2024 - 2025 Plan Year

LAKE TRAVIS ISD

BENEFIT GUIDE

EFFECTIVE: 11/01/2024 - 10/31/2025

WWW.MYBENEFITSHUB.COM/LAKETRAVISISD

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Benefit Contact Information

Lake Travis ISD BENEFITS	MEDICAL	HEALTH SAVINGS ACCOUNT (HSA)
Higginbotham Public Sector (800) 583-6908 www.mybenefitshub.com/laketravisisd	Blue Cross Blue Shield (800) 521-2227 www.bcbstx.com	EECU (817) 882-0800 https://www.eecu.org/
HOSPITAL INDEMNITY	**DENTAL**	**VISION**
Aetna (855) 513-9865 http://www.aetna.com/	MetLife (800) 438-6388 www.metlife.com	Eye Med (866) 800-5457 www.eyemed.com
DISABILITY	**ACCIDENT**	**CRITICAL ILLNESS**
The Hartford (866) 278-2655 www.TheHartford.com	MetLife (800) 438-6388 www.metlife.com	MetLife (800) 438-6388 www.metlife.com
LIFE AND AD&D	**FLEXIBLE SPENDING ACCOUNT (FSA)**	**PRESCRIPTION SAVINGS**
MetLife (800) 438-6388 www.metlife.com	Higginbotham (866) 419-3519 https://flexservices.higginbotham.net flexclaims@higginbotham.net	Clever RX Group ID: (800) 873-1195 http://www.cleverrx.com/laketravisisd

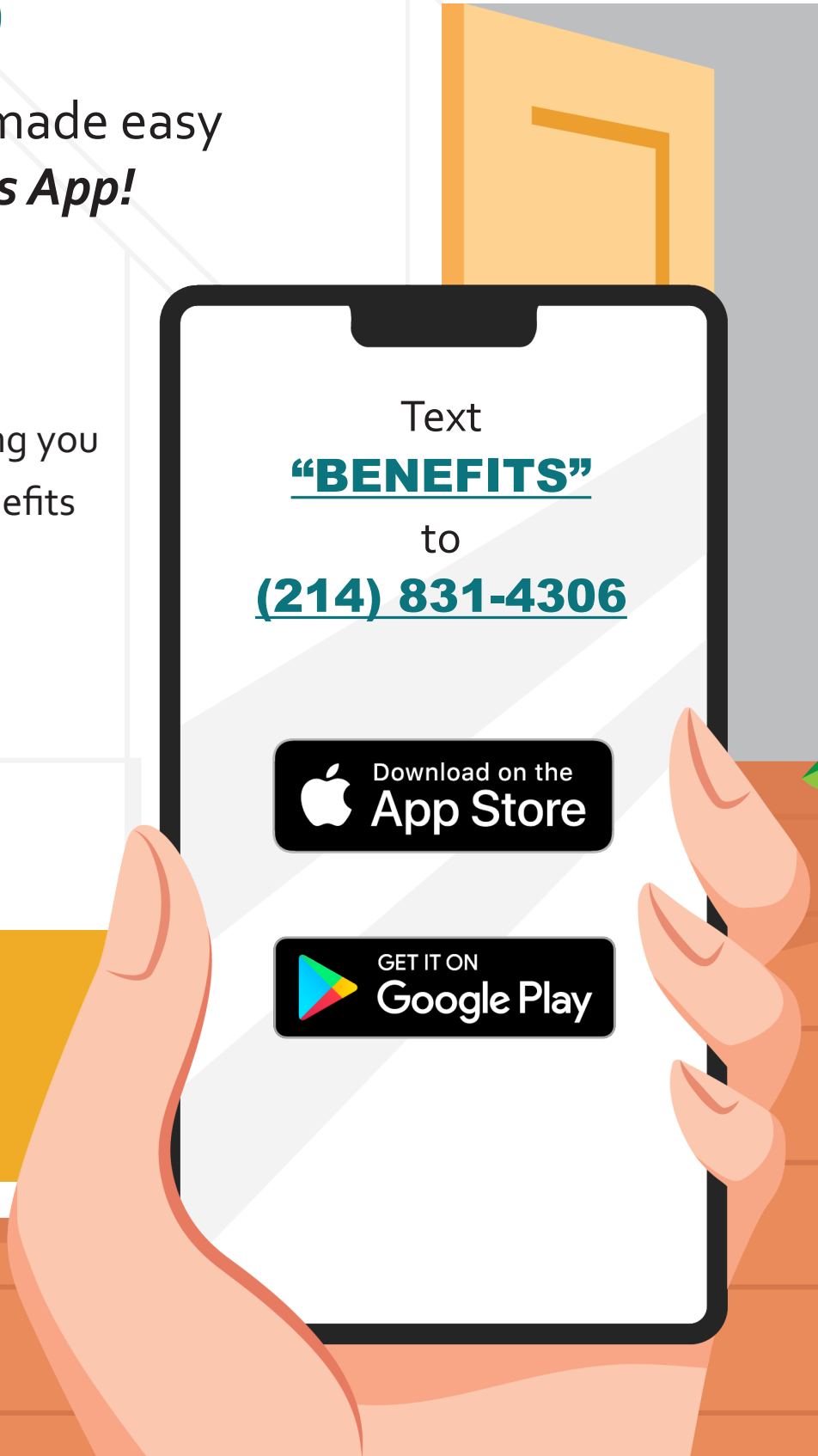
All Your Benefits - One App

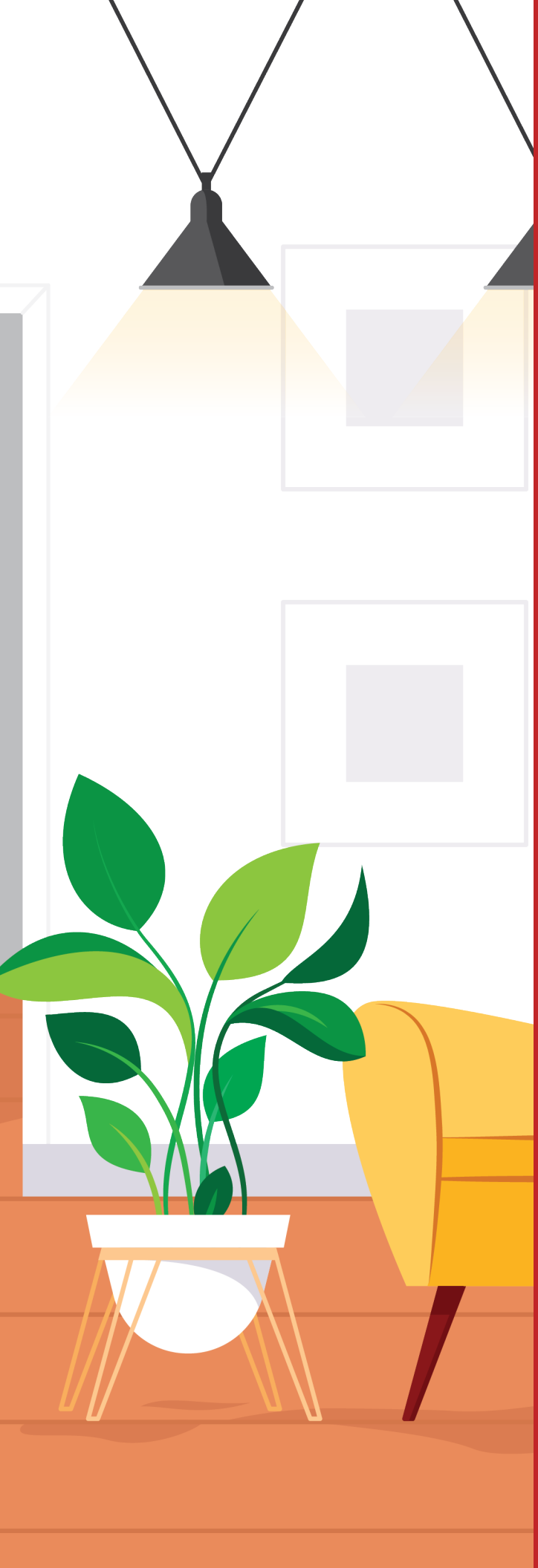
Employee benefits made easy through the ***Benefits App!***

Text **"BENEFITS"** to **(214) 831-4306** and get access to everything you need to complete your benefits enrollment:

- Benefit Resources
- Online Enrollment
- Interactive Tools
- And more!

App Group #:
FBSLAKETRAVIS





Login Process

1 www.mybenefitshub.com/laketravisisd

2 CLICK LOGIN

3 **Enter your Information**

- Last Name
- Date of Birth
- Last Four (4) of Social Security Number

NOTE: THE*benefits***HUB** *uses this information to check behind the scenes to confirm your employment status.*

4 Once confirmed, the Additional Security Verification page will list the contact options from your profile. Select either **Text**, **Email**, **Call**, or **Ask Admin** options to receive a code to complete the final verification step.

5 Enter the code that you receive and click **Verify**. You can now complete your benefits enrollment!

Annual Benefit Enrollment

SUMMARY PAGES

Annual Enrollment

During your annual enrollment period, you have the opportunity to review, change or continue benefit elections each year. Changes are not permitted during the plan year (outside of annual enrollment) unless a Section 125 qualifying event occurs.

- Changes, additions or drops may be made only during the annual enrollment period without a qualifying event.
- Employees must review their personal information and verify that dependents they wish to provide coverage for are included in the dependent profile. Additionally, you must notify your employer of any discrepancy in personal and/or benefit information.
- Employees must confirm on each benefit screen (medical, dental, vision, etc.) that each dependent to be covered is selected in order to be included in the coverage for that particular benefit.

