



RIVERBEND RESOLUTION NO. 20210623-01

AUTHORIZING THE EXECUTIVE DIRECTOR/CEO TO EXECUTE INTERLOCAL AGREEMENT(S) FOR EMPLOYEES HEALTH BENEFITS WITH TML HEALTH BENEFITS POOL

WHEREAS, Riverbend Water Resources District is a conservation and reclamation district created under and essential to accomplish the purposes of Section 59 Article XVI, Texas Constitution, existing pursuant to and having the powers set forth in Chapter 9601 of the Special District Local Laws Code of the State of Texas; and


WHEREAS, Riverbend Water Resources District currently has an interlocal agreement with TML Health Benefits Pool for a health benefits plan including health reimbursement and retirement reimbursement for district employees; and

WHEREAS, Riverbend Water Resources District has a continued need for health benefits, health reimbursement arrangement, and retirement reimbursement arrangement services to support the operation and management of its wet utilities; and

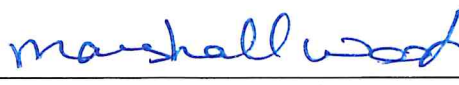
WHEREAS, TML Health Benefits Pool provides said needed health reimbursement arrangement and retirement reimbursement arrangement services and is fully qualified and certified to perform these services; and

NOW, THEREFORE, BE IT RESOLVED that the Executive Director/CEO shall be and is hereby authorized to enter into interlocal agreement(s) with TML Health Benefits Pool to provide health benefits under the employee benefits pool, health reimbursement arrangement, and retirement reimbursement arrangement services for Riverbend Water Resources District.

PASSED and APPROVED this 23rd day of June 2021


FOR Sonja Hubbard, President

ATTEST:


Marshall Wood, Vice President

Attached: TML Health Benefits Pool Plan Premium Options



MEDICAL COST PROJECTION

5/27/2021 8:20 AM

Riverbend WRD - PRIVERB1

05/27/21

MEMBER OPTION

Current Plan

3%

2020-2021
Current Rates
P85-100-30 \$25 OV
80% / 50%
PPO
\$1,000 In Ded
\$1,250 Out Ded
\$3,000 In OOP
\$25 OV
DAW1&2 Rx Plan

EE \$651.20
EE + Spouse \$1,321.94
EE + Child(ren) \$1,140.18
EE + Family \$2,040.86

New Plan Options

2021-2022

Option 1

3% Increase
Copay-1K-3K ER
80% / 50%
PPO (copay)
\$1,000 In Ded
\$2,000 Out Ded
\$3,000 In OOP
\$0 Tela Health Copay
\$30 OV/\$45 SP/\$75 UC/\$500 ER Copay
DAW1&2 Rx Plan

EE \$670.74
EE + Spouse \$1,361.60
EE + Child(ren) \$1,174.40
EE + Family \$2,102.10

Option 2

0.17% Increase
Copay-1K-4K ER
80% / 50%
PPO (copay)
\$1,000 In Ded
\$2,000 Out Ded
\$4,000 In OOP
\$0 Tela Health Copay
\$30 OV/\$45 SP/\$75 UC/\$500 ER Copay
DAW1&2 Rx Plan

\$652.30
\$1,324.16
\$1,142.12
\$2,044.30

Option 3

1.98% Decrease
Copay-1K-5K ER
80% / 50%
PPO (copay)
\$1,000 In Ded
\$2,000 Out Ded
\$5,000 In OOP
\$0 Tela Health Copay
\$30 OV/\$45 SP/\$75 UC/\$500 ER Copay
DAW1&2 Rx Plan

\$638.28
\$1,295.72
\$1,117.58
\$2,000.38

Option 4

1.18% Decrease
Copay-1500-3K ER
80% / 50%
PPO (copay)
\$1,500 In Ded
\$3,000 Out Ded
\$3,000 In OOP
\$0 Tela Health Copay
\$30 OV/\$45 SP/\$75 UC/\$500 ER Copay
DAW1&2 Rx Plan

