THE SCIOLI GROUP

EMPLOYEE BENEFITS & CONSULTANCY

PRESENTS

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER™ EL PASO

&

TTUHSC of El Paso at Transmountain

Resident Insurance Benefits Overview

2022-2023

YOUR LIST OF INSURANCE BENEFITS

Medical Insurance	• Blue Cross Blue Shield of Texas
Dental Insurance	• Blue Cross Blue Shield of Texas
Vision Insurance	• Avesis
Term Life Insurance	• Texas Medical Association Insurance Trust (TMAIT)
Long Term Disability Income	• Texas Medical Association Insurance Trust (TMAIT)
Medical Association Membership	• Texas Medical Association

WHO ARE YOUR CONTACTS?

- **The Scioli Group**
  - Toll Free: 1.877.211.1975
  - Account Manager: Monica Loya
    - *monica@scioligroup.com*
    - *If Monica is not available, please ask for Customer Service for Residents of TTUHSC El Paso or TTUHSC of El Paso at Transmountain*
- **TTUHSC El Paso Human Resources Department**
  - 1.915.215.5247
- **Blue Cross Blue Shield of Texas (Medical & Dental Benefits)**
  - 1.800.521.2227
  - www.bcbstx.com
- **Avesis (Vision Benefits)**
  - 1.800.828.9341
  - www.avesis.com

- Questions regarding your medical insurance with Blue Cross Blue Shield of Texas
- Questions regarding your vision insurance with Avesis
- Eligibility Questions
- Lost ID Card
- Claims Inquiries
  - It is helpful to send Monica a copy of the Explanation of Benefits as well as copies of any bills received from providers
- Network Provider Information

REASON TO CONTACT YOUR ACCOUNT MANAGER - MONICA LOYA

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KEY COMPONENTS OF YOUR INSURANCE BENEFITS

- As a new resident, your benefits will begin on the first day of your training.
- TTUHSC El Paso covers 100% of residents' and fellows' monthly health insurance premiums.
- Health insurance is also accessible for eligible dependents.
- Keep in mind the contribution from the institutions could change. If such change occurs, you will be notified.
- Eligible Dependents are:
  - Legally Married Spouse
    - *If spouse has a different last name, you may be required to provide a copy of the marriage certificate*
  - Children
    - *Birth*
    - *Adopted*
    - *Step*
  - You may NOT cover your parents, grandparents, aunts, uncles, cousins, etc.
- TTUHSC El Paso does NOT pay for deductibles, copays nor coinsurance.

INSURANCE BENEFIT ENROLLMENT & ELECTIONS

- You will use Employee Navigator to enroll in your insurance benefits including:
  - Medical
  - Dental
  - Vision
  - Group Term Life/AD&D Insurance
  - Long Term Disability Insurance

BEFORE YOU BEGIN ENROLLMENT

- Before you begin the enrollment process, it is important to have the following information:
  - Your SSN or identifying number assigned by the University
  - Your spouse and/or children's SSN
    - *If you, your spouse or children do not have a SSN and you have not received an identifying number from the University, please contact them prior to beginning your online enrollment*
    - *For residents moving to the United States: If your LEGAL spouse and/or children plan to move to El Paso to reside with you from another country, you can add them now. If you do not add them now, you cannot add them until open enrollment, unless there is a qualifying event.*
  - Your current address and phone number. If you do not have a current address or will be moving, please enter the University's address temporarily.
- The company identifier is **TTUHSC El Paso**

INSTRUCTIONS FOR EMPLOYEE NAVIGATOR

- You will receive an email from “Employee Navigator.” In this email, you will be given a “Registration” link and a “Company Identifier” which is ***TTUHSC El Paso***. Follow the link to create a username and password. You will need your SSN to complete your username and password. If you do not have a SSN a pin will have been sent to you in a separate email
- Once logged in to Employee Navigator to start benefits, you will click the “start benefits” option on your dashboard.
- You will be asked to provide your complete contact information.
- To add a dependent, select the “Add Dependent Option” from there you will be able to add your spouse and dependent children.
- Throughout the enrollment you will be asked ‘Who You Are Enrolling” and “To Make Selection.” You must select who you are enrolling and select for each benefit. Once completed, you will save and continue to move on to the next option.
- When making elections to enroll dependents, the green circle next to their name must be selected. You will confirm it is selected by seeing a check mark in the circle and confirming the coverage type is correct.
- Each benefit will have an enrollment screen. One you have enrolled in desired benefits and have confirmed your summary sheet is correct you will “Agree."
- If you have a questions or problems logging into the system, please call The Scioli Group or GME office. Our information can be found below or on the Employee Navigator Dashboard.
  - Monica Loya and Leslie Gonzalez - The Scioli Group 806.741.1050
  - TTUHSC El Paso Human Resources – 915.215.4217 or 915.215.4384
  - TTUHSC El Paso GME Office 915.215.4463 / Transmountain 915.215.5730

