# Open Enrollment

2017

TEACHERS HEALTH TRUST

*For Teachers By Teachers*

Welcome to the 2017 Open Enrollment.

This guide is designed to help walk you through each of the steps during your time in the Open Enrollment portal. If you have any questions that may not be listed in this document, please contact the Teachers Health Trust Member Services team at:

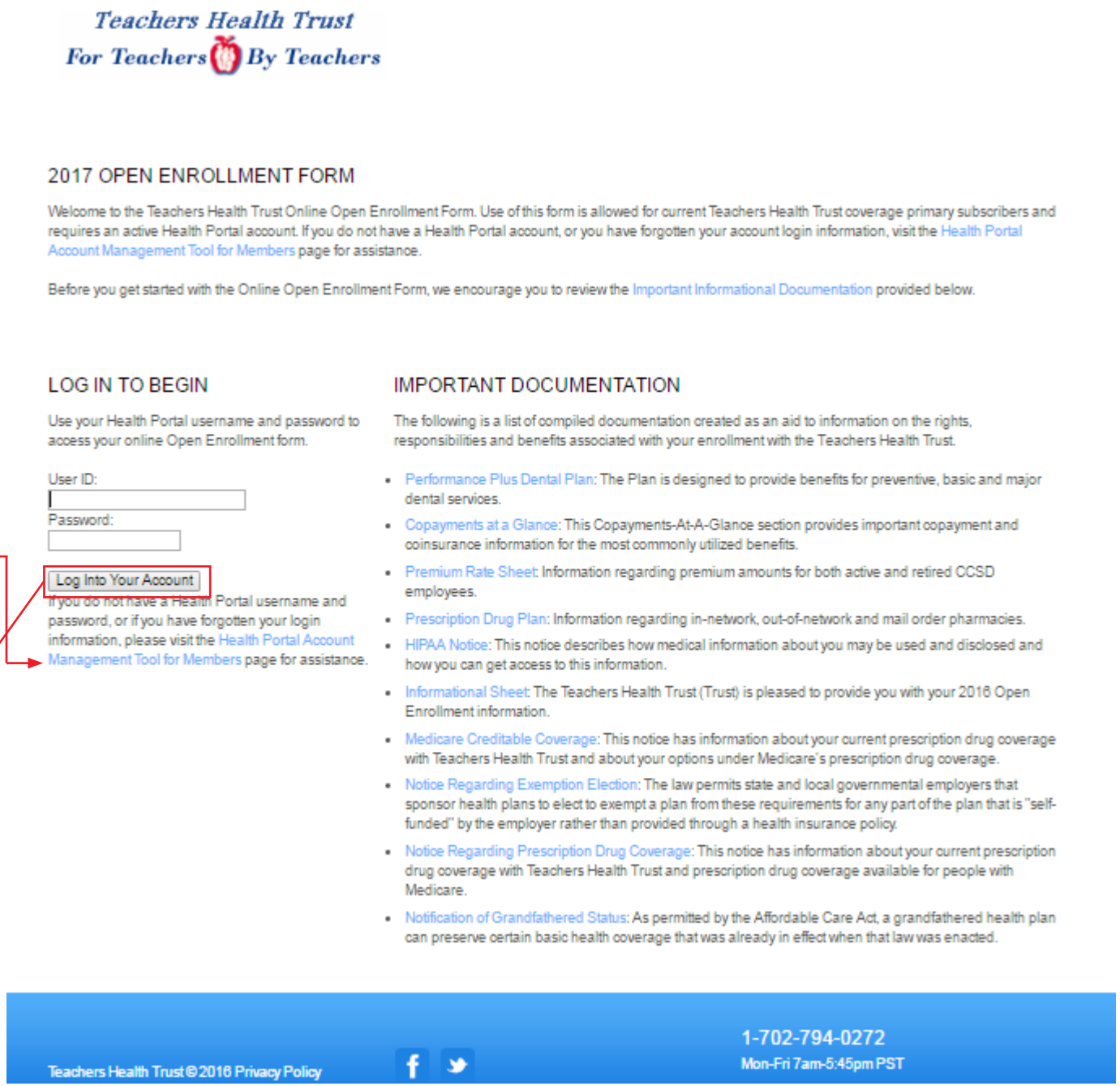
E: serviceteam@teachershealthtrust.org