New Hire Enrollment

All new hire enrollment elections must be completed in the online system within the specified time communicated in your new employee materials. Failure to complete elections during this timeframe will result in the forfeiture of coverage.

Q&A

Who do I contact with Questions?

For supplemental benefit questions, you can contact your benefits department or you can call Higginbotham Public Sector at (866) 914-5202 for assistance.

Where can I find forms?

For benefit summaries and claim forms, go to your benefit website: www.mybenefitshub.com/laketravisisd. Click the benefit plan you need information on (i.e., Dental) and you can find the forms you need under the Benefits and Forms section.

How can I find a Network Provider?

For benefit summaries and claim forms, go to the Lake Travis ISD benefit website: www.mybenefitshub.com/laketravisisd. Click on the benefit plan you need information on (i.e., Dental) and you can find provider search links under the Quick Links section.

When will I receive ID cards?

If the insurance carrier provides ID cards, you can expect to receive those 3-4 weeks after your effective date. For most dental and vision plans, you can login to the carrier website and print a temporary ID card or simply give your provider the insurance company's phone number and they can call and verify your coverage if you do not have an ID card at that time. If you do not receive your ID card, you can call the carrier's customer service number to request another card.

If the insurance carrier provides ID cards, but there are no changes to the plan, you typically will not receive a new ID card each year.

Section 125 Cafeteria Plan Guidelines

A Cafeteria plan enables you to save money by using pre-tax dollars to pay for eligible group insurance premiums sponsored and offered by your employer. Enrollment is automatic unless you decline this benefit. Elections made during annual enrollment will become effective on the plan effective date and will remain in effect during the entire plan year.

Changes in benefit elections can occur only if you experience a qualifying event. You must present proof of a qualifying event to your Benefit Office within 30 days of your qualifying event and meet with your Benefits Office Office to complete and sign the necessary paperwork in order to make a benefit election change. Benefit changes must be consistent with the qualifying event.

CHANGES IN STATUS (CIS):	QUALIFYING EVENTS
Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid change in status event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain/Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Judgment/ Decree/Order	If a judgment, decree, or order from a divorce, annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Eligibility for Government Programs	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.

Employee Eligibility Requirements

Medical and Supplemental Benefits: Eligible employees must work 25 or more regularly scheduled hours each work week.

Eligible employees must be actively at work on the plan effective date for new benefits to be effective, meaning you are physically capable of performing the functions of your job on the first day of work concurrent with the plan effective date. For example, if your 2024-2025 benefits become effective on November 1, 2024, you must be actively-at-work on November 1, 2024 to be eligible for your new benefits.

Dependent Eligibility Requirements

Dependent Eligibility: You can cover eligible dependent children under a benefit that offers dependent coverage, provided you participate in the same benefit, through the maximum age listed below. Dependents cannot be double covered by married spouses within the district as both employees and dependents.

PLAN	MAXIMUM AGE
Medical	To age 26
Hospital Indemnity	To age 26
Vision	To age 26
Dental	To age 26
Accident	To age 26
Life	To age 26
Cancer	To age 25
Critical Illness	To age 26
AD&D	To age 25

Please note, limits and exclusions may apply when obtaining coverage as a married couple or when obtaining coverage for dependents.

Potential Spouse Coverage Limitations: *When enrolling in coverage, please keep in mind that some benefits may not allow you to cover your spouse as a dependent if your spouse is enrolled for coverage as an employee under the same employer. Review the applicable plan documents, contact Higginbotham Public Sector, or contact the insurance carrier for additional information on spouse eligibility.*

FSA/HSA Limitations: *Please note, in general, per IRS regulations, married couples may not enroll in both a Flexible Spending Account (FSA) and a Health Savings Account (HSA). If your spouse is covered under an FSA that reimburses for medical expenses then you and your spouse are not HSA eligible, even if you would not use your spouse's FSA to reimburse your expenses. However, there are some exceptions to the general limitation regarding specific types of FSAs. To obtain more information on whether you can enroll in a specific type of FSA or HSA as a married couple, please reach out to the FSA and/or HSA provider prior to enrolling or reach out to your tax advisor for further guidance.*

Potential Dependent Coverage Limitations: *When enrolling for dependent coverage, please keep in mind that some benefits may not allow you to cover your eligible dependents if they are enrolled for coverage as an employee under the same employer. Review the applicable plan documents, contact Higginbotham Public Sector, or contact the insurance carrier for additional information on dependent eligibility.*

Disclaimer: *You acknowledge that you have read the limitations and exclusions that may apply to obtaining spouse and dependent coverage, including limitations and exclusions that may apply to enrollment in Flexible Spending Accounts and Health Savings Accounts as a married couple. You, the enrollee, shall hold harmless, defend, and indemnify Higginbotham Public Sector, LLC from any and all claims, actions, suits, charges, and judgments whatsoever that arise out of the enrollee's enrollment in spouse and/or dependent coverage, including enrollment in Flexible Spending Accounts and Health Savings Accounts.*

If your dependent is disabled, coverage may be able to continue past the maximum age under certain plans. If you have a disabled dependent who is reaching an ineligible age, you must provide a physician's statement confirming your dependent's disability. Contact your benefits department to request a continuation of coverage.

HSA vs. FSA

	Health Savings Account (HSA) (IRC Sec. 223)	Flexible Spending Account (FSA) (IRC Sec. 125)
Description	Approved by Congress in 2003, HSAs are actual bank accounts in employee's names that allow employees to save and pay for unreimbursed qualified medical expenses tax-free.	Allows employees to pay out-of-pocket expenses for copays, deductibles and certain services not covered by medical plan, tax-free. This also allows employees to pay for qualifying dependent care tax-free.
Employer Eligibility	A qualified high deductible health plan.	All employers
Contribution Source	Employee and/or employer	Employee and/or employer
Account Owner	Individual	Employer
Underlying Insurance Requirement	High deductible health plan	None
Minimum Deductible	$1,600 single (2024) $3,200 family (2024)	N/A
Maximum Contribution	$4,150 single (2024) $8,300 family (2024) 55+ catch up +$1,600	$3,200 (2024)
Permissible Use Of Funds	Employees may use funds any way they wish. If used for non-qualified medical expenses, subject to current tax rate plus 20% penalty.	Reimbursement for qualified medical expenses (as defined in Sec. 213(d) of IRC).
Cash-Outs of Unused Amounts (if no medical expenses)	Permitted, but subject to current tax rate plus 20% penalty (penalty waived after age 65).	Not permitted
Year-to-year rollover of account balance?	Yes, will roll over to use for subsequent year's health coverage.	No. Access to some funds may be extended if your employer's plan contains a 2 1/2 –month grace period or $610 rollover provision.
Does the account earn interest?	Yes	No
Portable?	Yes, portable year-to-year and between jobs.	No

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Medical Insurance
BCBS

EMPLOYEE BENEFITS

ABOUT MEDICAL

Major medical insurance is a type of health care coverage that provides benefits for a broad range of medical expenses that may be incurred either on an inpatient or outpatient basis.

For full plan details, please visit your benefit website:
www.mybenefitshub.com/laketravisisd

	Monthly Premium	District Contribution	Employee Cost
High Deductible Plan			
Employee Only	$570.00	$500.00	$70.00
Employee & Spouse	$1,247.00	$500.00	$747.00
Employee & Child(ren)	$1,097.00	$500.00	$597.00
Employee & Family	$1,472.00	$500.00	$972.00
Low Plan			
Employee Only	$791.00	$500.00	$291.00
Employee & Spouse	$1,359.00	$500.00	$859.00
Employee & Child(ren)	$1,254.00	$500.00	$754.00
Employee & Family	$1,715.00	$500.00	$1,215.00
High Plan			
Employee Only	$956.00	$500.00	$456.00
Employee & Spouse	$1,673.00	$500.00	$1,173.00
Employee & Child(ren)	$1,548.00	$500.00	$1,048.00
Employee & Family	$2,111.00	$500.00	$1,611.00

Medical Coverage

High Deductible Health Plan (HDHP)

High Deductible Health Plan (HDHP)	Premium Per Month	LTISD Contribution Per Month	Employee Total
Employee	$570.00	$500.00	$70.00
Employee + Spouse	$1,247.00	$500.00	$747.00
Employee + Children	$1,097.00	$500.00	$597.00
Employee + Family	$1,472.00	$500.00	$972.00

	In-Network	Out-of-Network
Annual Deductible	$3,500 / person $7,000 / family	$7,000 / person $14,000 / family
Out-of-Pocket Maximum	$6,900 / individual $13,800 / family	$13,800 / individual $27,600 / family
Office Visit Copayment	Deductible applies	Deductible applies
RX 90 Day	80% of allowable after deductible	80% of allowable after deductible
Mail Order Program	80% of allowable after deductible	80% of allowable after deductible

The participating pharmacies are HEB, Walmart, Walgreens, Randalls, Albertsons (and affiliates).

Drug Deductible and out-of-pocket is the same as the medical deductible and out-of-pocket. All benefits, including prescription drug benefits (retail and mail order) must apply to the plan's overall deductible and out-of-pocket maximum.

Information included in this section summarizes health and medical coverages provided by Blue Cross Blue Shield and is provided for general purposes only. HIPAA and Medicare information, as well as terms, coverages, exclusions, limitations, and other specifics defined in individual plan policies and contracts, can be obtained by contacting Blue Cross Blue Shield at **800-521-2227** or **bcbstx.com**.