BENEFITS CONFIRMATION STATEMENT
FOLLOWING COMPLETION OF ENROLLMENT

- At Orientation/Admin Day or through your Department Coordinator, everyone will receive a Benefit Confirmation Statement
- Carefully review the information
- This is the information YOU supplied in Employee Navigator during your enrollment process
  - Make corrections immediately
  - Check names are spelled correctly
  - Verify the most recent & accurate mailing address
  - Verify dates of birth
  - Verify last four digits of ID number
  - Verify your election for each insurance benefit

QUALIFYING EVENTS AFTER OPEN ENROLLMENT

- Marriage:
  - If you become married while covered under these benefit plans, you ONLY HAVE 30 DAYS from the date of marriage to add your spouse to the plans.
  - IT IS YOUR REPONSBILITY to inform GME/HR Department of this qualifying event.
  - If you do not add your spouse within the 30-day time period, then your spouse will NOT have coverage until open enrollment of the next plan year.

QUALIFYING EVENTS AFTER OPEN ENROLLMENT

- Birth, Adoption, Stepchildren:
  - If you have a baby, adopt a child or marry a spouse with children, you ONLY HAVE 30 DAYS from the date of birth, adoption and marriage to add dependent children to the plans.
  - IT IS YOUR REPONSBILITY to inform GME/HR Department of this qualifying event.
  - If you do not add your children within the 30-day time period, then your children will NOT have coverage until open enrollment of the next plan year.

MEDICAL INSURANCE

Blue Cross Blue Shield of Texas

Summary of Benefits & Coverage

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services.
NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-521-2227 or at https://policy-srv.box.com/s/267fcsssotmsyy1objsynw9r66y0cs3f.
For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network: $500 Individual/$1,500 Family For Out-of-Network: $1,000 Individual/$3,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services that charge a copay, prescription drugs, emergency room services, certain preventive care, and In-Network diagnostic tests, home health, skilled nursing, and hospice are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Per occurrence: $150 In-Network/$300 Out-of-Network inpatient admission. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For In-Network: $1,500 Individual/$3,500 Family For Out-of-Network: $3,000 Individual/$7,000 Family Prescription drug limit: $500 Individual/$1,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, preauthorization penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; deductible does not apply	40% coinsurance after deductible	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	$25 copay/visit; deductible does not apply	40% coinsurance after deductible	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	40% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No Charge for child immunizations Out-of-Network through the 6th birthday.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge; deductible does not apply	40% coinsurance after deductible	Office visit copay may apply.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	40% coinsurance after deductible	None

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/267fcsssotmsyy1objsynw9r66y0cs3f.

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	$25 copay/visit; deductible does not apply	40% coinsurance after deductible	None
	Children's glasses	Not Covered	Not Covered	None
	[illegible]	[illegible]	[illegible]	[illegible]

Excluded Services & Other Covered Services:

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

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

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

- Chiropractic care
- Hearing aids (limited to 1 per ear per 36-month period)
- Routine eye care (Adult)

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/267fcsssotmsyy1objsynw9r66y0cs3f.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider pay the least)	Out-of-Network Provider (You will (You will pay the most)	
If you are pregnant	Office visits	$25 copay/visit; deductible does not apply	40% coinsurance after deductible	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	10% coinsurance after deductible	40% coinsurance after deductible	$150 inpatient admission deductible for In-Network providers. $300 inpatient admission deductible for Out-of-Network providers. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
If you need help recovering or have other special health needs	Home health care	No Charge; deductible does not apply	40% coinsurance after deductible	Limited to 60 visits per calendar year. Preauthorization is required.
	Rehabilitation services	$25 copay/office visit; deductible does not apply 10% coinsurance after deductible for other outpatient services	40% coinsurance after deductible	Limited to 35 visits combined for all therapies per calendar year. Includes, but is not limited to, occupational, physical, and manipulative therapy.
	Habilitation services	$25 copay/office visit; deductible does not apply 10% coinsurance after deductible for other outpatient services	40% coinsurance after deductible	
	Skilled nursing care	No Charge; deductible does not apply	40% coinsurance after deductible	Limited to 25 days per calendar year. Preauthorization is required.
	Durable medical equipment	10% coinsurance after deductible	40% coinsurance after deductible	None
	Hospice services	No Charge; deductible does not apply	40% coinsurance after deductible	Preauthorization is required.

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/267fcsssotmsyy1objsynw9r66y0cs3f.

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	Facility Charges: $50 copay/visit plus 10% coinsurance; deductible does not apply ER Physician Charges: 10% coinsurance after deductible	Facility Charges: $50 copay/visit plus 10% coinsurance; deductible does not apply ER Physician Charges: 10% coinsurance after deductible	Emergency room copay waived if admitted.
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	Ground and air transportation covered.
	Urgent care	$35 copay/visit; deductible does not apply	40% coinsurance after deductible	You may have to pay for services that are not covered by the visit fee. For an example, see "If you have a test" on page 2.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	40% coinsurance after deductible	$150 inpatient admission deductible for In-Network providers. $300 inpatient admission deductible for Out-of-Network providers. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	10% coinsurance after deductible	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit; deductible does not apply 10% coinsurance after deductible for other outpatient services	40% coinsurance after deductible	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your plan policy for more details.
	Inpatient services	10% coinsurance after deductible	40% coinsurance after deductible	$150 inpatient admission deductible for In-Network providers. $300 inpatient admission deductible for Out-of-Network providers. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/267fcsssotmsyy1objsynw9r66y0cs3f.

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbstx.com	Generic drugs	$5 retail/$12.50 mail order copay/prescription; deductible does not apply	$5 copay/prescription plus 20% coinsurance; deductible does not apply	Prescription drug out-of-pocket limit: $500 Individual/$1,000 Family Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. Out-of-Network mail order is not covered. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Out-of-Network pharmacy, member must file claim. The cost-sharing for insulin included in the drug list will not exceed $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.
	Preferred brand drugs	$15 retail/$37.50 mail order copay/prescription; deductible does not apply	$15 copay/prescription plus 20% coinsurance; deductible does not apply	
	Non-preferred brand drugs	$30 retail/$75 mail order copay/prescription; deductible does not apply	$30 copay/prescription plus 20% coinsurance; deductible does not apply	
	Specialty drugs	$5/$15/$30 copay/prescription; deductible does not apply	$5/$15/$30 copay/prescription plus 20% coinsurance; deductible does not apply	For In-Network benefit, must be obtained from In-Network Specialty Pharmacy provider. Specialty retail limited to a 30-day supply. Mail order is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	40% coinsurance after deductible	None
	Physician/surgeon fees	10% coinsurance after deductible	40% coinsurance after deductible	None

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/267fcsssotmsyy1objsynw9r66y0cs3f.

Avesis

Benefits

VISION INSURANCE

Effective Date: 7/1/2022

Group Number: 10775-87

Plan Number: 962-L3

TTUHSC- El Paso

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Vision Examination (Includes Refraction)	Covered in full after $10 copay	Up to $35
Materials*	$25 copay (Materials copay applies to frame or spectacle lenses, if applicable.)	
Frame Allowance	Members receive a $50 wholesale allowance Up to $150 retail value†	Up to $45
Standard Spectacle Lenses		
Single Vision	Covered in full after $25 copay	Up to $25
Bifocal	Covered in full after $25 copay	Up to $40
Trifocal	Covered in full after $25 copay	Up to $50
Lenticular	Covered in full after $25 copay	Up to $80
Standard Progressives	Covered up to $50, plus 20% off retail	Up to $40
Other Lens Options **Level 3 Lens Option Package** Polycarbonate Standard Scratch-Resistant Coating Standard Tint Ultra-Violet Screening Standard Anti-Reflective Coating	Covered in Full	Up to $10.00 Up to $5.00 Up to $4.00 Up to $6.00 Up to $24.00
Contact Lenses‡ (in lieu of frame and spectacle lenses)		
Elective	$130 allowance	Up to $130
Medically Necessary	Covered in full	Up to $250
Refractive Laser Surgery	Onetime/lifetime $150 allowance Provider discount up to 25%	Onetime/lifetime $150 allowance
Frequency		
Eye Examination	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frame	Once every 24 months	

*Discounts are not insured benefits.
†Value may be less depending on the providers retail pricing.
‡Prior authorization is required for medically necessary contacts.

Reliable & Dependable

Avēsis is a national leader in providing exceptional vision care benefits for millions of commercial members throughout the country.

The Avēsis vision care products give our members an easy-to-use wellness benefit that provides excellent value and protection.

Employer Paid Rates

Please see your HR Department

DENTAL, GROUP TERM LIFE/&AD AND LTD

See TMAIT Presentation

Q&A

Q. How much of the monthly premium for the insurance benefits is deducted from my paycheck?	• A. $0
	  • *At this time, the institution pays 100% of the monthly premium*
	  • *However, this is subject to change each year. Should this change, you will be informed.*

Q. Who can I select insurance benefits for?	• A. Yourself, legal spouse and your child(ren)
Q. My mom lives with me, can I add her?	• A. No
Q. I am getting married soon, when can I add my spouse?	• A. 30 days from the date of marriage
Q. I and my spouse are having a baby, when can I add the baby?	• A. 30 days from the date of birth
Q. Where do I find a list of the in-network providers for BCBS of Texas?	• A. www.bcbstx.com
Q. Who do I contact if I have questions about a medical bill I have received?	• A. Monica Loya with The Scioli Group (see contact page)

DEFINITIONS

Deductible:

- As the insured, it is your first dollar responsibility of medical claims. It is the amount of covered expenses that the insured must pay before the insurance company starts to pay for eligible expenses.

Out of Pocket Maximum

- The maximum amount that an insured is required to pay under a plan or insurance contract.

Copay

- A small charge paid at the time medical service is received. Copays accumulate towards the out-of-pocket maximum, but not towards the deductible.

CONGRATULATIONS AND WELCOME TO TTUHSC EL PASO