P: (702) 794 0272

## Login Page

**Step 1:**
Each participant will need to create a new login, click here to start that process.

**Step 2:**
Once you have create your login, click here to enter the portal.

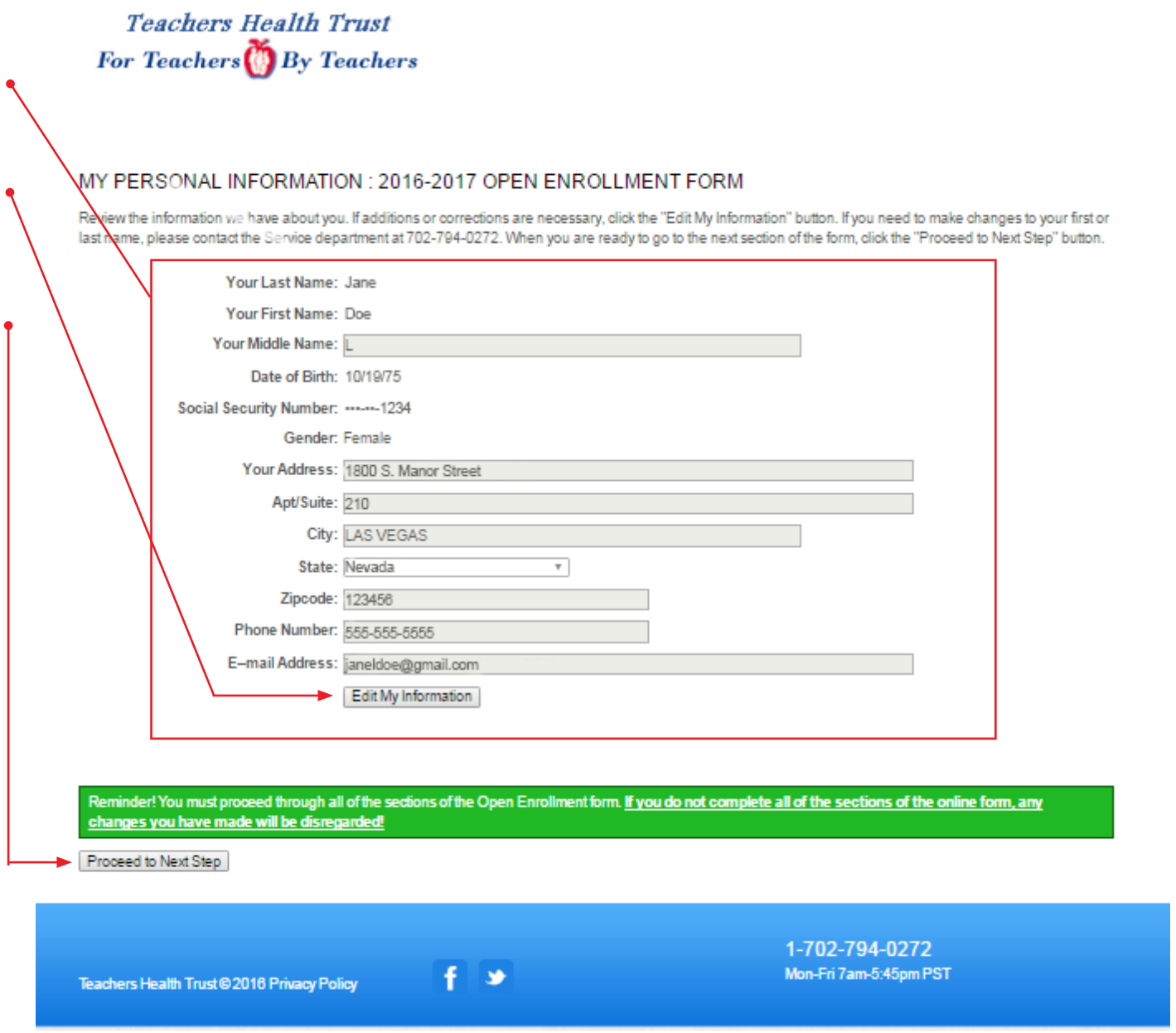


## Personal Information

**Step 3:**
Verify that your personal information is correct.

If you need to change any of the information listed, click the “Edit My Information” button located here.