Medical Coverage

Low Plan

Low Plan	Premium Per Month	LTISD Contribution Per Month	Employee Total
Employee	$791.00	$500.00	$291.00
Employee + Spouse	$1,359.00	$500.00	$859.00
Employee + Children	$1,254.00	$500.00	$754.00
Employee + Family	$1,715.00	$500.00	$1,215.00

	In-Network	Out-of-Network
Annual Deductible	$2,000 / Person $4,000 / Family	$250 / Admission deductible $2,500 / Person $5,000 / Family
Out-of-Pocket Maximum	$6,000 / Individual $12,000 / Family	$9,000 / Individual $15,000 / Family
Office Visit Copayment	$30 for PCP $50 Specialty Care	None
Generic (Retail, 30-day Supply)	$25 Copayment Amount	80% of Allowable Amount minus copay
Preferred, Brand Name (Retail, 30-day Supply)	$40 Copayment Amount	80% of Allowable Amount minus copay
Non-Preferred, Brand Name (Retail, 30-day Supply)	$55 Copayment Amount	80% of Allowable Amount minus copay
Speciality Drug	80% of Allowable Amount	80% of Allowable Amount

The participating pharmacies are HEB, Walmart, Walgreens, Randalls, Albertsons (and affiliates).

Drug Deductible and out-of-pocket is the same as the medical deductible and out-of-pocket. All benefits, including prescription drug benefits (retail and mail order) must apply to the plan's overall deductible and out-of-pocket maximum.

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Medical Coverage
High Plan

High Plan	Premium Per Month	LTISD Contribution Per Month	Employee Total
Employee	$956.00	$500.00	$456.00
Employee + Spouse	$1,673.00	$500.00	$1,173.00
Employee + Children	$1,548.00	$500.00	$1,048.00
Employee + Family	$2,111.00	$500.00	$1,611.00

	In-Network	Out-of-Network
Annual Deductible	$1,250 / Person $2,500 / Family	$250 / Admission deductible $1,725 / Person $3,500 / Family
Out-of-Pocket Maximum	$3,750 / Individual $7,500 / Family	$5,250 Individual $10,500 / Family
Office Visit Copayment	$25 for PCP	None
Generic (Retail, 30-day Supply)	$15 Copayment Amount	80% of Allowable Amount minus copay
Preferred, Brand Name (Retail, 30-day Supply)	$25 Copayment Amount	80% of Allowable Amount minus copay
Non-Preferred, Brand Name (Retail, 30-day Supply)	$40 Copayment Amount	80% of Allowable Amount minus copay
Speciality Drug	90% of Allowable Amount	80% of Allowable Amount

The participating pharmacies are HEB, Walmart, Walgreens, Randalls, Albertsons (and affiliates).

Drug Deductible and out-of-pocket is the same as the medical deductible and out-of-pocket. All benefits, including prescription drug benefits (retail and mail order) must apply to the plan's overall deductible and out-of-pocket maximum.

Information included in this section summarizes health and medical coverages provided by Blue Cross Blue Shield and is provided for general purposes only. HIPAA and Medicare information, as well as terms, coverages, exclusions, limitations, and other specifics defined in individual plan policies and contracts, can be obtained by contacting Blue Cross Blue Shield at **800-521-2227** or **bcbstx.com**.

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 www.bcbstx.com. 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?	In-Network: $3,500 Individual / $7,000 Family Out-of-Network: $7,000 Individual / $14,000 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. Certain preventive care is 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $6,900 Individual / $13,800 Family Out-of-Network: $13,800 Individual / $27,600 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		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	40% coinsurance	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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Generic drugs	20% preferred retail 25% participating retail 20% mail order coinsurance	25% coinsurance	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. For Out-of-Network pharmacy, member must file claim.
	Preferred brand drugs	20% preferred retail 30% participating retail 20% mail order coinsurance	30% coinsurance	
	Non-preferred brand drugs	20% preferred retail 30% participating retail 20% mail order coinsurance	30% coinsurance	
	Specialty drugs	20% coinsurance	Not Covered	Specialty drugs must be obtained from In-Network specialty pharmacy provider. Specialty retail limited to a 30-day supply. Mail order is not covered.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	Facility Charges: 20% coinsurance ER Physician Charges: 20% coinsurance	Facility Charges: 20% coinsurance ER Physician Charges: 20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground and air transportation covered.
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Certain services must be preauthorized; refer to your benefit booklet* for details.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	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 www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 25 days per calendar year. Preauthorization is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	40% coinsurance	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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 (diagnosis of infertility covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (with the exception of person with diagnosis of diabetes)
- 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 (limited to 35 visits per calendar year)
- 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 www.bcbstx.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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 www.bcbstx.com. 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: $2,000 Individual / $4,000 Family For Out-of-Network: $2,500 Individual / $5,000 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, inpatient hospital expenses, emergency room services, and In-Network preventive care, diagnostic test, 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Per occurrence: $250 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: $6,000 Individual / $12,000 Family For Out-of-Network: $9,000 Individual / $15,000 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, preauthorization penalties, balance-billing charges, 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		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit; deductible does not apply	40% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	$50 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	40% coinsurance	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	Office visit copay may apply.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Generic drugs	$25 preferred retail $30 participating retail $25 mail order copay/prescription; deductible does not apply	$30 copay/prescription plus 20% coinsurance; deductible does not apply	Retail and mail order cover a 30-day supply. With appropriate prescription, up to a 90-day supply is available. 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.
	Preferred brand drugs	$40 preferred retail $50 participating retail $40 mail order copay/prescription; deductible does not apply	$50 copay/prescription plus 20% coinsurance; deductible does not apply	
	Non-preferred brand drugs	$55 preferred retail $65 participating retail $55 mail order copay/prescription; deductible does not apply	$65 copay/prescription plus 20% coinsurance; deductible does not apply	
	Specialty drugs	20% coinsurance; deductible does not apply	Not Covered	Specialty drugs must be obtained from In-Network specialty pharmacy provider. Specialty retail limited to a 30-day supply. Mail order is not covered.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	Facility Charges: $300 copay/visit plus 20% coinsurance; deductible does not apply ER Physician Charges: 20% coinsurance	Facility Charges: $300 copay/visit plus 20% coinsurance; deductible does not apply ER Physician Charges: 20% coinsurance	Emergency room copay waived if admitted. If admitted, inpatient hospital expenses will apply.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground and air transportation covered.
	Urgent care	$75 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance; deductible does not apply	40% coinsurance; deductible does not apply	Plan deductible does not apply; a per-admission deductible of $250 applies Out-of-Network. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit; deductible does not apply 20% coinsurance for other outpatient services	40% coinsurance	Certain services must be preauthorized; refer to your benefit booklet* for details.
	Inpatient services	20% coinsurance; deductible does not apply	40% coinsurance; deductible does not apply	Plan deductible does not apply; a per-admission deductible of $250 applies Out-of-Network. 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 www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$30 PCP / $50 SPC copay/visit; deductible does not apply	40% coinsurance	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 services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance; deductible does not apply	40% coinsurance; deductible does not apply	Plan deductible does not apply; a per-admission deductible of $250 applies Out-of-Network. 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	Limited to 60 visits per calendar year. Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	No Charge; deductible does not apply	40% coinsurance	Limited to 25 days per calendar year. Preauthorization is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	No Charge; deductible does not apply	40% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$30 PCP / $50 SPC copay/visit; deductible does not apply	40% coinsurance	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

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 (diagnosis of infertility covered)
- Long-term care
- 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 (limited to 35 visits per calendar year)
- Hearing aids (limited to 1 per ear per 36-month period)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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 www.bcbstx.com. 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: $1,250 Individual / $2,500 Family For Out-of-Network: $1,725 Individual / $3,500 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, inpatient hospital expenses, emergency room services, and In-Network preventive care, diagnostic test, 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Per occurrence: $250 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: $3,750 Individual / $7,500 Family For Out-of-Network: $5,250 Individual / $10,500 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, preauthorization penalties, balance-billing charges, 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		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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	30% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	$25 copay/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance	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	30% coinsurance	Office visit copay may apply.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Generic drugs	$15 preferred retail $20 participating retail $15 mail order copay/prescription; deductible does not apply	$20 copay/prescription plus 20% coinsurance; deductible does not apply	Retail and mail order cover a 30-day supply. With appropriate prescription, up to a 90-day supply is available. 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.
	Preferred brand drugs	$25 preferred retail $35 participating retail $25 mail order copay/prescription; deductible does not apply	$35 copay/prescription plus 20% coinsurance; deductible does not apply	
	Non-preferred brand drugs	$40 preferred retail $50 participating retail $40 mail order copay/prescription; deductible does not apply	$50 copay/prescription plus 20% coinsurance; deductible does not apply	
	Specialty drugs	10% coinsurance; deductible does not apply	Not Covered	Specialty drugs must be obtained from In-Network specialty pharmacy provider. Specialty retail limited to a 30-day supply. Mail order is not covered.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	Facility Charges: $300 copay/visit plus 10% coinsurance; deductible does not apply ER Physician Charges: 10% coinsurance	Facility Charges: $300 copay/visit plus 10% coinsurance; deductible does not apply ER Physician Charges: 10% coinsurance	Emergency room copay waived if admitted. If admitted, inpatient hospital expenses will apply.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Ground and air transportation covered.
	Urgent care	$50 copay/visit; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance; deductible does not apply	30% coinsurance; deductible does not apply	Plan deductible does not apply; a per-admission deductible of $250 applies Out-of-Network. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit; deductible does not apply 10% coinsurance for other outpatient services	30% coinsurance	Certain services must be preauthorized; refer to your benefit booklet* for details.
	Inpatient services	10% coinsurance; deductible does not apply	30% coinsurance; deductible does not apply	Plan deductible does not apply; a per-admission deductible of $250 applies Out-of-Network. 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 www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$25 copay/visit; deductible does not apply	30% coinsurance	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 services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance; deductible does not apply	30% coinsurance; deductible does not apply	Plan deductible does not apply; a per-admission deductible of $250 applies Out-of-Network. 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	30% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required.
	Rehabilitation services	10% coinsurance	30% coinsurance	None
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	No Charge; deductible does not apply	30% coinsurance	Limited to 25 days per calendar year. Preauthorization is required.
	Durable medical equipment	10% coinsurance	30% coinsurance	None
	Hospice services	No Charge; deductible does not apply	30% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$25 copay/visit; deductible does not apply	30% coinsurance	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

& Other Covered Services:

Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other exclu

- Dental care (Adult)
- Infertility treatment (diagnosis of infertility covered)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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Download your Clever RX card or Clever RX App to unlock exclusive savings.

