

RESOLUTION

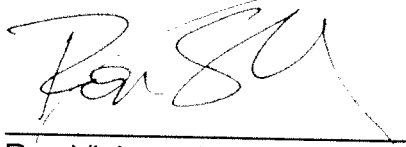
WHEREAS, the Tyler Independent School District wishes to provide a self-insurance plan for the provision of medical, hospital, and other health services available to its employees;

WHEREAS, the district has entered into an agreement with a preferred provider physician and hospital network;

WHEREAS, the district agrees to an open enrollment period beginning on September 1, 2009 for coverage to be effective October 1, 2009 to encourage its employees to join one of the self-insured plans: therefore, be it

RESOLVED that the Board of Trustees has reviewed the district's ability to cover the assumed liability; and be it

RESOLVED FURTHER that the district will provide a copy of this resolution to the executive director of the Teacher Retirement System of Texas as required by Section 22.004 of the Texas Education code.



Ron Vickery, President
Tyler ISD Board of Trustees

8/20/09

Date

PLAN A SCHEDULE OF BENEFITS – TYLER ISD

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
MAXIMUM LIFETIME BENEFIT	\$1,000,000		
Notes: The maximums listed below are the total for In-Network, Out-Of-Network and Out-Of-Area expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total, which may be split between In-Network, Out-Of-Network, and Out-Of-Area providers.			
DEDUCTIBLE, PER CALENDAR YEAR			
Per Covered Person	\$100 individual	\$100 individual	\$100 individual
Per Family Unit	\$300 or three persons	\$300 or three persons	\$300 or three persons
The Calendar Year deductible is waived for the following Covered Charges: - Accidents			
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR FOR COINSURANCE			
Per Covered Person	\$875		
Per Family Unit	\$2,625 or three persons		
The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year unless stated otherwise.			
PRE-CERTIFICATION NON COMPLIANCE PENALTY	\$500 Payable		
The following charges do not apply toward the out-of-pocket maximum: Deductibles, Copayments, Penalties, Pharmacy Coinsurance and Amounts over Maximum Allowable			
HOSPITAL SERVICES			
Inpatient Services	85% after Calendar Year deductible	65% after Calendar Year deductible and \$1,000 confinement penalty. Not to exceed Max Allowable	80% after Calendar Year deductible
Outpatient	85% after Calendar Year deductible	65% after Calendar Year deductible. Not to exceed Max Allowable	80% after Calendar Year deductible
Emergency Care (See note #3, page 14)	85% after Calendar Year deductible	65% after Calendar Year deductible. Not to exceed Max Allowable	80% after Calendar Year deductible
** Special Procedures and Tests e.g., Ultrasound, MRI and CT			
Skilled Nursing Facility	80% after Calendar Year deductible / 60 day Calendar Year maximum	65% after Calendar Year deductible / 60 day Calendar Year maximum. Not to exceed Max Allowable	75% after Calendar Year deductible / 60 day Calendar Year maximum
Physician Office Visits	80% after Calendar Year deductible	80% after Calendar Year deductible. Not to exceed Max Allowable	80% after Calendar Year deductible
Other Physician Services	80% after Calendar Year deductible	80% after Calendar Year deductible. Not to exceed Max Allowable	80% after Calendar Year deductible