**Step 4:**
Once your information is verified, click the “proceed to next step” button located here.

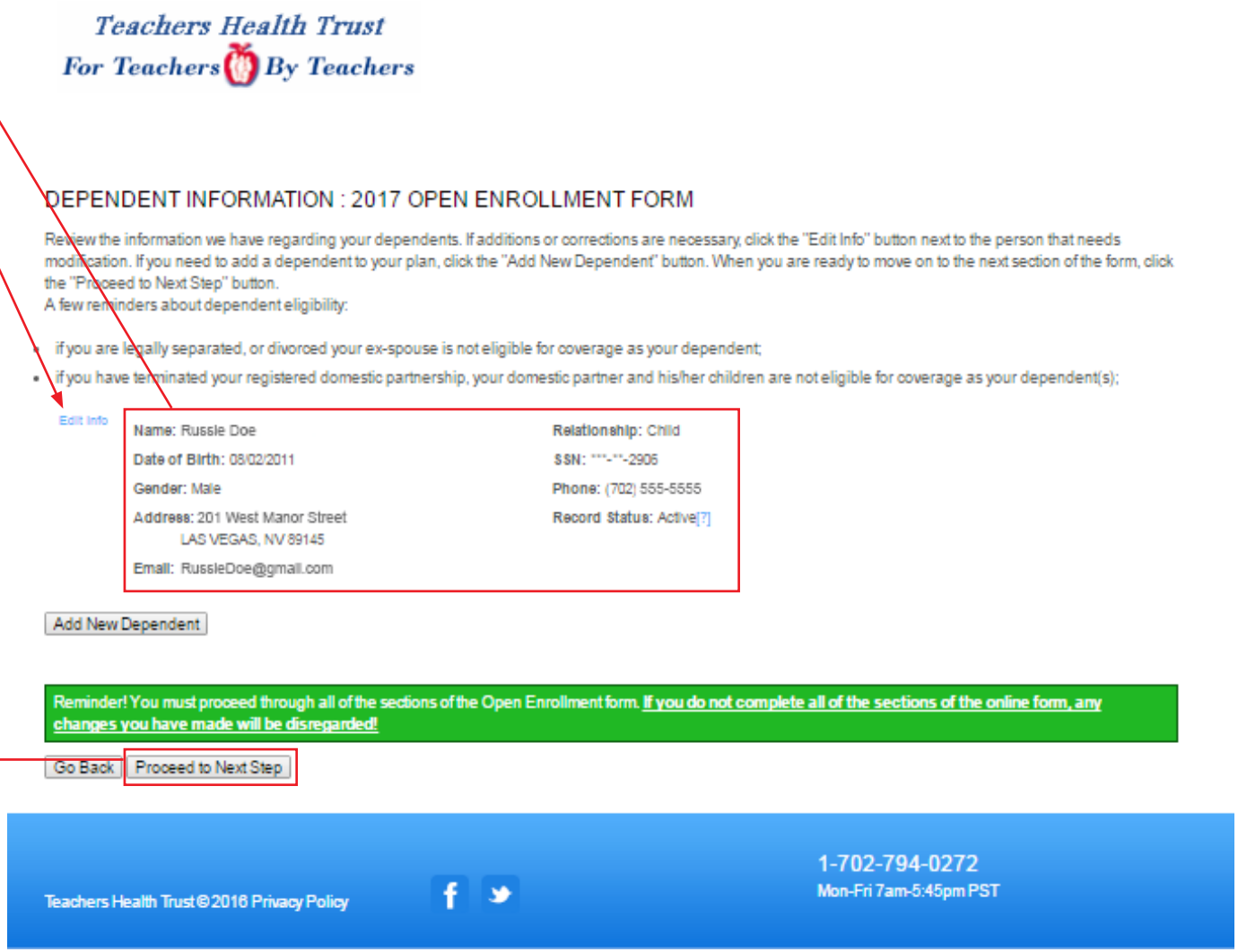


# My Dependents

**Step 5:**
Verify that your dependent information is correct.

If you need to change any of the information listed, click the “Edit My Information” button located here.

**Step 6:**
Once your information is verified, click the “proceed to next step” button located here.



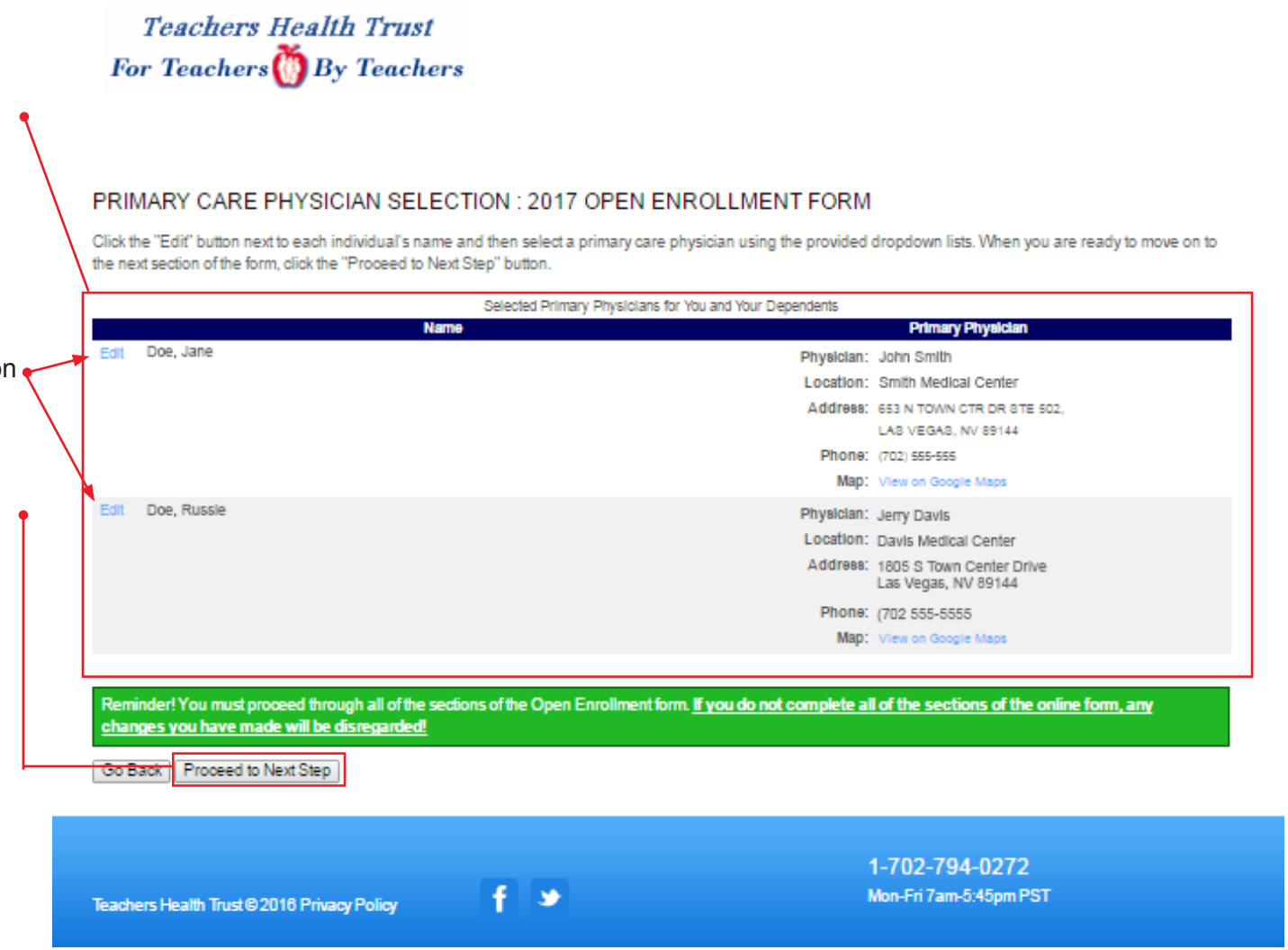
# Patient Centered Medical Home (PCMH) Information

**Step 7:**
Verify that your PCMH information is correct.

Please Note: If you choose to change your PCMH provider, your change will become effective on January 1, 2017.

If you need to change any of the information listed, click the “Edit” button located here.

**Step 8:**
Once your information is verified, click the “proceed to next step” button located here.

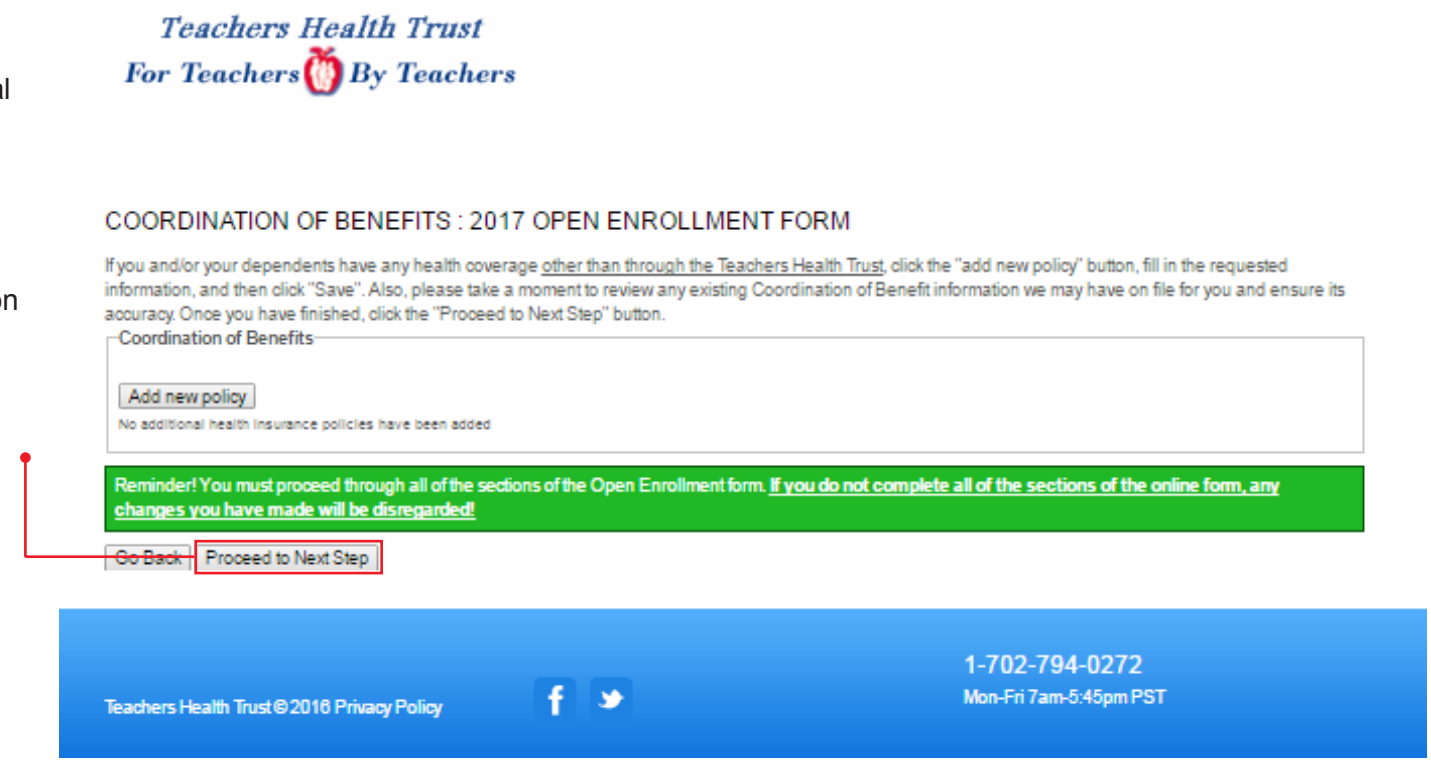


## Coordination of Benefits

**Step 9:**
If you have additional benefits (i.e. yourself or dependents have additional insurance coverage through an additional plan), you must re-submit verification of coverage to the Trust.

If you need to change any of the information listed, click the “Edit” button located here.

**Step 10:**
Once your information is verified, click the “proceed to next step” button located here.

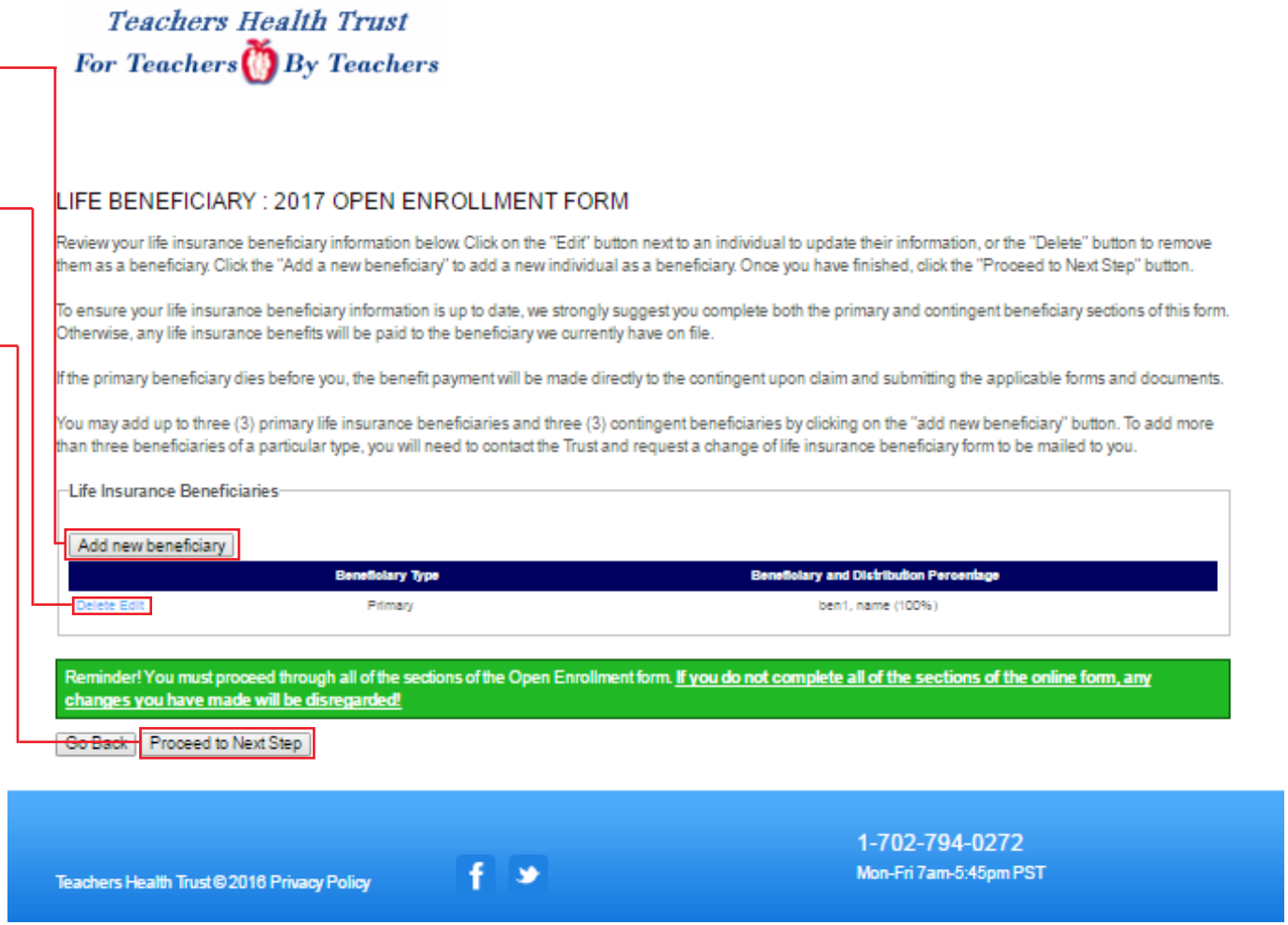


## Life Insurance

**Step 11:**
Please note: It is important that you verify your life insurance beneficiary. You can add up to three beneficiaries.

If you need to change any of the information listed, click the “Edit” button located here.

**Step 12:**
Once your information is verified, click the “proceed to next step” button located here.



## Review Your Choices

**Step 13:**
Review your personal information, verifying that the information in the sections filled out previously are correct.

This is the final opportunity to look at the additions, deletes, or edits. Be sure to make note of the documentation you will need to send to the Trust by December 16th, 2016.

Continued on next page →


REVIEW : 2017 OPEN ENROLLMENT FORM

Review your information below. Be sure to take note of any required documentation necessary to complete the enrollment of your dependents. If changes are necessary, use the Back button to navigate back to the section that needs to be changed. If everything looks ok, click the "Proceed to Next Step" button.

**Reminder! You must proceed through all of the sections of the Open Enrollment form. If you do not complete all of the sections of the online form, any changes you have made will be disregarded!**

**Required Documentation**

No further documentation required

If you are adding dependents, the documents listed above are required in order to complete the enrollment process. You may fax, e-mail or mail in the documents to the Teachers Health Trust (Trust). If the required documentation is not received in the Trust office, your dependents will not be able to enroll for coverage until the next Open Enrollment, unless they experience a life event.

**Primary Subscriber Information**

| | |
|---|---|
| Name: | Jane Doe |
| Address: | 1800 S. Manor Street<br>LAS VEGAS, NV 89145 |
| Email: | JaneDoe@gmail.com |
| Date of Birth: | 10/19/75 |
| SSN: | ***-**-1234 |
| Gender: | Female |
| Phone: | 555-555-5555 |

**Dependent Information**

| | |
|---|---|
| Name: | Russle Doe |
| Address: | 201 West Manor Street<br>Las Vegas, NV 89145 |
| Relationship: | Child |
| Email: | RussleDoe@gmail.com |
| Date of Birth: | 5/02/11 |
| SSN: | ***-**-2905 |
| Gender: | Male |
| Phone: | 702-555-5555 |
| Participant Record | Active |

## Review Your Choices (cont.)

**Step 13:**
Review your personal information, verifying that the information in the sections filled out previous are correct.

This is the final opportunity to look at the additions, deletes, or edits. Be sure to make note of the documentation you will need to send to the Trust by December 16th, 2016

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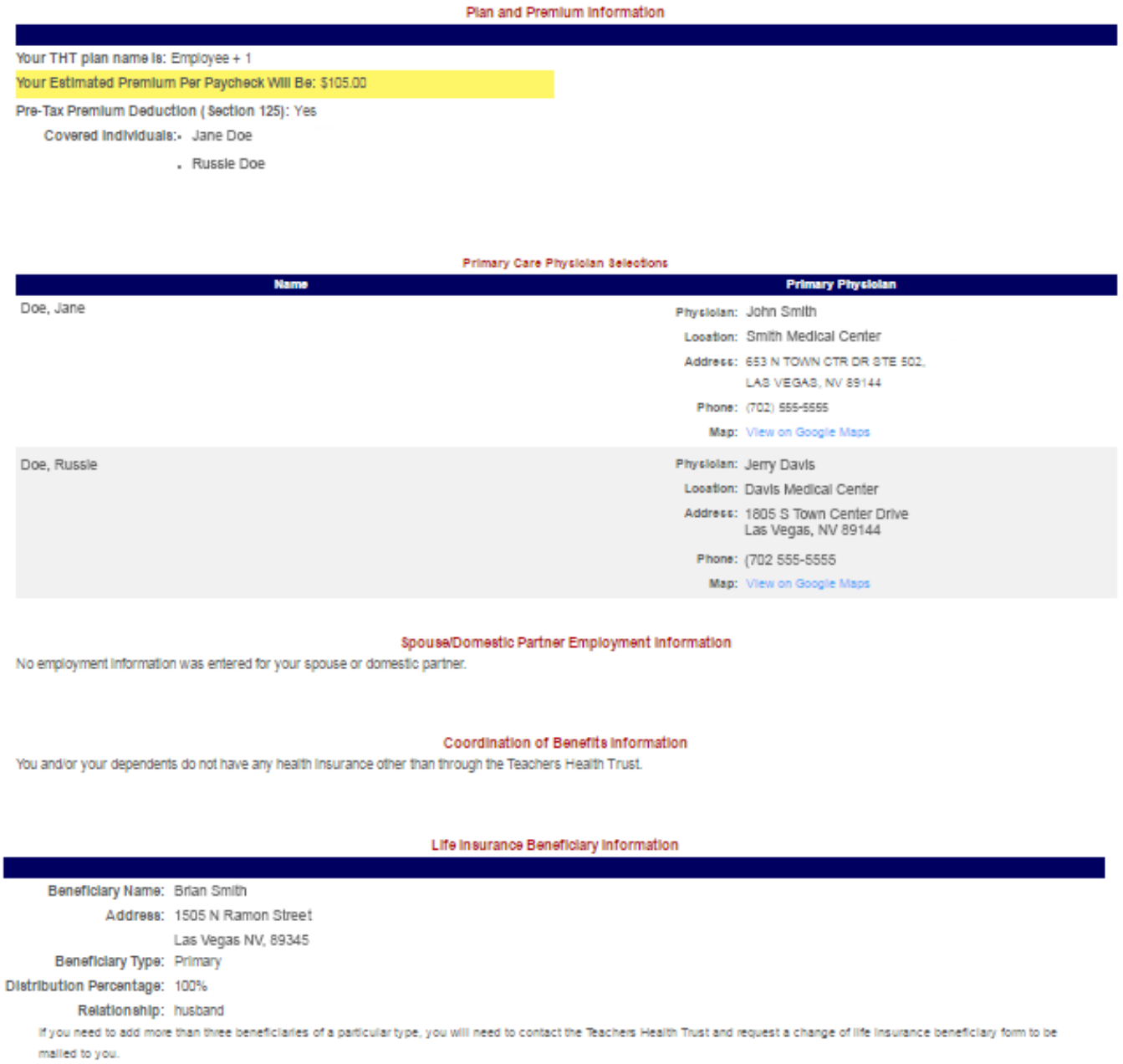


Plan and Premium Information

Your THT plan name is: Employee + 1
Your Estimated Premium Per Paycheck Will Be: $105.00
Pre-Tax Premium Deduction ( Section 125): Yes
Covered Individuals:
- Jane Doe
- Russle Doe

Primary Care Physician Selections

| Name | Primary Physician |
|---|---|
| Doe, Jane | Physician: John Smith<br>Location: Smith Medical Center<br>Address: 653 N TOWN CTR DR STE 502, LAS VEGAS, NV 89144<br>Phone: (702) 555-5555<br>Map: View on Google Maps |
| Doe, Russle | Physician: Jerry Davis<br>Location: Davis Medical Center<br>Address: 1805 S Town Center Drive Las Vegas, NV 89144<br>Phone: (702 555-5555<br>Map: View on Google Maps |

Spouse/Domestic Partner Employment Information

No employment information was entered for your spouse or domestic partner.

Coordination of Benefits Information

You and/or your dependents do not have any health insurance other than through the Teachers Health Trust.

Life Insurance Beneficiary Information

Beneficiary Name: Brian Smith
Address: 1505 N Ramon Street
Las Vegas NV, 89345
Beneficiary Type: Primary
Distribution Percentage: 100%
Relationship: husband

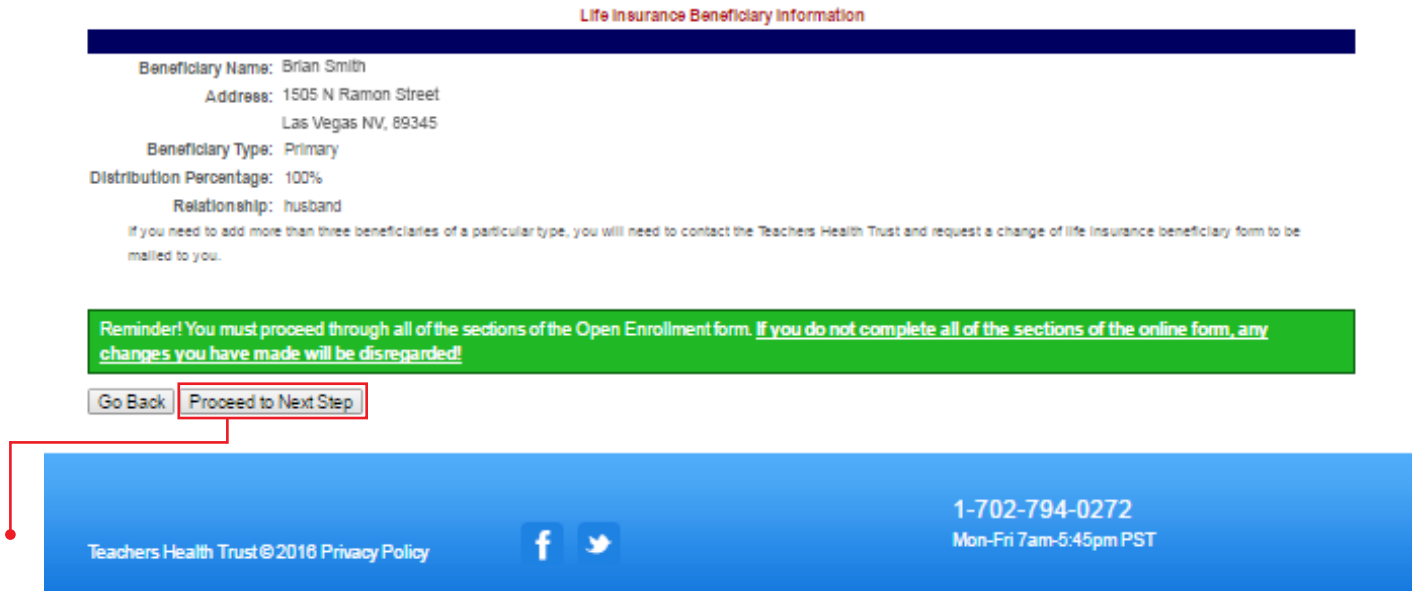
If you need to add more than three beneficiaries of a particular type, you will need to contact the Teachers Health Trust and request a change of life insurance beneficiary form to be mailed to you.

## Review Your Choices (cont.)

**Step 13:**
Review your personal information, verifying that the information in the sections filled out previously are correct.

This is the final opportunity to look at the additions, deletes, or edits. Be sure to make note of the documentation you will need to send to the Trust by December 16th, 2016

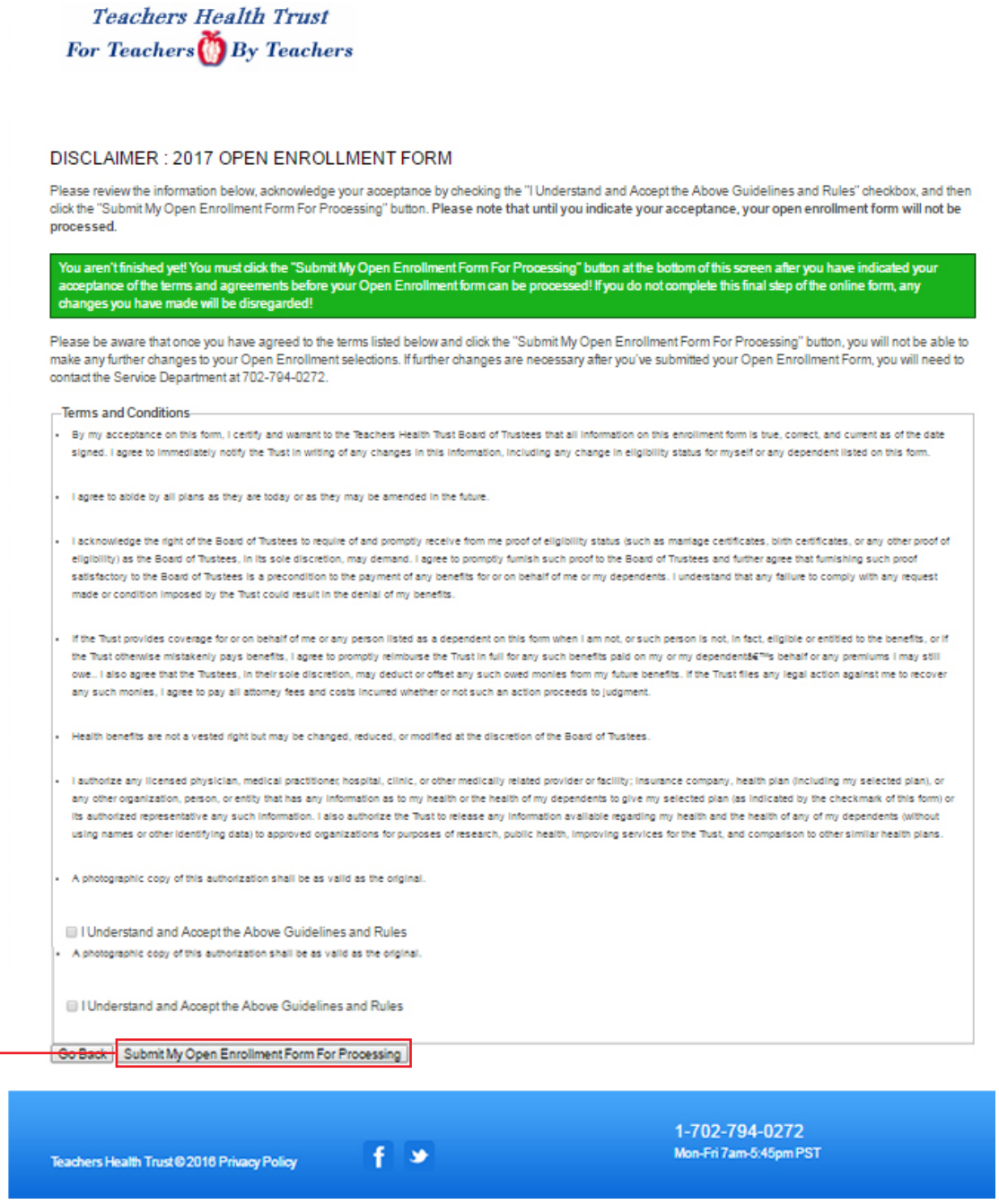
**Step 14:**
Once your information is verified, click the “proceed to next step” button located here.



## Disclaimer Agreement

**Step 15:**
Read and review the Terms and Conditions. Once you have read through and agreed, please click the Submit My Open Enrollment Form For Processing.

**Please Note:**
You must click the “Submit My Open Enrollment Form For Processing” to finalize your Open Enrollment.



Teachers Health Trust
For Teachers By Teachers

DISCLAIMER : 2017 OPEN ENROLLMENT FORM

Please review the information below, acknowledge your acceptance by checking the "I Understand and Accept the Above Guidelines and Rules" checkbox, and then click the "Submit My Open Enrollment Form For Processing" button. **Please note that until you indicate your acceptance, your open enrollment form will not be processed.**

**You aren't finished yet! You must click the "Submit My Open Enrollment Form For Processing" button at the bottom of this screen after you have indicated your acceptance of the terms and agreements before your Open Enrollment form can be processed! If you do not complete this final step of the online form, any changes you have made will be disregarded!**

Please be aware that once you have agreed to the terms listed below and click the "Submit My Open Enrollment Form For Processing" button, you will not be able to make any further changes to your Open Enrollment selections. If further changes are necessary after you've submitted your Open Enrollment Form, you will need to contact the Service Department at 702-794-0272.

Terms and Conditions

- By my acceptance on this form, I certify and warrant to the Teachers Health Trust Board of Trustees that all information on this enrollment form is true, correct, and current as of the date signed. I agree to immediately notify the Trust in writing of any changes in this information, including any change in eligibility status for myself or any dependent listed on this form.
- I agree to abide by all plans as they are today or as they may be amended in the future.
- I acknowledge the right of the Board of Trustees to require of and promptly receive from me proof of eligibility status (such as marriage certificates, birth certificates, or any other proof of eligibility) as the Board of Trustees, in its sole discretion, may demand. I agree to promptly furnish such proof to the Board of Trustees and further agree that furnishing such proof satisfactory to the Board of Trustees is a precondition to the payment of any benefits for or on behalf of me or my dependents. I understand that any failure to comply with any request made or condition imposed by the Trust could result in the denial of my benefits.
- If the Trust provides coverage for or on behalf of me or any person listed as a dependent on this form when I am not, or such person is not, in fact, eligible or entitled to the benefits, or if the Trust otherwise mistakenly pays benefits, I agree to promptly reimburse the Trust in full for any such benefits paid on my or my dependentâ€™s behalf or any premiums I may still owe.. I also agree that the Trustees, in their sole discretion, may deduct or offset any such owed monies from my future benefits. If the Trust files any legal action against me to recover any such monies, I agree to pay all attorney fees and costs incurred whether or not such an action proceeds to judgment.
- Health benefits are not a vested right but may be changed, reduced, or modified at the discretion of the Board of Trustees.
- I authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related provider or facility; insurance company, health plan (including my selected plan), or any other organization, person, or entity that has any information as to my health or the health of my dependents to give my selected plan (as indicated by the checkmark of this form) or its authorized representative any such information. I also authorize the Trust to release any information available regarding my health and the health of any of my dependents (without using names or other identifying data) to approved organizations for purposes of research, public health, improving services for the Trust, and comparison to other similar health plans.
- A photographic copy of this authorization shall be as valid as the original.

☐ I Understand and Accept the Above Guidelines and Rules

- A photographic copy of this authorization shall be as valid as the original.

☐ I Understand and Accept the Above Guidelines and Rules

Go Back | Submit My Open Enrollment Form For Processing

Teachers Health Trust © 2016 Privacy Policy

1-702-794-0272
Mon-Fri 7am-5:45pm PST

TEACHERS HEALTH TRUST
*For Teachers By Teachers*

Thank you for completing the 2017 Open Enrollment. Remember to send your documents to the Trust by December 16, 2017. You can submit documentation via:

E: ServiceTeam@TeachersHealthTrust.org
F: 1-702-794-2093

Be sure to have your participant ID on each piece you send.

Thank you.