Plan*	Preferred Plan*
\$16 Individual/\$25 Family, Monthly \$176 Individual/\$275 Family, Annually	\$25 Individual/\$40 Family, Monthly \$275 Individual/\$440 Family, Annually

GENERAL ATTORNEY ACCESS & DISCOUNTS		
Legal Access Line Dedicated hotline for quick legal questions and general legal advice	Included	Included
Attorney Consultations	4 Consultations	4 Consultations
General Legal Services Anything not covered, but not excluded	4 Hours Covered	6 Hours Covered
In-Network Discount	25% Discount	25% Discount
ESTATE PLANNING		
Wills, Trusts, Living Wills & Power of Attorney	Covered	Covered
Elder Law	2 Hours Covered	4 Hours Covered
Social Security / Veterans / Medicare	2 Hours Covered	4 Hours Covered
Probate	25% Discount	Uncontested — Covered All Others — 15 Hours Covered
FAMILY LAW		
Pre / Postnuptial Agreements	25% Discount	Covered
Adoption	25% Discount	Covered
Name Change	Covered	Covered
Gender Identifier Change	25% Discount	Covered
Divorce -OR- Modification / Establishment or Enforcements	15 Hours Covered	All Uncontested — Covered Contested Divorce: w/o children — 15 Hours Covered with children — 30 Hours Covered Contested Mod/Establishment/Enforce: 20 Hours Covered
Protective Order	25% Discount	Covered
Guardianship / Conservatorship	25% Discount	Uncontested — Covered Contested — 15 Hours Covered
Annual Accounting of Guardianship	25% Discount	6 Hours Covered
Family Immigration Assistance	25% Discount	6 Hours Covered
CIVIL LAW		
Defense of Civil Action	10 Hours Covered	20 Hours Covered
Consumer Protection	Negotiations Only	Covered
School Administrative Hearings	25% Discount	4 Hours Covered
CRIMINAL LAW		
Habeas Corpus	25% Discount	Covered
Misdemeanor	25% Discount	Covered
Felony	25% Discount	Covered
Driving / Boating while Intoxicated	25% Discount	Covered
Public Intoxication	25% Discount	Covered
Defense of Incompetency or Infirmary	25% Discount	Covered
Juvenile Court	25% Discount	Covered
Traffic Tickets	Covered	Covered
Defense of Driving Privileges	25% Discount	Covered
Expunction & Order of Nondisclosure	25% Discount	Covered
REAL ESTATE & FINANCIAL		
Residential Real Estate Transaction	Covered	Covered
Property Tax - Primary Residence	Covered	Covered
Deeds	2 Hours Covered	2 Hours Covered
Bankruptcy Chapter 7 -OR- Chapter 13	25% Discount	Covered
Tax Audit	25% Discount	4 Hours Covered
Free Financial Counseling with Balance Pro	Included	Included
Experian Identity Theft Monitoring & Repair	Included	Included

This document is for illustrative purposes only, and is not a contract. Please see the Summary of Benefits or a sample Plan Policy for details.

Gain priceless peace of mind – don't put legal issues off another day

For more information, visit TexasLegal.org or contact us at 1.800.252.9346.



How MHMR of Tarrant County Employees Sign Up

- Enroll Anytime!
- Easy Online Sign up at TexasLegal.org/join
- Select **My Employer**
- Select **Group I: My Employer**
- List **MHMR of Tarrant County** as your employer/group name
- Members will receive Member Welcome Packet by mail within two weeks

All applications received by the 25th of any month are effective the first of the following month.

Questions?

Members can always call our dedicated member services team at 1-800-252-9346 or email members@texaslegal.org or visit our website at www.texaslegal.org

Paid Time Off (PTO), Holidays, Discounts

Holidays and Paid Time Off (PTO)

- Employees immediately receive 10 paid holidays: There are observed on different days each year based upon a pre-approved holiday schedule. The days considered are Labor Day, Thanksgiving, the day after Thanksgiving, Christmas Eve, Christmas Day, New Year’s Day, Martin Luther King’s Birthday, Good Friday, Memorial Day and Independence Day. There is also one (1) Floating Holiday available each Sept 1 to those who accrue PTO and expires each Aug 31.
- When a holiday falls on a weekend date; Holidays are observed on Monday or Friday as applicable.
- Fulltime Employees accrue PTO each week (schedule below). **Contact Payroll for Holiday and PTO questions.**

PTO Bank-Tenure Level	Level I	Level II	Level III	Level IV	Level V
Employment Months/Years	0 – 24 mos. 0 thru 2 yrs.	25 – 60 mos. 2+ thru 5 yrs.	61 – 120 mos. 5+ thru 10 yrs.	121 – 180 mos. 10+ thru 15 yrs.	181+ mos. 15+ yrs.
Hours Per Pay Week	2.63	3.25	4.00	4.00	4.00
Maximum Carryover	204	252	312	342	372
Payoff Hours at Termination/Resignation	0	50% of balance with a max of 126 hours	75% of balance with a max of 234 hours	85% of balance with a maximum of 291 hours	100% of balance with a maximum of 372 hours

Employees can carryover their maximum only on their anniversary date. Hours accrued after their anniversary date may be accumulated above their maximum but must be used before their following anniversary date. PTO plan hours that have been accrued are eligible after hire date and upon supervisor approval.

Employee Discounts

- DELL computer, AT&T, Verizon, T-Mobile Legal Protection Plan, MetLife Personal Auto and Home Insurance and discounts at fitness facilities including YMCA and many others under Care.com/LifeMart
- Use Care.com/yourbenefits for additional discounts.
- www.Ticketsatwork.com
- At various times, discount tickets are available to locations such as the Fort Worth Zoo, Six Flags, Hurricane Harbor, Hawaiian Falls, Circus, and Motor Cross Events
-

Other Benefits/Perks

- ✓ Diverse and inclusive culture that encourages everyone to bring their authentic selves to work
- ✓ Ability to make a lasting impact on the lives of people and their families and be a part of changing lives in health care in our community
- ✓ Flexible hours with some hybrid and remote opportunities where available
- ✓ Bereavement leave
- ✓ Tuition reimbursement (subject to availability of funds)
- ✓ Working at MHMR may qualify you for the public service school loan forgiveness programs as they become available
- ✓ Be a part of changing lives in health care in our community.

Affordable Care Act

Health Insurance Marketplace Coverage Options and Your Health Coverage

Part A: General Information

When key parts of the healthcare law took effect in 2014, there are 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 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 usually around October for coverage starting as early as January.

Can I Save Money on My Health Insurance Premium 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, check your summary plan description or contact Human Resources benefits team.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. 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.

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. The MHMR notice that indicates that the medical plan meets minimum value is located on Benefits Website.

Mandated notices

Patient Protection and Affordable Care Act Disclosure Notice

This group health plan believes three of the 4 offered medical plans are "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. **Note** – Employees enrolled in the HDHP are not grandfathered plans which began 9/1/2022.

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the following address:

MHMR of Tarrant County
Human Resources, 3840 Hulen St, Fort Worth, Texas 76107
817-569-4350 or Human.Resources@mhmrtc.org

Women's Health & Cancer Rights Notice

As required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), this medical plan provides coverage for:

- ▶ All stages of reconstruction of the breast of which the mastectomy was performed;
- ▶ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ▶ Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information of WHCRA benefits, call your plan administrator.

Special Enrollment Notice

MHMR offers health benefit coverage to all eligible employees during the initial enrollment period. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage). In addition, if you have a new dependent because of marriage, birth, adoption or placement for adoption (qualifying event), you may be able to enroll yourself and your dependents; however, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption and provide applicable documentation within the deadline.

To request special enrollment or to obtain more information, contact your Plan Administrator.

HIPAA Privacy Notice The Plan protects your Private Health Information as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Our Plan's HIPAA Privacy Notice and Your Rights under HIPAA are posted on the Company Intranet or a printed copy can be requested from HR.

Your Prescription Drug Coverage and Medicare – Also visit 211Texas.org where you can find more about 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 MHMR and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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. If you have both coverages, MHMR's plan is primary.

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. MHMR has determined that the prescription drug coverage offered by the MHMR Employee 3 Health Plans that are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are 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. The 4th plan offered, qualified HDHP-HSA offers as much as standard Medicare prescription coverage AFTER the deductible is met.

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 Nov. 15 through Dec. 31.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you also will be eligible for a two-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 coverage will not be affected. You may keep this coverage if you elect Part D and MHMR Employee Health Plan will continue to be your primary carrier as long as you are actively employed. See your Employee Welfare Benefit Plan summary of benefits for the prescription drug program currently available to you.

If you do decide to join a Medicare drug plan, you cannot drop your current Employee Welfare Benefit Plan prescription drug coverage without dropping the medical plan. A member may not opt out of only the prescription drug portion of the plan.

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

You should also know that if you drop or lose your current coverage with MHMR under Employee Welfare Benefit Plan 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 November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MHMR Employee Welfare Benefit Plan 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 also may 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: Annual in July
Name of Entity/Sender: MHMR of Tarrant County (MHMR)
Contact--Position/Office: **Human Resources**
Address: **3840 Hulen St.**
Fort Worth, Texas 76107
Phone Number: **817-569-4350**

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage (Texas currently does offer this plan). These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in the state listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan - as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

You should contact your State for further information on eligibility:

TEXAS - Medicaid
Website: www.hhs.texas.gov
Phone: 1-800-440-0493

To see if any more States have added a premium assistance program and for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Services
Employee Benefits Security Administration
www.dol.gov/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, ext. 61565

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're

in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

**Employee Benefits Security Administration, U.S. Department of Labor <https://www.dol.gov/agencies/ebsa>
Employee Benefits Security Administration, U.S. Department of Labor 200 Constitution Avenue, N.W.
Washington, D.C., 20210 1-866-4-USA-DOL
1-866-487-2365**



MHMR of Tarrant County

Medical Insurance - Working Spouse Carve-out Form

Upload signed form to benefits portal - Select Benefit Account to access the document center: www.mhmrarrantbenefits.hrintouch.com/

MHMR does not offer healthcare coverage to spouses of employees who have healthcare insurance available to them through his/her employer. Employees must attest to the fact that their spouses are not eligible under any other major medical/drug group coverage (to include a prescription drug plan) should they desire to enroll their spouses in the healthcare coverage offered through MHMR. If it is your desire to enroll your spouse on the healthcare coverage offered by MHMR, then please attest to the following statement, which will be placed in your benefit file with our organization:

"I hereby attest that my spouse is not eligible under any other major medical/drug group coverage (to include a prescription drug plan) available from his/her employer, therefore making him/her eligible for MHMR's group medical/drug coverage. If my spouse changes employers and/or becomes eligible during the plan year under his/her employer's medical plan, I will notify MHMR's Human Resource Department immediately.

I understand that misrepresenting my spouse's ability to enroll in his/her employer's healthcare plan may lead to serious consequences, which could include that I reimburse MHMR for premiums paid by the organization, as well any claims paid on behalf of my spouse. I also understand that any misrepresentation on my part could lead to disciplinary action, up to and including termination of employment.

*I further understand that it is my responsibility to submit this attestation to the HR Department no later **than my designated deadline to submit/request enrollment for insurance**, and failure to do so will result in my spouse automatically being dropped or not eligible from medical coverage offered through MHMR."*

Signature

Printed Name

Date

Spouse's Signature

Spouse's Printed Name

Date

Please remember that it is your responsibility to notify Human Resources of the status of your spouse's eligibility for other employer group medical insurance during the plan year.