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
Routine Preventive Care (Adult & Child)	100% of allowable charges up to \$300 per Calendar Year maximum, then 80% of allowable charges after deductible.	100% of billed charges up to the \$300 per Calendar Year maximum.	100% of allowable charges up to \$300 per Calendar Year maximum, then 80% of allowable charges after deductible.
In-network or out-of-area allowable charges exceeding the \$300 per Calendar Year maximum are subject to deductibles and coinsurance. Out-of-network charges are subject to the \$300 per Calendar Year maximum. The services must be billed as "preventive care." See page 23 (8) (n) for further details and limits.			
Adult Care includes: colorectal cancer screenings, gynecological exams, immunizations, laboratory tests, mammograms, office visits, pap smear, prostate screening, routine physical examinations, and x-rays.			
Frequency limits for mammograms: Ages 35 through 39.....single baseline mammogram Ages 40 and over.....one per calendar year			
Child Care includes: immunizations, laboratory tests, office visits, routine physical examinations for age two and over, well baby exams, and x-rays.			
Pregnancy**	80% after Calendar Year deductible	80% after Calendar Year deductible. Not to exceed Max Allowable	80% after Calendar Year deductible
**Dependent daughters not covered			
Laboratory Services	80% after Calendar Year deductible	80% after Calendar Year deductible. Not to exceed Max Allowable	80% after Calendar Year deductible
Home Health Care Services & Supplies	80% After Calendar Year deductible / 120 visits per Calendar Year Maximum	80% After Calendar Year deductible / 120 visits per Calendar Year Maximum. Not to exceed Max Allowable	80% After Calendar Year deductible / 120 visits per Calendar Year Maximum
Hospice Care Services & Supplies	80% after Calendar Year deductible / \$10,000 Plan maximum.	80% after Calendar Year deductible / \$10,000 Plan maximum. Not to exceed Max Allowable	80% after Calendar Year deductible / \$10,000 Plan maximum
Ambulance Service	80% after Calendar Year deductible. Allowable not to exceed \$750 ground, \$3,500 air	80% after Calendar Year deductible. Allowable not to exceed \$750 ground, \$3,500 air	80% after Calendar Year deductible. Allowable not to exceed \$750 ground, \$3,500 air
Speech Therapy	80% after Calendar Year deductible	80% after Calendar Year deductible. Not to exceed Max Allowable	80% after Calendar Year deductible
Chiropractic Services	80% after Calendar Year deductible / \$1,000 Calendar Year maximum	80% after Calendar Year deductible / \$1,000 Calendar Year maximum. Not to exceed Max Allowable	80% after Calendar Year deductible / \$1,000 Calendar Year maximum
Physical or Occupational Therapy	80% after Calendar Year deductible	80% after Calendar Year deductible. Not to exceed Max Allowable	80% after Calendar Year deductible
Durable Medical Equipment (DME) & Prosthetics	80% after Calendar Year deductible	80% after Calendar Year deductible. Not to exceed Max Allowable	80% after Calendar Year deductible
Testing / Treatment of Sleep Disorders	80% after Calendar Year deductible / \$5,000 Lifetime Maximum	80% after Calendar Year deductible / \$5,000 Lifetime Maximum. Not to exceed Max Allowable	80% after Calendar Year deductible / \$5,000 Lifetime Maximum

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
MENTAL DISORDERS/SUBSTANCE ABUSE			
Inpatient Care 14 days Calendar Year maximum	80% after Calendar Year deductible.	80% after Calendar Year deductible. Not to exceed Max Allowable.	80% after Calendar Year deductible.
Outpatient Care 30 days Calendar Year maximum	80% after Calendar Year deductible.	80% after Calendar Year deductible. Not to exceed Max Allowable.	80% after Calendar Year deductible.
Coinsurance Amount does not apply to Annual Maximum Out-of-Pocket			
SERIOUS MENTAL ILLNESS			
Inpatient Care 45 days Calendar Year maximum	80% after Calendar Year deductible.	80% after Calendar Year deductible. Not to exceed Max Allowable	80% after Calendar Year deductible.
Outpatient Care 45 days Calendar Year maximum	80% after Calendar Year deductible.	80% after Calendar Year deductible. Not to exceed Max Allowable	80% after Calendar Year deductible.
Coinsurance Amount does not apply to Annual Maximum Out-of-Pocket			
TRANSPLANT			
Organ Transplant	80% after Calendar Year deductible	80% after Calendar Year deductible. Not to exceed Max Allowable	80% after Calendar Year deductible
PRESCRIPTION DRUGS			
Plans A and B			
Drug Card	Generic - \$10.00 co-payment		
	Brand (no Generic available) - 30% coinsurance \$125 maximum out of pocket per prescription		
	Brand (Generic available) - 50% coinsurance (30 Day Supply)		
	Generic - \$0.00 co-payment		
Mail Order	Brand (no Generic available) - 25% coinsurance \$250 maximum out of pocket per prescription		
	Brand (Generic available) - 35% coinsurance (90-Day Supply)		