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FREE to use. Save up to 80% off prescription drugs and beat copay prices.

STEP 1:

Download the FREE Clever RX App. From your App Store search for "Clever RX" and hit download. Make sure you enter in Group ID **1085** and in Member ID **1111** during the on-boarding process. This will unlock exclusive savings for you and your family!

STEP 2:

Find where you can save on your medication. Using your zip code, when you search for your medication Clever RX checks which pharmacies near you offer the lowest price. Savings can be up to 80% compared to what you're currently paying.

STEP 3:

Click the voucher with the lowest price, closest location, and/or at your preferred pharmacy. Click "share" to text yourself the voucher for easy access when you are ready to use it. Show the voucher on your screen to the pharmacist when you pick up your medication.

STEP 4:

Share the Clever RX App. Click "Share" on the bottom of the Clever RX App to send your friends, family, and anyone else you want to help receive instant discounts on their prescription medication. Over 70% of people can benefit from a prescription savings card.

NOW THAT IS NOT ONLY CLEVER, IT IS CLEVER RX.

DID YOU KNOW?

70%

Over 70% of people can benefit from a prescription savings card due to high deductible health plans, high copays, and being underinsured or uninsured.

30%

Over 30% of prescriptions never get filled due to high costs.

40%

40% of the top ten most prescribed drugs have increased in cost by over 100%

70%

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Health Savings Account (HSA)
EECU

ABOUT HSA

A Health Savings Account (HSA) is a personal savings account where the money can only be used for eligible medical expenses. Unlike a flexible spending account (FSA), the money rolls over year to year however only those funds that have been deposited in your account can be used. Contributions to a Health Savings Account can only be used if you are also enrolled in a High Deductible Health Care Plan (HDHP).

For full plan details, please visit your benefit website:
www.mybenefitshub.com/laketravisisd

A Health Savings Account (HSA) is more than a way to help you and your family cover health care costs – it is also a tax-exempt tool to supplement your retirement savings and cover health expenses during retirement. An HSA can provide the funds to help pay current health care expenses as well as future health care costs.

A type of personal savings account, an HSA is always yours even if you change health plans or jobs. The money in your HSA (including interest and investment earnings) grows tax-free and spends tax-free if used to pay for qualified medical expenses. There is no "use it or lose it" rule — you do not lose your money if you do not spend it in the calendar year — and there are no vesting requirements or forfeiture provisions. The account automatically rolls over year after year.

HSA Eligibility

You are eligible to open and contribute to an HSA if you are:

- Enrolled in an HSA-eligible HDHP (High Deductible Health Plan) Not covered by another plan that is not a qualified HDHP, such as your spouse's health plan
- Not enrolled in a Health Care Flexible Spending Account, nor should your spouse be contributing towards a Health Care Flexible Spending Account
- Not eligible to be claimed as a dependent on someone else's tax return
- Not enrolled in Medicare or TRICARE
- Not receiving Veterans Administration benefits

You can use the money in your HSA to pay for qualified medical expenses now or in the future. You can also use HSA funds to pay health care expenses for your dependents, even if they are not covered under your HDHP.

Maximum Contributions

Your HSA contributions may not exceed the annual maximum amount established by the Internal Revenue Service. The annual contribution maximum for 2024 is based on the coverage option you elect:

- Individual – $4,150
- Family (filing jointly) – $8,300

You decide whether to use the money in your account to pay for qualified expenses or let it grow for future use. If you are 55 or older, you may make a yearly catch-up contribution of up to $1,000 to your HSA. If you turn 55 at any time during the plan year, you are eligible to make the catch-up contribution for the entire plan year.

Opening an HSA

If you meet the eligibility requirements, you may open an HSA administered by EECU. You will receive a debit card to manage your HSA account reimbursements. Keep in mind, available funds are limited to the balance in your HSA.

Important HSA Information

- Always ask your health care provider to file claims with your medical provider so network discounts can be applied. You can pay the provider with your HSA debit card based on the balance due after discount.
- You, not your employer, are responsible for maintaining ALL records and receipts for HSA reimbursements in the event of an IRS audit.
- You may open an HSA at the financial institution of your choice, but only accounts opened through EECU are eligible for automatic payroll deduction and company contributions.

How To Use Your HSA

- Online/Mobile: Sign-in for 24/7 account access to check your balance, pay bills and more.
- Call/Text: (817) 882-0800 EECU's dedicated member service representatives are available to assist you with any questions. Their hours of operation are Monday through Friday from 8:00 a.m. to 7:00 p.m. CT, Saturday 9:00 a.m. to 1:00 p.m. CT and closed on Sunday.
- Lost/Stolen Debit Card: Call the 24/7 debit card hotline at (800) 333-9934.
- Stop by a local EECU financial center: www.eecu.org/locations.

Hospital Indemnity
Aetna

EMPLOYEE BENEFITS

ABOUT HOSPITAL INDEMNITY

This is an affordable supplemental plan that pays you should you be in-patient hospital confined. This plan complements your health insurance by helping you pay for costs left unpaid by your health insurance.

For full plan details, please visit your benefit website:
www.mybenefitshub.com/laketravisisd

Inpatient Stays

Covered Benefit	Low	High
Hospital stay - Admission Provides a lump sum benefit for the initial day of your stay in a hospital. *No Maximum stays per plan year; separated by 30 days in a row*	$750	$1,500
Hospital stay - Daily Pays a daily benefit, beginning on day one of your stay in a non-ICU room of a hospital. *Maximum 30 days per plan year*	$50	$100
Hospital stay - (ICU) Daily Pays a daily benefit, beginning on day one of your stay in an ICU room of a hospital. *Maximum 30 days per plan year*	$100	$200
Newborn routine care Provides a lump-sum benefit after the birth of your newborn. This will not pay for an outpatient birth.	$100	$100
Observation unit Provides a lump sum benefit for the initial day of your stay in an observation unit as the result of an illness or accidental injury. *Maximum 1 day per plan year*	$100	$100
Substance abuse stay - Daily Pays a daily benefit for each day you have a stay in a hospital or substance abuse treatment facility for the treatment of substance abuse. *Maximum 30 days per plan year*	$50	$100
Mental disorder stay - Daily Pays a daily benefit for each day you have a stay in a hospital or mental disorder treatment facility for the treatment of mental disorders. *Maximum 30 days per plan year*	$50	$100
Rehabilitation unit stay - Daily Pays a benefit each day of your stay in a rehabilitation unit immediately after your hospital stay due to an illness or accidental injury. *Maximum 30 days per plan year*	$25	$50

Important Note: All daily inpatient stay benefits begin on day one and count toward the plan year maximum.

Hospital Indemnity
Aetna

Do I have to be actively at work to enroll in coverage?
Yes, you must be actively at work in order to enroll and for coverage to take effect. You are actively at work if you are working, or are available to work, and meet the criteria set by your employer to be eligible to enroll.

Can I enroll in the Aetna Hospital Indemnity plan even though I have a Health Savings Account (HSA)?
Yes, you can still enroll in the Aetna Hospital Indemnity plan if you have a Health Savings Account.

What is considered a hospital stay?
A stay is a period during which you are admitted as an inpatient; and are confined in a: hospital, non-hospital residential facility, rehabilitation facility; and are charged for room, board and general nursing services. A stay does not include time in the hospital because of custodial or personal needs that do not require medical skills or training. A stay specifically excludes time in the hospital for observation or in the emergency room unless this leads to a stay.
If I lose my employment, can I take the Hospital Indemnity Plan with me?
Yes, you are able to continue coverage under the portability provision. You will need to pay premiums directly to Aetna.

How do I file a claim?
Go to myaetnasupplemental.com and either “Log In” or “Register”, depending on if you’ve set up your account. Click the “Create a new claim” button and answer a few quick questions. You can even save your claim to finish later. You can also print/mail in form(s) to: Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512- 4079, or you can ask us to mail you a printed form.

What should I do in case of an emergency?
In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

What if I don’t understand something I’ve read here, or have more questions?
Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives Monday through Friday, 8 a.m. to 6 p.m., by calling 1-800-607-3366.

Hospital Indemnity		
	LOW	HIGH
Employee Only	$8.83	$17.24
Employee and Spouse	$18.64	$36.61
Employee and Child(ren)	$13.94	$27.13
Employee and Family	$22.35	$43.63

Dental Insurance
MetLife

EMPLOYEE BENEFITS

ABOUT DENTAL

Dental insurance is a coverage that helps defray the costs of dental care. It insures against the expense of routine care, dental treatment and disease.

For full plan details, please visit your benefit website:
www.mybenefitshub.com/laketravisisd

Network: PDP Plus	Plan Option 1: Low Plan		Plan Option 2: High Plan	
	In-Network % of Negotiated Fee	Out-of-Network Scheduled Amount	In-Network % of Negotiated Fee	Out-of-Network 90% of R&C Fee
Coverage Type				
Type: Preventive (cleanings, exams, X-rays)	100%	100%	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%	80%	80%
Type C: Major Restorative (bridges, dentures)	25%	25%	50%	50%
Type D: Orthodontia	Not Covered	Not Covered	50%	50%
Deductible				
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
Annual Maximum Benefit				
Per Person	$750	$750	$1,000	$1,000
Orthodontia Lifetime Maximum				
Per Person	Not Covered	Not Covered	$1,000	$1,000

Child(ren)'s eligibility for dental coverage is from birth up to age 26.
Late-enrollment waiting period: There is a one-year waiting period for all services following date of request.

Plan Type	Plan Option 1: Low Plan How Many/How Often	Plan Option 2: High Plan How Many/How Often
Type A — Preventive		
Prophylaxis (cleanings)	Two per 12 months	
Oral Examinations	Two exams per 12 months	
Topical Fluoride Applications	Two fluoride treatment per 12 months for dependent children up to his/her 19th birthday	
Sealants	One 1st /2nd molar per lifetime for dependent children up to his/her 16th birthday	One per molar per lifetime for dependent children up to his/her 16th birthday
Space Maintainers	One per lifetime for dependent children up to his/her 19th birthday	

Dental Insurance
MetLife

EMPLOYEE BENEFITS

Type B — Basic Restorative		
Fillings	Amalgam; One replacement per surface per 24 months	
X-rays	Full mouth X-rays; one per 60 months	
Type C — Major Restorative		
Simple Extractions		
Crown, Denture and Bridge Repair	Two per 12 months	Two per 12 months
Recementations		
Oral Surgery		
Implants	Replacement once every 5 years	Replacement once every 5 years
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; one in 60 months • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed	
Crowns, Inlays and Onlays	Replacement once every 5 calendar years	
Endodontics	Root canal treatment limited to once per tooth per lifetime	
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services	
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 24 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year	
Type D — Orthodontia	Not Covered	• You, your spouse and your children, up to age 19, are covered while Dental insurance is in effect • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia • Payments are on a repetitive basis • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary • Orthodontic benefits end at cancellation of coverage

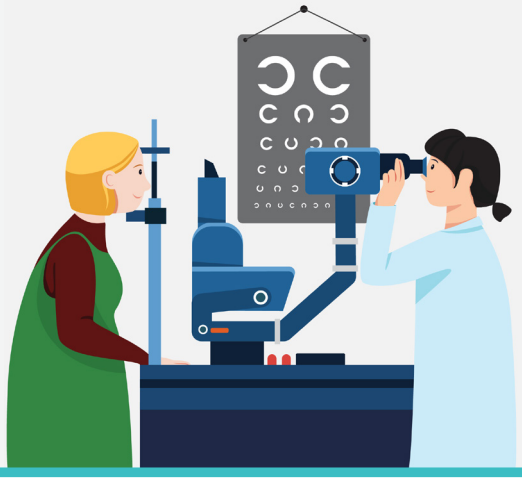
Dental		
	Low Plan	**High Plan**
Employee Only	$18.44	$44.48
Employee and Spouse	$36.90	$85.43
Employee and Child(ren)	$49.46	$110.77
Employee and Family	$78.27	$151.69

Vision Insurance
EyeMed

ABOUT VISION

Vision insurance provides coverage for routine eye examinations and can help with covering some of the costs for eyeglass frames, lenses or contact lenses.

For full plan details, please visit your benefit website:
www.mybenefitshub.com/laketravisisd



Schedule of Benefits		
VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	*$10 copay*	*Up to $40*
Retinal Imaging	*Up to $39*	*Not Covered*
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up- Standard	*Up to $40; contact lens fit and two follow-up visits*	*Not covered*
Fit and Follow-up- Premium	*10% off retail price*	*Not covered*
FRAME		
Frame	*$0 copay; 20% off balance over $130 allowance*	*Up to $65*
STANDARD PLASTIC LENSES		
Single Vision	*$25 copay*	*Up to $30*
Bifocal	*$25 copay*	*Up to $50*
Trifocal / Lenticular	*$25 copay*	*Up to $70*
Progressive- Standard	*$80 copay*	*Up to $50*
Progressive- Premium Tier 1- 4	*$110 - 240*	*Up to $50*
LENS OPTIONS		
Anti Reflective Coating- Standard	*$45 copay*	*Up to $23*
Anti Reflective Coating- Premium Tier 1- 3	*$57 - 100*	*Up to $23*
Photochromic- Non-Glass	*$75*	*Not covered*

INDEPENDENT PROVIDER NETWORK + OPTICAL PEARLE VISION LENSCRAFTERS

Vision Insurance
EyeMed

EMPLOYEE BENEFITS

ABOUT VISION

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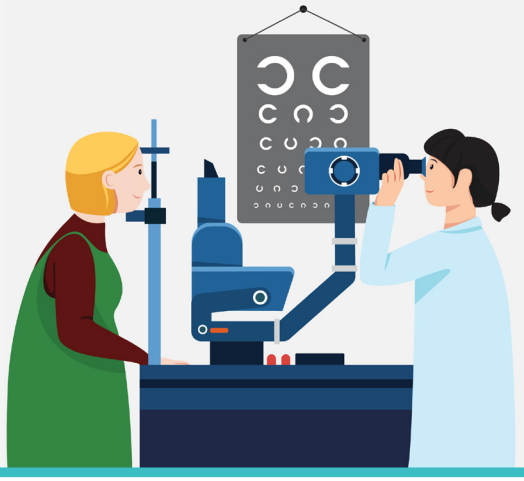


Schedule of Benefits		
Polycarbonate- Standard	*$40*	*Not covered*
Polycarbonate- Std < 19 years of age	*$0 copay*	*Up to $20*
Scratch Coating	*$15*	*Not covered*
Tint	*$0 copay*	*Up to $8*
UV Treatment	*$15*	*Not covered*
All Other Lens Options	*20% off retail price*	*Not covered*
CONTACT LENSES		*Up to $65*
Contacts- Conventional	*$0 copay; 15% off balance over $130 allowance*	*Up to $65*
Contacts- Disposable	*$0 copay; 100% of balance over $130 allowance*	*Up to $65*
Contacts- Medically Necessary	*$0 copay; paid-in-full*	*Up to $300*
OTHER		
Hearing Care from Amplifon Network	*Discounts on hearing aids; call 1.877.203.0675*	*Not covered*
Lasik or PRK from U.S. Laser Network	*15% off retail or 5% off promo price; call 1.800.988.4221*	*Not covered*

40% OFF
additional complete pair of prescrption eyeglasses

20% OFF
non-covered items, including non-prescription sunglasses

Vision	Monthly Premium
Employee Only	$5.91
Employee and Spouse	$11.23
Employee and Child(ren)	$11.82
Employee and Family	$17.40

Frequency

Exam
once every plan year

Frame
once every plan year

Lens
once every plan year

Contact Lens
once every plan year

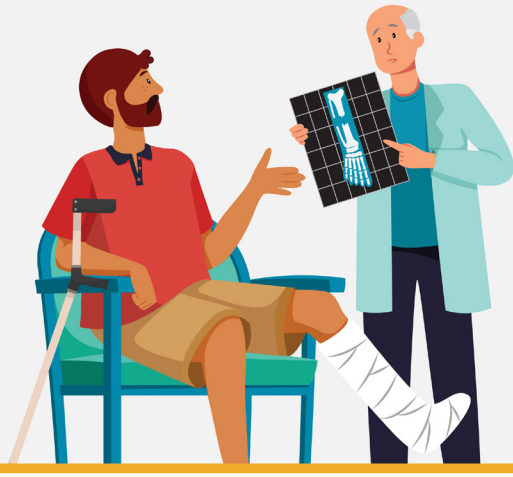
(Plan allows member to receive either contacts and frame, or frames and lens services)

Disability Insurance
The Hartford

EMPLOYEE BENEFITS

ABOUT DISABILITY

Disability insurance protects one of your most valuable assets, your paycheck. This insurance will replace a portion of your income in the event that you become physically unable to work due to sickness or injury for an extended period of time.



For full plan details, please visit your benefit website:
www.mybenefitshub.com/laketravisisd

What is Educator Disability Insurance?

Educator Disability insurance is a hybrid that combines features of short-term and long-term disability into one plan. Disability insurance provides partial income protection if you are unable to work due to a covered accident or illness. The plan gives you flexibility to be able to choose an amount of coverage and waiting period that suits your needs. We offer Educator Disability insurance for you to purchase through The Hartford.

If you need to file a claim, contact TheHartford at 866-278-2655. Full instructions can be found at www.mybenefitshub.com/laketravisisd

Actively at Work: You must be at work with your Employer on your regularly scheduled workday. On that day, you must be performing for wage or profit all of your regular duties in the usual way and for your usual number of hours. If school is not in session due to normal vacation or school break(s), Actively at Work shall mean you are able to report for work with your Employer, performing all of the regular duties of Your Occupation in the usual way for your usual number of hours as if school was in session.

Benefit Amount: You may purchase coverage that will pay you a monthly flat dollar benefit in $100 increments between $200 and $8,000 that cannot exceed 66 2/3% of your current monthly earnings. Earnings are defined in The Hartford's contract with your employer.

Elimination Period: You must be disabled for at least the number of days indicated by the elimination period that you select before you can receive a Disability benefit payment. The elimination period that you select consists of two numbers. The first number shows the number of days you must be disabled by an accident before your benefits can begin. The second number indicates the number of days you must be disabled by a sickness before your benefits can begin.

For those employees electing an elimination period of 30 days or less, if you are confined to a hospital for 24 hours or more due to a disability, the elimination period will be waived, and benefits will be payable from the first day of hospitalization.

Definition of Disability: Disability is defined as The Hartford's contract with your employer. Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical conditions covered by the insurance, and as a result, your current monthly earnings are 80% or less of your pre-disability earnings. One you have been disabled for 24 months, you must be prevented from performing one or more essential duties of any occupation, and as a result, your monthly earnings are 66 2/3% or less of your pre-disability earnings.

Pre-Existing Condition Limitation: Your policy limits the benefits you can receive for a disability caused by a pre-existing condition. In general, if you were diagnosed or received care for a disabling condition within the 3 consecutive months just prior to the effective date of this policy, your benefit payment will be limited, unless: You have not received treatment for the disabling condition within 3 months, while insured under this policy, before the disability begins, or You have been insured under this policy for 12 months before your disability begins. *If your disability is a result of a pre-existing condition, we will pay benefits for a maximum of 1 month.*

Maximum Benefit Duration: Benefit Duration is the maximum time for which we pay benefits for disability resulting from sickness or injury. Depending on the schedule selected and the age at which disability occurs, the maximum duration may vary. Please see the applicable schedules on the plan summary document that can be found at www.mybenefitshub.com/laketravisisd for full details.

Benefit Integration: Your benefit may be reduced by other income you receive or are eligible to receive due to your disability, such as:

- Social Security Disability Insurance
- State Teacher Retirement Disability Plans
- Workers' Compensation
- Other employer-based disability insurance coverage you may have
- Unemployment benefits
- Retirement benefits that your employer fully or partially pays for (such as a pension plan)

Educator Disability - Definitions

What is disability insurance? Disability insurance protects one of your most valuable assets, your paycheck. This insurance will replace a portion of your income in the event that you become physically unable to work due to sickness or injury for an extended period of time. This type of disability plan is called an educator disability plan and includes both long and short term coverage into one convenient plan.

Pre-Existing Condition Limitations - Please note that all plans will include pre-existing condition limitations that could impact you if you are a first-time enrollee in your employer's disability plan. This includes during your initial new hire enrollment. Please review your plan details to find more information about pre-existing condition limitations.

How do I choose which plan to enroll in during my open enrollment?

1. First choose your elimination period. The elimination period, sometimes referred to as the waiting period, is how long you are disabled and unable to work before your benefit will begin. This will be displayed as 2 numbers such as 0/7, 14/14, 30/30, 60/60, 90/90, etc.

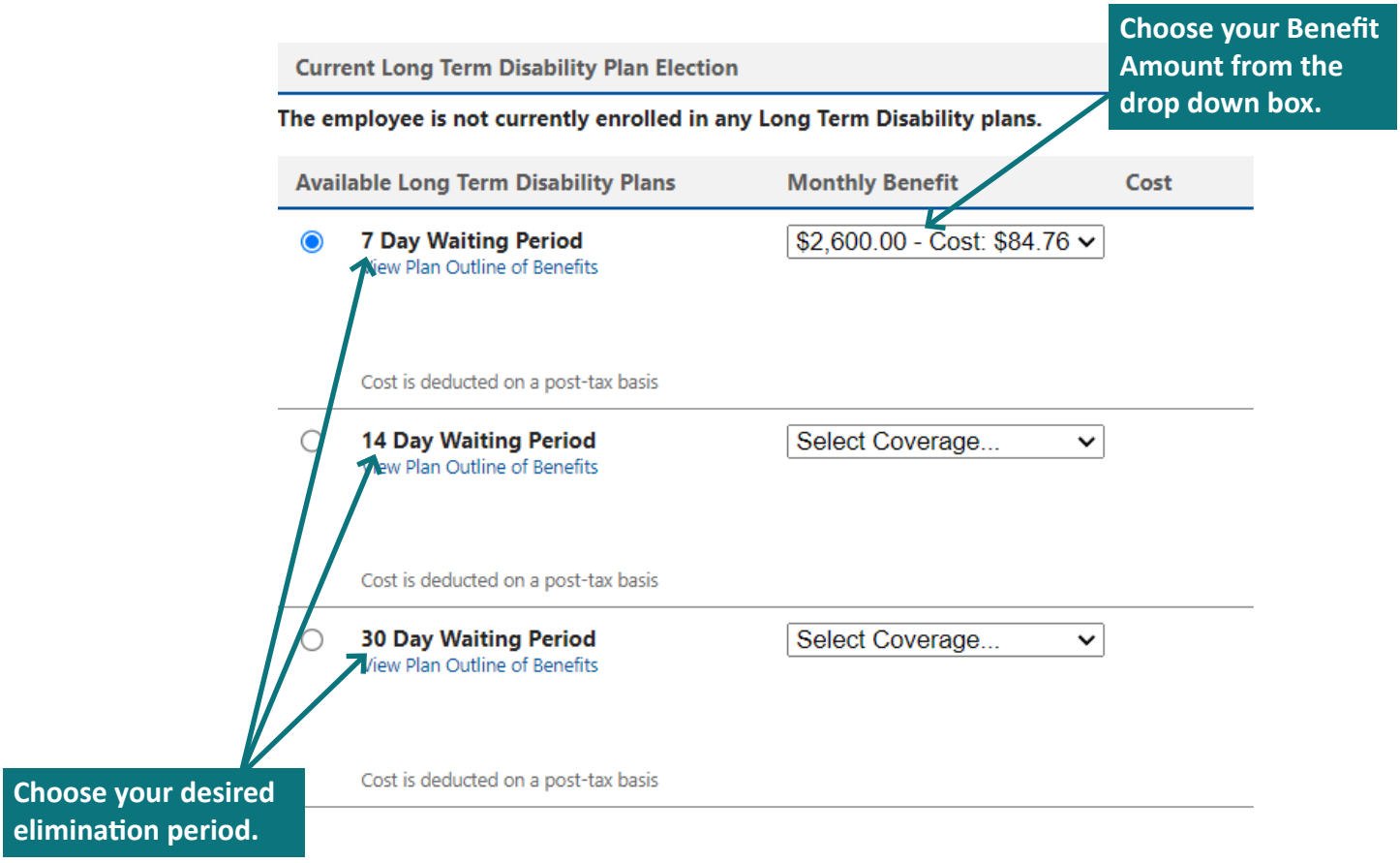
   The first number indicates the number of days you must be disabled due to ***Injury*** and the second number indicates the number of days you must be disabled due to ***Sickness***.

   When choosing your elimination period, ask yourself, "How long can I go without a paycheck?" Based on the answer to this question, choose your elimination period accordingly.

   Important Note- some plans will waive the elimination period if you choose 30/30 or less and you are confined as an inpatient to the hospital for a specific time period. Please review your plan details to see if this feature is available to you.

2. Next choose your benefit amount. This is the maximum amount of money you would receive from the carrier on a monthly basis once your disability claim is approved by the carrier.

   When choosing your monthly benefit, ask yourself, "How much money do I need to be able to pay my monthly expenses?" Based on the answer to this question, choose your monthly benefit accordingly.



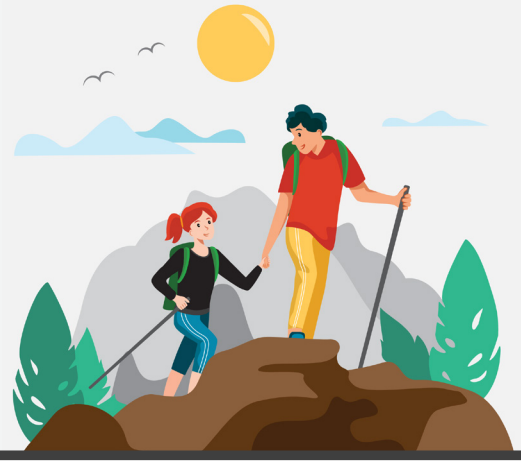
Accident Insurance
MetLife

EMPLOYEE BENEFITS

ABOUT ACCIDENT

Do you have kids playing sports, are you a weekend warrior, or maybe accident prone? Accident plans are designed to help pay for medical costs associated with accidents and benefits are paid directly to you.

For full plan details, please visit your benefit website:
www.mybenefitshub.com/laketravisisd



Benefit Type	Low Plan Benefits	High Plan Benefits
Accidental Injury Benefits		
Fracture Benefit	$100 – $8,000 depending on the fracture and type of repair	$200 – $10,000 depending on the fracture and type of repair
Dislocation Benefit	$100 – $8,000 depending on the dislocation and type of repair	$200 – $10,000 depending on the dislocation and type of repair
Second or Third Degree Burn Benefit	$75 – $10,000 depending on the degree of the burn and the percentage of burnt skin	$100 – $15,000 depending on the degree of the burn and the percentage of burnt skin
Concussion Benefit	$250	$500
Coma Benefit	$7,500	$12,500
Laceration Benefit	$50 – $400 depending on the length of the cut and type of repair	$75 – $700 depending on the length of the cut and type of repair
Broken Tooth Benefit	Crown: $200 Filling: $25 Extraction: $100	Crown: $300 Filling: $50 Extraction: $150
Eye Injury Benefit	$300	$400
Accident - Medical Services & Treatment Benefits		
Ambulance Benefit	Ground: $300 Air: $1,000	Ground: $400 Air: $1,500
Emergency Care Benefit	$75 – $150 depending on location of care	$100 – $200 depending on location of care
Non-Emergency Initial Care Benefit	$75	$100
Physician Follow-Up Visit Benefit	$75	$100
Therapy Services Benefit (including physical therapy)	$35	$50
Medical Testing Benefit	$150	$200
Medical Appliance Benefit	$75 – $750 depending on the appliance	$150 – $1,000 depending on the appliance
Transportation Benefit	$300	$600
Pain Management Benefit (for epidural anesthesia)	$75	$100

Accident Insurance
MetLife

Prosthetic Device Benefit	One device: $750 More than one device: $1,500	One device: $1,000 More than one device: $2,000
Modification Benefit	$1,000	$1,500
Blood/Plasma/Platelets Benefit	$400	$500
Surgical Repair Benefit	$150 – $1,500 depending on the type of surgery	$200 – $2,000 depending on the type of surgery
Exploratory Surgery Benefit	$150	$200
Other Outpatient Surgery Benefit	$300	$400
Hospital Benefits		
Admission Benefit	$1,000 for the day of admission	$1,500 for the day of admission
ICU Supplemental Admission Benefit	$1,000 for the day of admission	$2,000 for the day of admission
Confinement Benefit (paid for up to 365 days per accident)	$200 per day	$300 per day
ICU Supplemental Confinement Benefit (paid for up to 15 days per accident)	$200 per day	$300 per day
Inpatient Rehabilitation Benefit (paid for up to 15 days per accident)	$150 per day	$200 per day
Accidental Death Benefit		
Accidental Death Benefit	$25,000 $75,000 for accidental death on common carrier	$50,000 $150,000 for accidental death on common carrier
Accidental Dismemberment, Functional Loss & Paralysis Benefits		
Dismemberment/Functional Loss	$750 – $20,000 depending on the injury	$1,000 – $40,000 depending on the injury
Paralysis	$10,000 – $20,000 depending on the number of limbs	$20,000 – $40,000 depending on the number of limbs
Other Benefits		
Health Screening Benefit- benefit provided for certain screening/prevention tests	$50 Paid 1 time per calendar year	$50 Paid 1 time per calendar year
Lodging Benefit- for a companion of a covered person who is hospitalized	$100 per day	$200 per day
Waiver of Premium Benefit – if you become disabled, premiums will be waived if requirements for waiver are met	Not Included	Not Included

Accident		
	Low Plan	High Plan
Employee Only	$6.12	$10.83
Employee and Spouse	$10.28	$17.92
Employee and Child(ren)	$11.48	$20.90
Employee and Family	$18.16	$32.77

Critical Illness Insurance
MetLife

EMPLOYEE BENEFITS

ABOUT CRITICAL ILLNESS

Critical illness insurance can be used towards medical or other expenses. It provides a lump sum benefit payable directly to the insured upon diagnosis of a covered condition or event, like a heart attack or stroke. The money can also be used for non-medical costs related to the illness, including transportation, child care, etc.

For full plan details, please visit your benefit website:
www.mybenefitshub.com/laketravisisd

Eligible Individual	Benefit Amount	Requirements
Coverage Options		
Employee	$5,000, $10,000, $15,000, $20,000, $25,000, $30,000, $35,000, $40,000, $45,000 or $50,000	Coverage is guaranteed provided you are actively at work.
Spouse	50% 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.
Dependent Child(ren)	50% 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.

Benefit Payment

Your plan pays a lump-sum Initial Benefit upon the first verified diagnosis of a Covered Condition. Your plan also pays a lump- sum Recurrence Benefit for a subsequent verified diagnosis of certain Covered Conditions as shown in the table below. A Recurrence Benefit is only available if an Initial Benefit has been paid for the same Covered Condition. There is a Benefit Suspension Period that applies to Recurrence Benefits. In addition, there is a Benefit Suspension Period that applies to Initial Benefits for different conditions. Please refer to the table below for the percentage benefit payable for each Covered Condition.

Covered Conditions	Initial Benefit	Recurrence Benefit
Benign Tumor Category		
Benign Brain Tumor	100% of Benefit Amount	100% of Initial Benefit
Cancer Category		
Invasive Cancer	100% of Benefit Amount	100% of Initial Benefit
Non-Invasive Cancer	25% of Benefit Amount	100% of Initial Benefit
Skin Cancer	5% of Benefit Amount, but not less than $250	NONE
Coronary Artery Disease Category		
Coronary Artery Bypass Graft (CABG)- where surgery involving either a median sternotomy or minimally invasive procedure is performed	50% of Benefit Amount	100% of Initial Benefit
Childhood Disease Category		
Cerebral Palsy	100% of Benefit Amount	NONE
Cleft Lip or Cleft Palate	100% of Benefit Amount	NONE
Cystic Fibrosis	100% of Benefit Amount	NONE
Diabetes (Type 1)	100% of Benefit Amount	NONE
Down Syndrome	100% of Benefit Amount	NONE
Sickle Cell Anemia	100% of Benefit Amount	NONE
Spina Bifida	100% of Benefit Amount	NONE

Critical Illness Insurance
MetLife

Functional Loss Category		
Coma	100% of Benefit Amount	100% of Initial Benefit
Loss of: Ability to Speak; Hearing; or Sight	100% of Benefit Amount	NONE
Paralysis of 2 or more limbs	100% of Benefit Amount	NONE
Heart Attack Category		
Heart Attack	100% of Benefit Amount	100% of Initial Benefit
Sudden Cardiac Arrest	50% of Benefit Amount	NONE
Infectious Disease Category		
Bacterial Cerebrospinal Meningitis	25% of Benefit Amount	NONE
Diphtheria	25% of Benefit Amount	NONE
Encephalitis	25% of Benefit Amount	NONE
Legionnaire's Disease	25% of Benefit Amount	NONE
Malaria	25% of Benefit Amount	NONE
Necrotizing Fasciitis	25% of Benefit Amount	NONE
Osteomyelitis	25% of Benefit Amount	NONE
Rabies	25% of Benefit Amount	NONE
Tetanus	25% of Benefit Amount	NONE
Tuberculosis	25% of Benefit Amount	NONE
Kidney Failure Category		
Kidney Failure	100% of Benefit Amount	NONE
Major Organ Transplant Category		
Major Organ Transplant- For bone marrow, heart, lung, pancreas, and liver	100% of Benefit Amount	NONE
Progressive Disease Category		
ALS	100% of Benefit Amount	NONE
Alzheimer's Disease	100% of Benefit Amount	NONE
Multiple Sclerosis	100% of Benefit Amount	NONE
Muscular Dystrophy	100% of Benefit Amount	NONE
Parkinson's Disease (Advanced)	100% of Benefit Amount	NONE
Systemic Lupus Erythematosus (SLE)	100% of Benefit Amount	NONE
Severe Burn Category		
Severe Burn	100% of Benefit Amount	100% of Initial Benefit
Stroke Category		
Stroke	100% of Benefit Amount	100% of Initial Benefit

Questions & Answers

Q. Who is eligible to enroll for this critical illness coverage?

A. You are eligible to enroll yourself and your eligible family members!5 You need to enroll during your Enrollment Period and to be actively at work for your coverage to be effective.

Q. How do I pay for my critical illness coverage?

A. Premiums will be paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

Q. What happens if my employment status changes? Can I take my coverage with me?

A. Yes, you can take your coverage with you.6 You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Q. Who do I call for assistance?

A. Please call MetLife directly at 1-855-JOIN-MET (1-855-564-6638), Monday through Friday from 8:00 a.m. to 8 p.m., EST and talk with a benefits consultant.

Life and AD&D
MetLife

EMPLOYEE BENEFITS

ABOUT LIFE AND AD&D

Group term life is the most inexpensive way to purchase life insurance. You have the freedom to select an amount of life insurance coverage you need to help protect the well-being of your family.

Accidental Death & Dismemberment is life insurance coverage that pays a death benefit to the beneficiary, should death occur due to a covered accident. Dismemberment benefits are paid to you, according to the benefit level you select, if accidentally dismembered.

For full plan details, please visit your benefit website:
www.mybenefitshub.com/laketravisisd

Basic Term Life and Accidental Death and Dismemberment (AD&D) Insurance

Your employer provides you with Basic Term Life and AD&D insurance coverage in the amount of $10,000.

Supplemental Term Life Insurance Coverage Options

- **For You:** $10,000 increments to the lesser of 5 times your basic annual earnings or $250,000
- **For Your Spouse:** $5,000 increments to $60,000 up to 50% of your supplemental term life coverage amount
- **For Your Dependent Children***
  - ◊ Birth to to 6 months old: $1,000
  - ◊ Child more than 6 months old: $1,000 increments to a maximum of $10,000

*Child(ren)'s Eligibility: Dependent children ages from birth to 26 years old if a child is a full-time student, are eligible for coverage.

What's Not Covered? Please note that a reduction schedule may apply. Please see your plan employer or certificate for specific details.

Accidental Death & Dismemberment (AD&D) coverage is a coverage separate and apart from your Basic and Supplemental Life insurance coverage and helps protect you 24 hours a day, 365 days a year.

Accidental Death & Dismemberment Coverage Options

This coverage provides benefits beyond your disability or life insurance for losses due to covered accidents — including while commuting, traveling by public or private transportation and during business trips. MetLife's AD&D insurance pays you benefits if you suffer a covered accident that results in paralysis or the loss of a limb, speech, hearing or sight, brain damage or coma. If you suffer a covered fatal accident, benefits will be paid to your beneficiary.

Supplemental AD&D Coverage Amounts for You

- Your Supplemental AD&D amount is equal to your Supplemental Term Life amount.

Supplemental AD&D Coverage Amounts for Spouse and Child(ren)

- You can choose to cover your dependent spouse and child(ren) with AD&D coverage. Your dependents will be eligible for coverage amounts equal to their amounts of Dependent Term Life coverage.

*Child(ren)'s Eligibility: Dependent children ages from birth to 26 years old are eligible for coverage.

Covered Losses: This AD&D insurance pays benefits for covered losses that are the result of an accidental injury or loss of life. The full amount of AD&D coverage you select is called the "Full Amount" and is equal to the benefit payable for the loss of life. Benefits for other losses are payable as a predetermined percentage of the Full Amount, and will be listed in your coverage in a table of Covered Losses. Such losses include loss of limbs, sight, speech and hearing, various forms of paralysis, brain damage and coma. The maximum amount payable for all Covered Losses sustained in any one accident is capped at 100% of the Full Amount.
Standard Additional Benefits Include: Some of the standard additional benefits included in your coverage that may increase the amounts payable to you and/or defray

About Your Coverage Effective Date: You must be Actively at Work on the date your coverage becomes effective. Your coverage must be in effect in order for your spouse's and eligible children's coverage to take effect. In addition, your spouse and eligible child(ren) must not be home or hospital confined or receiving or applying to receive disability benefits from any source when their coverage becomes effective.

Life and AD&D
MetLife

If Actively at Work requirements are met, coverage will become effective on 11/1/2024 or the first of the month following the receipt of your completed application for all requests that do not require additional medical information. A request for your amount that requires additional medical information and is not approved by the date listed above will not be effective until the later of the date that notice is received that MetLife has approved the coverage or increase if you meet Actively at Work requirements on that date, or the date that Actively at Work requirements are met after MetLife has approved the coverage or increase. The coverage for your spouse and eligible child(ren) will take effect on the date they are no longer confined, receiving or applying for disability benefits from any source or hospitalized.

Portability: So you can keep your coverage even if you leave your current employer - Should you leave Lake Travis Independent School District for any reason, and your Basic and Supplemental and Dependent Term Life and Personal and Supplemental and Dependent insurance under this plan terminates, you will have an opportunity to continue group term coverage ("portability") under a different policy, subject to plan design and state availability. Rates will be based on the experience of the ported group and MetLife will bill you directly. Rates may be higher than your current rates. To take advantage of this feature, you must have coverage of at least $10,000 up to a maximum of $2,000,000.

Portability is also available on coverage you've selected for your spouse/domestic partner and dependent child(ren). The maximum amount of coverage for spouse/domestic partners is $250,000; the maximum amount of dependent child coverage is $25,000. Increases, decreases and maximums are subject to state availability.

Accelerate Benefits Option: For access to funds during a difficult time - Supplemental and Supplemental Dependent Life: If you become terminally ill and are diagnosed with 24 months or less to live, you have the option to receive up to 80% of your life insurance proceeds. This can go a long way towards helping your family meet medical and other expenses at a difficult time. Amounts not accelerated will continue under your employer's plan for as long as you remain eligible per the certificate requirements and the group policy remains in effect.

The accelerated life insurance benefits offered under your certificate are intended to qualify for favorable tax treatment under Section 101(g) of the Internal Revenue Code (26 U.S.C.Sec 101(g)).

Accelerated Benefits Option is not the same as long term care insurance (LTC). LTC provides nursing home care, home-health care, personal or adult day care for individuals above age 65 or with chronic or disabling conditions that require constant supervision.

The Accelerated Benefits Option is also available to spouses insured under Dependent Life insurance plans. This option is not available for dependent child coverage.

Conversion: For protection after your coverage terminates - You can generally convert your group term life insurance benefits to an individual whole life insurance policy if your coverage terminates in whole or in part due to your retirement, termination of employment, or change in employee class. Conversion is available on all group life insurance coverages. Please note that conversion is not available on AD&D coverage. If you experience an event thatmakes you eligible to convert your coverage, please call 1-877-275-6387 to begin the conversion process. Please contact your plan employer for more information.

Supplemental Life Monthly Premiums
(per $1,000 of covered volume)

Age	Employee	Age	Dependent
Less than 20	$0.020	Less than 30	$0.040
20-24	$0.030	30-34	$0.040
25-29	$0.030	35-39	$0.060
30-34	$0.030	40-44	$0.080
35-39	$0.050	45-49	$0.130
40-44	$0.070	50-54	$0.220
45-49	$0.110	55-59	$0.410
50-54	$0.170	60-64	$0.850
55-59	$0.260	65-69	$1.830
60-64	$0.360	70-74	$3.460
65-69	$0.670	75 and older	$4.420
70-74	$1.090		
75 and older	$1.850	**Child**	$0.180

Supplemental AD&D Monthly Premiums
(per $1,000 of covered volume)

Employee	$0.020
Dependent Spouse	$0.020
Dependent Child	$0.020

Flexible Spending Account (FSA)
Higginbotham

ABOUT FSA

A Flexible Spending Account allows you to pay for eligible healthcare expenses with a pre-loaded debit card. You choose the amount to set aside from your paycheck every plan year, based on your employer's annual plan limit. This money is use it or lose it within the plan year.

For full plan details, please visit your benefit website:
www.mybenefitshub.com/laketravisisd

Health Care FSA
The Health Care FSA covers qualified medical, dental and vision expenses for you or your eligible dependents. You may contribute up to $3,200 annually to a Health Care FSA and you are entitled to the full election from day one of your plan year. Eligible expenses include:

- Dental and vision expenses
- Medical deductibles and coinsurance
- Prescription copays
- Hearing aids and batteries

You may not contribute to a Health Care FSA if you contribute to a Health Savings Account (HSA).

Higginbotham Benefits Debit Card
The Higginbotham Benefits Debit Card gives you immediate access to funds in your Health Care FSA when you make a purchase without needing to file a claim for reimbursement. If you use the debit card to pay anything other than a copay amount, you will need to submit an itemized receipt or an Explanation of Benefits (EOB).

Dependent Care FSA
The Dependent Care FSA helps pay for expenses associated with caring for elder or child dependents so you or your spouse can work or attend school full time. You can use the account to pay for day care or baby sitter expenses for your children under age 13 and qualifying older dependents, such as dependent parents. Reimbursement from your Depend ent Care FSA is limited to the total amount deposited in your account at that time. To be eligible, you must be a single parent or you and your spouse must be employed outside the home, disabled or a full-time student.

Things to Consider Regarding the Dependent Care FSA

- Overnight camps are not eligible for reimbursement (only day camps can be considered).
- If your child turns 13 midyear, you may only request reimbursement for the part of the year when the child is under age 13.
- You may request reimbursement for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.

Flexible Spending Accounts
Higginbotham

Important FSA Rules

- The maximum per plan year you can contribute to a Health Care FSA is $3,200. The maximum per plan year you can contribute to a Dependent Care FSA is $5,000 when filing jointly or head of household and $2,500 when married filing separately.
- You cannot change your election during the year unless you experience a Qualifying Life Event.
- In most cases, you can continue to file claims incurred during the plan year for another 90 days after the plan year ends.
- Your Health Care FSA debit card can be used for health care expenses only. It cannot be used to pay for dependent care expenses.
- Review your employer's Summary Plan Document for full details. FSA rules vary by employer.

Over-the-Counter Item Rule Reminder

Health care reform legislation requires that certain over-the-counter (OTC) items require a prescription to qualify as an eligible Health Care FSA expense. You will only need to obtain a one-time prescription for the current plan year. You can continue to purchase your regular prescription medications with your FSA debit card. However, the FSA debit card may not be used as payment for an OTC item, even when accompanied by a prescription.

Higginbotham Portal

The Higginbotham Portal provides information and resources to help you manage your FSAs.

- Access plan documents, letters and notices, forms, account balances, contributions and other plan information
- Update your personal information
- Utilize Section 125 tax calculators
- Look up qualified expenses
- Submit claims
- Request a new or replacement Benefits Debit Card

Register on the Higginbotham Portal

Visit https://flexservices.higginbotham.net and click Register. Follow the instructions and scroll down to enter your information.

- Enter your Employee ID, which is your Social Security number with no dashes or spaces.
- Follow the prompts to navigate the site.
- If you have any questions or concerns, contact Higginbotham:
    - Phone – (866) 419-3519
    - Questions – flexsupport@higginbotham.net
    - Fax – (866) 419-3516
    - Claims- flexclaims@higginbotham.net

Notes

2024 - 2025 Plan Year

Enrollment Guide General Disclaimer: This summary of benefits for employees is meant only as a brief description of some of the programs for which employees may be eligible. This summary does not include specific plan details. You must refer to the specific plan documentation for specific plan details such as coverage expenses, limitations, exclusions, and other plan terms, which can be found at the Lake Travis ISD Benefits Website. This summary does not replace or amend the underlying plan documentation. In the event of a discrepancy between this summary and the plan documentation the plan documentation governs. All plans and benefits described in this summary may be discontinued, increased, decreased, or altered at any time with or without notice.

Rate Sheet General Disclaimer: The rate information provided in this guide is subject to change at any time by your employer and/or the plan provider. The rate information included herein, does not guarantee coverage or change or otherwise interpret the terms of the specific plan documentation, available at the Lake Travis ISD Benefits Website, which may include additional exclusions and limitations and may require an application for coverage to determine eligibility for the health benefit plan. To the extent the information provided in this summary is inconsistent with the specific plan documentation, the provisions of the specific plan documentation will govern in all cases.

WWW.MYBENEFITSHUB.COM/LAKETRAVISISD