\$643.52
\$1,306.34
\$1,126.74
\$2,016.78

Option 1

Option 2

Option 3

Option 4

Please sign & date option chosen:

Signature / Date

Signature / Date

Signature / Date

Signature / Date

DAW1&2 Plan: If a brand name drug is dispensed and a generic alternate drug exists, the Covered Individual pays the difference between the brand name and generic price in addition to the appropriate copayment for the brand name. The cost difference between the brand name and generic price does not apply to any individual deductibles or out of pocket amounts. The differential applies to all prescriptions purchased through this program when a generic alternate is available.

NonDAW Plan: If a brand name drug is dispensed and a generic alternate drug exists, the Covered Individual pays the appropriate brand copay.

THIS DOES NOT COMPLETE THE RERATE PROCESS. YOU WILL NEED TO SIGN THE MEMBER OPTION AND DO ONE OF THE FOLLOWING BY 06/25/2021:

1. Scan an image of the signed member option and email it to underwriting@tmlhb.org, or
 2. Fax the signed member option to (512) 719-6541, attn: Underwriting
- THEN A NEW RERATE NOTICE WILL BE GENERATED AND MAILED TO YOU. THE RERATE SHEET MUST BE SIGNED AND RECEIVED IN AUSTIN BY 07/01/2021 FOR THE NEW BENEFITS AND RATES TO BE EFFECTIVE FOR 10/01/2021.



Vision Selection Form



Selection

<input type="checkbox"/>	OPTION A: EyeMed Standard Benefit (Employer Paid) – Two-tier Monthly Rates Subscriber Only: \$6.79 Subscriber + Family: \$17.30
<input type="checkbox"/>	OPTION B: EyeMed Premium Benefit (Employer Paid) – Two-tier Monthly Rates Subscriber Only: \$9.86 Subscriber + Family: \$25.14
<input type="checkbox"/>	OPTION C: EyeMed Standard Benefit – Voluntary (Employee Paid) – Two-tier Monthly Rates Subscriber Only: \$6.88 Subscriber + Family: \$17.53
<input type="checkbox"/>	OPTION D: EyeMed Premium Benefit – Voluntary (Employee Paid) – Two-tier Monthly Rates Subscriber Only: \$9.99 Subscriber + Family: \$25.47
<input type="checkbox"/>	OPTION E: EyeMed Standard Benefit – (Employer Paid) – Four-tier Monthly Rates Subscriber Only: \$6.16 Employee + Child(ren): \$12.32 Subscriber + Spouse: \$11.70 Employee + Family: \$15.71
<input type="checkbox"/>	OPTION F: EyeMed Premium Benefit – (Employer Paid) – Four-tier Monthly Rates Subscriber Only: \$8.93 Employee + Child(ren): \$17.86 Subscriber + Spouse: \$16.97 Employee + Family: \$22.78
<input type="checkbox"/>	OPTION G: EyeMed Standard Benefit – Voluntary (Employee Paid) – Four-tier Monthly Rates Subscriber Only: \$7.22 Employee + Child(ren): \$14.43 Subscriber + Spouse: \$13.71 Employee + Family: \$18.40
<input type="checkbox"/>	OPTION H: EyeMed Premium Benefit – Voluntary (Employee Paid) – Four-tier Monthly Rates Subscriber Only: \$10.47 Employee + Child(ren): \$20.94 Subscriber + Spouse: \$19.90 Employee + Family: \$26.71

Group Name: _____ Group Number: _____

Name: _____

Title: _____

Signature: _____

Date: _____

Phone Number: _____

Email: _____



Vision Selection Form



Vision Care Services	EyeMed STANDARD Benefit		EyeMed PREMIUM Benefit	
	IN NETWORK	OUT OF NETWORK Reimbursed UP TO:	IN NETWORK	OUT OF NETWORK Reimbursed UP TO:
Exam with Dilation as Necessary	\$0 Copay	\$65	\$0 Copay	\$65
Retinal Imaging	Up to \$39	N/A	Up to \$39	N/A
Exam Options				
Standard Contact Lens Fit & Follow-up	Up to \$40	N/A	\$0 Copay	\$40
Premium Contact Lens Fit & Follow-up	10% off retail price	N/A	\$0 Copay, 10% off retail, then apply \$40 allowance	\$40
Frames				
Any available frame at provider location	\$175 allowance, 20% off balance over \$175	\$125	\$225 allowance, 20% off balance over \$225	\$160
Standard Plastic Lenses				
Single Vision	\$10 Copay	\$30	\$0 Copay	\$40
Bifocal – Lined	\$10 Copay	\$50	\$0 Copay	\$60
Trifocal – Lined	\$10 Copay	\$70	\$0 Copay	\$80
Standard Progressive Lens	\$65 Copay	\$50	\$0 Copay	\$60
Premium Progressive Lens	FIXED PRICING includes lens copay Tier 1 - \$95 Tier 2 - \$105 Tier 3 - \$120 Tier 4 - \$185	\$50	FIXED PRICING includes lens copay Tier 1 - \$30 Tier 2 - \$40 Tier 3 - \$55 Tier 4 - \$175	\$60
Lens Options				
UV Treatment	\$15	N/A	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A	\$15	N/A
Standard Plastic Scratch Coating	\$15	N/A	\$15	N/A
Standard Polycarbonate – Adults	\$40	N/A	\$0	\$5
Standard Polycarbonate – Kids under 19	\$0	\$5	\$0	\$5
Standard Anti-Reflective Coating	\$45	\$5	\$45	\$5
Premium Anti-Reflective Coating	Tier 1 - \$57 Tier 2 - \$68 Tier 3 - \$85	\$5	Tier 1 - \$57 Tier 2 - \$68 Tier 3 - \$85	\$5
Photochromatic/Transition – Plastic	\$75	N/A	\$75	N/A
Contact Lenses	Contact lenses in lieu of spectacle lenses only – member still able to use their frame benefit		Contact lenses in lieu of spectacle lenses only – member still able to use their frame benefit	
Elective Contact Lenses	\$175	\$125	\$225	\$160
Medically Necessary	Covered in full	\$210	Covered in full	\$210
Frequency				
Examination	Once every plan year		Once every plan year	
Lenses or Contact Lenses	Once every plan year		Once every plan year	
Frames	Once every plan year		Once every plan year	
	STANDARD PLAN		PREMIUM PLAN	
	OPTION A: Employer Paid		OPTION B: Employer Paid	
	Subscriber:	\$6.79	Subscriber:	\$9.86
	Subscriber + Family:	\$17.30	Subscriber + Family:	\$25.14
	OPTION C: Voluntary (Employee Paid)		OPTION D: Voluntary (Employee Paid)	
	Subscriber:	\$6.88	Subscriber:	\$9.99
	Subscriber + Family:	\$17.53	Subscriber + Family:	\$25.47
	OPTION E: Employer Paid		OPTION F: Employer Paid	
	Subscriber:	\$6.16	Subscriber:	\$8.93
	Subscriber + Spouse:	\$11.70	Subscriber + Spouse:	\$16.97
	Subscriber + Child(ren):	\$12.32	Subscriber + Child(ren):	\$17.86
	Subscriber + Family:	\$15.71	Subscriber + Family:	\$22.78
	OPTION G: Voluntary (Employee Paid)		OPTION H: Voluntary (Employee Paid)	
	Subscriber:	\$7.22	Subscriber:	\$10.47
	Subscriber + Spouse:	\$13.71	Subscriber + Spouse:	\$19.90
	Subscriber + Child(ren):	\$14.43	Subscriber + Child(ren):	\$20.94
	Subscriber + Family:	\$18.40	Subscriber + Family:	\$26.71