PPO Notes:

1. When using an In-Network PPO provider you receive your best benefits without being subject to provider charges over Plan Max Allowable.
2. **Payments are subject to Max Allowable (see "Max Allowable Amount" under "Defined Terms") when receiving services from Out of Network Providers.** - You will be responsible for charges over the Maximum Allowable amount unless your health care provider will accept the Maximum Allowable as payment in full. If you receive treatment from a Non Network PPO Provider, your out of pocket may exceed the scheduled amount because the provider may be charging above the Maximum Allowable.
3. Max Allowable may be waived when covered individuals receive services from Out of Network Providers under emergency care as defined in the most current Tyler ISD Medical Benefit Plan Document. If an Out of Network Physician provides Emergency Care in an In Network facility, the Physician charges will be allowed at a percentage of billed charges and the claim will be processed as In Network. The member may be balanced billed for the undiscounted portion of the charges.
4. Coinsurance for Mental Disorders/Substance Abuse and Serious mental Illness does not apply to the annual Maximum Out-of-Pocket Amount.

PLAN B SCHEDULE OF BENEFITS – TYLER ISD

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
MAXIMUM LIFETIME BENEFIT	\$1,000,000		
Notes: The maximums listed below are the total for In-Network, Out-Of-Network and Out-Of-Area expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total, which may be split between In-Network, Out-Of-Network, and Out-Of-Area providers.			
DEDUCTIBLE, PER CALENDAR YEAR			
Per Covered Person	\$500 individual	\$1,000 individual	\$500 individual
Per Family Unit	\$1,500 or three persons	\$3,000 or three persons	\$1,500 or three persons
The Calendar Year deductible is waived for the following Covered Charges: - Accidents			
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR FOR COINSURANCE			
Per Covered Person	\$1,250 individual	\$2,500 individual	\$1,250 individual
Per Family Unit	\$3,750 Family	\$7,500 Family	\$3,750 Family
The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year unless stated otherwise.			
PRE-CERTIFICATION NON COMPLIANCE PENALTY	\$500 Payable		
The following charges do not apply toward the out-of-pocket maximum: Deductibles, Co-Payments, Penalties, Pharmacy Coinsurance and Amounts over Maximum Allowable			
HOSPITAL SERVICES	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
Inpatient Services	75% after Calendar Year deductible	55% after Calendar Year deductible and \$1,000 confinement penalty. Not to exceed Max Allowable	70% after Calendar Year deductible
Outpatient	75% after Calendar Year deductible	55% after Calendar Year deductible. Not to exceed Max Allowable	70% after Calendar Year deductible
Emergency Care** (See note #3, page 17)	\$75 Co-payment, (co-payment waived if admitted)	55% after Calendar Year deductible. Not to exceed Max Allowable	70% after Calendar Year deductible
** Special Procedures and Tests, e.g., Ultrasound, MRI and CT, are subject to deductibles and coinsurance.			
Skilled Nursing Facility	75% after Calendar Year deductible / \$5,000 Calendar Year maximum	55% after Calendar Year deductible / \$5,000 Calendar Year maximum. Not to exceed Max Allowable	70% after Calendar Year deductible / \$5,000 Calendar Year maximum
Physician Office Visits	\$30 Co-payment	55% after Calendar Year deductible. Not to exceed Max Allowable	70% after Calendar Year deductible
Other Physician Services	75% after Calendar Year deductible	55% after Calendar Year deductible. Not to exceed Max Allowable	70% after Calendar Year deductible

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
Routine Preventive Care (Adult & Child)	100% of allowable charges up to \$300 per Calendar Year maximum, then 75% of allowable charges after deductible.	100% of billed charges up to the \$300 per Calendar Year maximum.	100% of allowable charges up to \$300 per Calendar Year maximum, then 70% of allowable charges after deductible.
In-network or out-of-area allowable charges exceeding the \$300 per Calendar Year maximum are subject to deductibles and coinsurance. Out-of-network charges are subject to the \$300 per Calendar Year maximum. The services must be billed as "preventive care." See page 23 (8) (n) for further details and limits.			
Adult Care includes: colorectal cancer screenings, gynecological exams, immunizations, laboratory tests, mammograms, office visits, pap smear, prostate screening, routine physical examinations, and x-rays.			
Frequency limits for mammograms: Ages 35 through 39.....single baseline mammogram Ages 40 and over.....one per calendar year			
Child Care includes: immunizations, laboratory tests, office visits, routine physical examinations for age two and over, well baby exams, and x-rays.			
Pregnancy**	75% after Calendar Year deductible	55% after Calendar Year deductible. Not to exceed Max Allowable	70% after Calendar Year deductible
**Dependent daughters not covered			
Laboratory Services	75% after Calendar Year deductible	55% after Calendar Year deductible. Not to exceed Max Allowable	70% after Calendar Year deductible
Home Health Care Services & Supplies	75% After Calendar Year deductible / \$5,000 Calendar Year Maximum	55% After Calendar Year deductible / \$5,000 Calendar Year Maximum. Not to exceed Max Allowable	70% After Calendar Year deductible / \$5,000 Calendar Year Maximum
Hospice Care Services & Supplies	75% after Calendar Year deductible / \$10,000 Plan maximum	55% after Calendar Year deductible / \$10,000 Plan maximum. Not to exceed Max Allowable	70% after Calendar Year deductible / \$10,000 Plan maximum
Ambulance Service	75% after Calendar Year deductible. Allowable not to exceed \$750 ground, \$3,500 air	55% after Calendar Year deductible. Allowable not to exceed \$750 ground, \$3,500 air	70% after Calendar Year deductible. Allowable not to exceed \$750 ground, \$3,500 air
Speech Therapy	75% after Calendar Year deductible	55% after Calendar Year deductible. Not to exceed Max Allowable	70% after Calendar Year deductible
Chiropractic Services	75% after Calendar Year deductible / \$1,000 Calendar Year maximum	55% after Calendar Year deductible / \$1,000 Calendar Year maximum. Not to exceed Max Allowable	70% after Calendar Year deductible / \$1,000 Calendar Year maximum
Physical or Occupational Therapy	75% after Calendar Year deductible / \$1,000 Calendar Year maximum	55% after Calendar Year deductible / \$1,000 Calendar Year maximum. Not to exceed Max Allowable	70% after Calendar Year deductible / \$1,000 Calendar Year maximum
Durable Medical Equipment (DME) & Prosthetics	75% after Calendar Year deductible	55% after Calendar Year deductible. Not to exceed Max Allowable	70% after Calendar Year deductible

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
MENTAL DISORDERS/SUBSTANCE ABUSE			
Inpatient Care 14 days Calendar Year maximum	75% after Calendar Year deductible.	55% after Calendar Year deductible. Not to exceed Max Allowable	70% after Calendar Year deductible.
Outpatient Care 30 days Calendar Year maximum	75% after Calendar Year deductible.	55% after Calendar Year deductible. Not to exceed Max Allowable.	70% after Calendar Year deductible.
Coinsurance Amount does not apply to Annual Maximum Out-of-Pocket			
SERIOUS MENTAL ILLNESS			
Inpatient Care 45 days Calendar Year maximum	75% after Calendar Year deductible.	55% after Calendar Year deductible. Not to exceed Max Allowable.	70% after Calendar Year deductible.
Outpatient Care 45 days Calendar Year maximum	75% after Calendar Year deductible.	55% after Calendar Year deductible. Not to exceed Max Allowable.	70% after Calendar Year deductible.
Coinsurance Amount does not apply to Annual Maximum Out-of-Pocket			
TRANSPLANT			
Organ Transplant	75% after Calendar Year deductible	55% after Calendar Year deductible. Not to exceed Max Allowable	70% after Calendar Year deductible
PRESCRIPTION DRUGS			
Plans A and B			
Drug Card	Generic - \$10.00 co-payment		
	Brand (no Generic available) - 30% coinsurance \$125 maximum out of pocket per prescription		
	Brand (Generic available) - 50% coinsurance (30 Day Supply)		
	Generic - \$0.00 co-payment		
Mail Order	Brand (no Generic available) - 25% coinsurance \$250 maximum out of pocket per prescription		
	Brand (Generic available) - 35% coinsurance (90-Day Supply)		

PPO Notes:

1. When using an In-Network PPO provider you receive your best benefits without being subject to provider charges over Plan Max Allowable.
2. **Payments are subject to Max Allowable (see “Max Allowable Amount” under “Defined Terms”) when receiving services from Out of Network Providers.** - You will be responsible for charges over the Maximum Allowable amount unless your health care provider will accept the Maximum Allowable as payment in full. If you receive treatment from a Non Network PPO Provider, your out of pocket may exceed the scheduled amount because the provider may be charging above the Maximum Allowable.
3. Max Allowable may be waived when covered individuals receive services from Out of Network Providers under emergency care as defined in the most current Tyler ISD Medical Benefit Plan Document. If an Out of Network Physician provides Emergency Care in an In Network facility, the Physician charges will be allowed at a percentage of billed charges and the claim will be processed as In Network. The member may be balanced billed for the undiscounted portion of the charges.
4. Coinsurance for Mental Disorders/Substance Abuse and Serious mental Illness does not apply to the annual Maximum Out-of-Pocket Amount.

**TYLER INDEPENDENT SCHOOL DISTRICT
HEALTH INSURANCE RATES**

October 1, 2009 - September 30, 2010

TYPE OF COVERAGE	PLAN A		PLAN B	
	Employee Costs	TISD Costs	Employee Costs	TISD Costs
Employee Only	\$ 210.00	\$ 225.00	\$ 120.00	\$ 225.00
Employee & Child	380.00	225.00	250.00	225.00
Employee & Spouse	455.00	225.00	305.00	225.00
2 Employees & Spouse*	230.00	450.00	80.00	450.00
Employee & Family	630.00	225.00	440.00	225.00
2 Employees & Family*	405.00	450.00	215.00	450.00

* If an employee and spouse both work for TISD, the District pays \$225 for each employee. It is the employee's responsibility to inform the Insurance Department at the time of enrollment.

**CENSUS INFORMATION
AS OF OCTOBER 1, 2009**

Number of Employees Covered	1,541
Total Number of Covered Lives (including dependents)	2,874
Number of Employees Eligible for Health Insurance	2,797

TYLER INDEPENDENT SCHOOL DISTRICT

2009-2010 COMPARABILITY REPORT
Information Concerning the Ease of Completing
the 2009-2010 Comparability Report Form
and
Compliance Statement

In order to comply with Education Code 22.004(b), specific information on the Tyler Independent School District Medical Benefit Plan was compared to HealthSelect, the coverage provided to state employees. The specific data considered were deductible amount, maximum amount of coinsurance, coinsurance percentages, office visit copayments, lifetime maximum benefit amount and annual deductible for prescription coverage. The schedule of benefits and the scope of coverage for each plan were also reviewed.

This information was presented to the Insurance Committee on March 25, 2010 for review and approval.

It was determined that the Tyler Independent School District Medical Benefit Plan coverage is comparable to the coverage offered state employees through HealthSelect.

The information required by Code 22.004(b) will be posted on the District web site and the 2009-2010 Comparability Report Form will be completed and mailed to the Teacher Retirement System of Texas.

TISD Insurance Committee:

