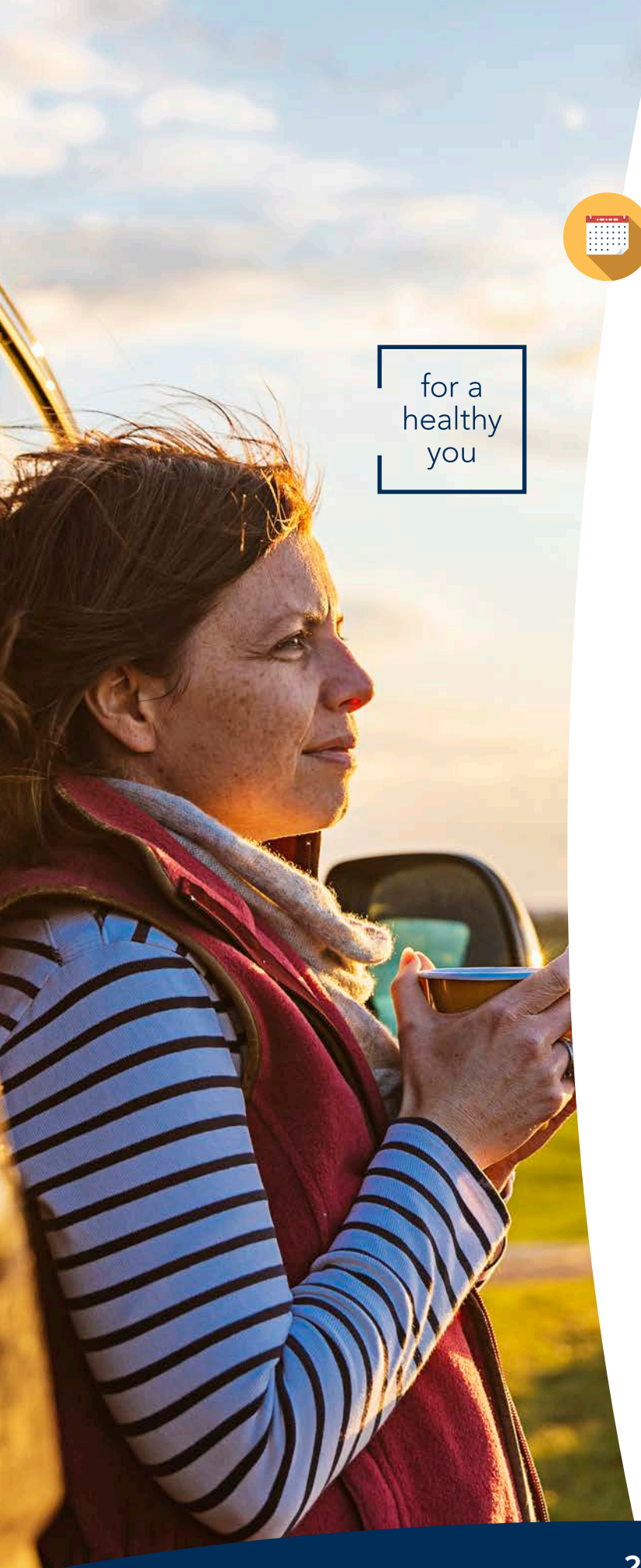
25
26

EMPLOYEE BENEFITS GUIDE

for a healthy you



YOUR NEW BENEFITS BEGIN AND END

September 1, 2025 – August 31, 2026

Welcome

We are pleased to offer a full benefits package to you and your eligible dependents. Read this guide to know what benefits are available to you. You may only enroll for or make changes to your benefits during Open Enrollment or when you have a Qualifying Life Event.

Availability Of Summary Health Information

Your plan offers medical coverage options. To help you make an informed choice, review each plan's Summary of Benefits and Coverage (SBC) available by accessing **www.mybenefitshub.com/redoakisd**.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices for your prescription drug coverage. Please see Important Legal Notices for more details.

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Red Oak Benefits
Higginbotham Public Sector
833-870-3436
www.mybenefitshub.com/redoakisd

Medical
BCBSTX
866-355-5999
www.bcbstx.com/trsactivecare

Telemedicine
Recuro
855-673-2876
www.recurohealth.com

Dental
Renaissance
800-894-4532
www.myrenproviders.com/

Vision
EyeMed
Group # 1006662
866-804-0982
www.eyemed.com

Health Savings Account
EECU
817-882-0800
www.eecu.com

Flexible Spending Accounts
Higginbotham
866-419-3519
flexclaims@higginbotham.net

Basic and Voluntary Life and AD&D
The Hartford
Group # 136135
866-574-9124
www.thehartford.com

Disability
The Hartford
Group # 395307
866-574-9124
www.thehartford.com

Accident
Lincoln Financial Group
Group # ACC-0000005996
800-423-2765
www.lincolnfinancial.com

Cancer
Chubb
Group # 100000046
Phone: 888-499-0425
Fax: 312-351-7114
https://my.combinedinsurance.com

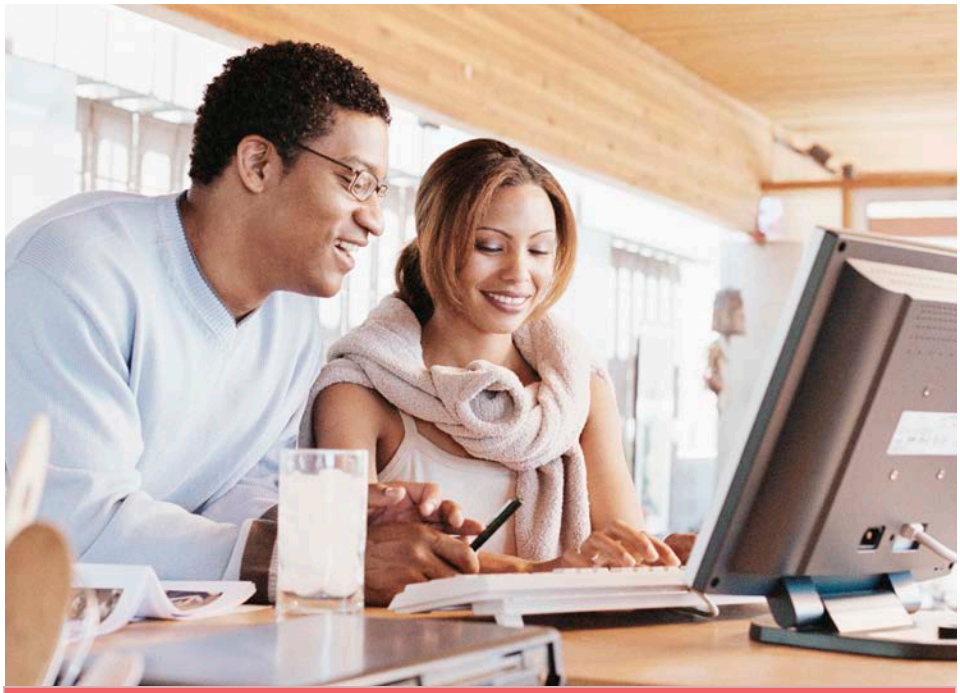
Hospital Indemnity
Chubb
Group # 100000046
https://my.combinedinsurance.com

Identity Theft Support
Experian
Group # 8413581
855-797-0052
www.experian.com

Emergency Transportation
MASA
Group # MKROISD
800-423-3226
www.masamts.com

Prescription Discount Program
CleverRX
Group ID: 1085
Member ID: 1720
Customer Help Line
800-873-1195
www.cleverrx.com

How to Enroll



LOGIN PROCESS	
1	Go to **www.mybenefitshub.com/redoakisd**. Scan the QR code to the right.
2	Click *Login*.
3	Enter your information: • Last name • Date of birth • Last four digits of your 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 the ***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*** to begin your benefits enrollment.

Mobile Enrollment

Enrollment made easy with your smartphone or tablet.

Text **BENEFITS** to **214-831-4284** to opt into important text message* enrollment reminders. Scan the QR code to go to your benefit website for:

- Benefits resources
- Interactive tools
- Online enrollment
- And more!

* Standard message rates may apply.

Benefit questions?

Ask your Benefits Department.

Call **833-870-3436** for Higginbotham Public Sector.

Frequently Asked Questions

Enrollment FAQs

What if I miss the enrollment deadline?

You may only enroll for or change your benefits during Open Enrollment or if you have a Qualifying Life Event.

Is there an age limit for dependents to be covered under my benefits?

You may cover dependents up to age 26 on most benefit plans, but there are exceptions. See the Eligibility section for more details.

Where do I find benefit summaries and forms?

Access **www.mybenefitshub.com/redoakisd** and click on the benefit plan you need (i.e., Dental). Forms and benefits information are under the *Benefits and Form* section.

How do I find an in-network provider?

Access **www.mybenefitshub.com/redoakisd** and click on the benefit plan for the provider you need to find. Click on the *Quick Links* section to find provider search links.

When will I get my ID cards?

If the medical carrier provides ID cards and there is a plan change, new cards usually arrive within four weeks of your effective date. If there are no plan changes, a new card may not be issued.

You may not need a card for dental and vision plans. Simply give your provider the insurance company's name and phone number to verify benefits. You can also print a temporary card by visiting the insurance company's website.

Benefit questions?

Ask your Benefits Department.

Call **833-870-3436** for Higginbotham Public Sector.

Important Limitations and Exclusions Information

The following limitations and exclusions may apply when obtaining coverage as a married couple or for your dependents.

Can I cover my family — a spouse or a dependent — as dependents on my benefits if we work for the same employer?

Some benefits may not allow you to do this if you work for the same employer. Review the applicable plan documents, contact Higginbotham Public Sector, or contact the insurance carrier for spouse and dependent eligibility.

Eligibility

Who is Eligible for Benefits

You are eligible for coverage if you are a regular, full-time employee. You may only enroll for coverage when:

- You are a new hire
- It is Open Enrollment (OE)
- You have a Qualifying Life Event (QLE)

See page 5 for Important Exclusions and Limitations.

About Your Coverage Effective Date

You must be Actively at Work on the date your coverage becomes effective. Your coverage must be in effect for your spouse's and eligible children's coverage to take effect. See plan documents for specific details.

New Hire

Who is Eligible

- A regular, full-time employee working an average of 15 hours per week

When to Enroll

- Enroll by the deadline given by Human Resources

When Coverage Starts

- First day of work concurrent with the plan effective date

Employee

Who is Eligible

- A regular, full-time employee working an average of 15 hours per week

When to Enroll

- Enroll during OE or when you have a QLE

When Coverage Starts

- You must be actively at work on the plan effective date for new benefits to be effective
- QLE: Ask Human Resources

Dependent(s)

Who is Eligible

- Your legal spouse
- Child(ren) under age 26, regardless of student, dependency, or marital status
- Child(ren) over age 26 who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

When to Enroll

- You must enroll the dependent(s) during OE or when you have a QLE
- When covering dependents, you must enroll for and be on the same plans
- Dependents cannot be double-covered by married spouses within the district as both employees and dependents

When Coverage Starts

- Based on OE or QLE effective dates

MAXIMUM DEPENDENT ELIGIBILITY AGE BY PLAN
To Age 26
Medical, Telemedicine, Dental, Vision, Voluntary Life and AD&D, Cancer, Accident, Hospital Indemnity, Employee Assistance Program, Emergency Medical Transportation

Qualifying Life Events

You may only change coverage during the plan year if you have a Qualifying Life Event, such as:

- Marriage
- Divorce
- Legal separation
- Annulment

- Birth
- Adoption
- Placement for adoption
- Change in benefits eligibility
- Death

- Undergoing COBRA event, court judgment, or decree
- Becoming eligible for Medicare, Medicaid, or TRICARE
- Receiving a Qualified Medical Child Support Order

- Gain or loss of benefits coverage
- Change in employment status affecting benefits

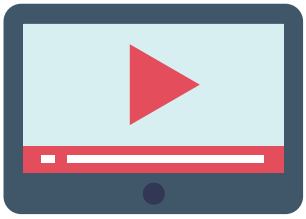
You have 31 days from the event to **notify Human Resources** and **complete your changes**. You may need to provide documents to verify the change.

Medical Coverage

Our medical plans protect you and your family from major financial hardship in the event of illness or injury. You have a choice of 3 plans:

- ActiveCare HD – This plan is an HDHP.
- ActiveCare Primary – This plan is a PPO.
- ActiveCare Primary + – This plan is a PPO.

TRS ACTIVECARE MEDICAL RATES			
ActiveCare HD	Total Monthly Premium	Employer Contribution	Employee Cost
Employee Only	$570.00	$325.00	**$245.00**
Employee and Spouse	$1,539.00	$325.00	**$1,214.00**
Employee and Child(ren)	$969.00	$325.00	**$644.00**
Employee and Family	$1,938.00	$325.00	**$1,613.00**
ActiveCare 2	Total Monthly Premium	Employer Contribution	Employee Cost
Employee Only	$1,013.00	$325.00	**$688.00**
Employee and Spouse	$2,402.00	$325.00	**$2,077.00**
Employee and Child(ren)	$1,507.00	$325.00	**$1,182.00**
Employee and Family	$2,841.00	$325.00	**$2,516.00**
ActiveCare Primary	Total Monthly Premium	Employer Contribution	Employee Cost
Employee Only	$556.00	$325.00	**$231.00**
Employee and Spouse	$1,502.00	$325.00	**$1,177.00**
Employee and Child(ren)	$946.00	$325.00	**$621.00**
Employee and Family	$1,891.00	$325.00	**$1,566.00**
ActiveCare Primary+	Total Monthly Premium	Employer Contribution	Employee Cost
Employee Only	$653.00	$325.00	**$328.00**
Employee and Spouse	$1,698.00	$325.00	**$1,373.00**
Employee and Child(ren)	$1,111.00	$325.00	**$786.00**
Employee and Family	$2,155.00	$325.00	**$1,830.00**



Watch and learn more!

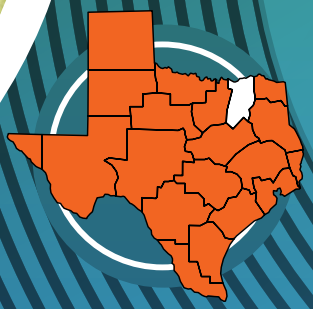
Find an In-Network Provider

Visit **www.bcbstx.com/trsactivecare**.

Call **866-355-5999**.

TRS ACTIVECARE
TEACHER RETIREMENT SYSTEM OF TEXAS

TRS-ActiveCare
PLAN HIGHLIGHTS 2025-26



TRS-ActiveCare

REGION 10

LEARN THE TERMS

- **PREMIUM:** The monthly amount you pay for health care coverage.
- **DEDUCTIBLE:** The annual amount for medical expenses you're responsible to pay before your plan begins to pay.
- **COPAY:** The set amount you pay for a covered service at the time you receive it. The amount can vary based on the service.
- **COINSURANCE:** The portion you're required to pay for services after you meet your deductible. It's often a specified percentage of the costs; e.g., you pay 20% while the health care plan pays 80%.
- **OUT-OF-POCKET MAXIMUM:** The maximum amount you pay each year for medical costs. After reaching the out-of-pocket maximum, the plan pays 100% of allowable charges for covered services.

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2025-26 TRS-ActiveCare Plan Highlights Sept. 1, 2025 – A

All TRS-ActiveCare participants have **three plan options**. E

How to Calculate Your Monthly Premium

Total Monthly Premium

− Your Employer Contribution

= **Your Premium**

Ask your Benefits Administrator for your district's specific premiums.

Wellness Benefits at No Extra Cost*

Being healthy is easy with:

- $0 preventive care
- 24/7 customer service
- One-on-one health coaches
- Weight loss programs
- Nutrition programs
- Ovia™ pregnancy support
- TRS Virtual Health
- Mental health benefits
- And much more!

**Available for all plans.*
See the benefits guide for more details.

Primary Plans & Mental Health

- Both Primary and Primary+ offer $0 virtual mental health visits with any in-network provider.

	TRS-ActiveCare Primary	TRS-
Plan Summary	• Lowest premium of all three plans • Copays for doctor visits before you meet your deductible • Statewide network • Primary Care Provider referrals required to see specialists • Not compatible with a Health Savings Account • No out-of-network coverage	• Lower deductible th • Copays for many se • Higher premium • Statewide network • Primary Care Provid • Not compatible with • No out-of-network

Monthly Premiums	Total Premium	Employer Contribution	Your Premium	Total Premium
Employee Only	$556			$653
Employee and Spouse	$1,502			$1,698
Employee and Children	$946			$1,111
Employee and Family	$1,891			$2,155

Plan Features		
Type of Coverage	In-Network Coverage Only	In
Individual/Family Deductible	$2,500/$5,000	
Coinsurance	You pay 30% after deductible	You
Individual/Family Maximum Out of Pocket	$8,050/$16,100	
Network	Statewide Network	
PCP Required	Yes	

Doctor Visits		
Primary Care	$30 copay	
Specialist	$70 copay	

Immediate Care		
Urgent Care	$50 copay	
Emergency Care	You pay 30% after deductible	You
TRS Virtual Health-RediMD™	$0 per medical consultation	$0
TRS Virtual Health-Teladoc®	$12 per medical consultation	$1

Prescription Drugs		
Drug Deductible	Integrated with medical	$200 deducti
Generics (31-Day Supply/90-Day Supply)	$15/$45 copay; $0 copay for certain generics	
Preferred (Max does not apply if brand is selected and generic is available)	You pay 30% after deductible	You pay 2 You pay 2
Non-preferred	You pay 50% after deductible	You
Specialty (31-Day Max)	$0 if SaveOnSP eligible; You pay 30% after deductible	$0 if SaveOnSP
Insulin Out-of-Pocket Costs	$25 copay for 31-day supply; $75 for 61-90 day supply	$25 copay for 3

Aug. 31, 2026

TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

Each includes a wide range of wellness benefits.

This plan is closed and not accepting new enrollees. If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan.

ActiveCare Primary+	TRS-ActiveCare HD	TRS-ActiveCare 2
han the HD and Primary plans ervices and drugs der referrals required to see specialists h a Health Savings Account coverage	• Compatible with a Health Savings Account • Nationwide network with out-of-network coverage • No requirement for Primary Care Providers or referrals • Must meet your deductible before plan pays for non-preventive care	• Closed to new enrollees • Current enrollees can choose to stay in plan • Lower deductible • Copays for many services and drugs • Nationwide network with out-of-network coverage • No requirement for Primary Care Providers or referrals

Employer Contribution	Your Premium	Total Premium	Employer Contribution	Your Premium	Total Premium	Employer Contribution	Your Premium
		$570			$1,013		
		$1,539			$2,402		
		$969			$1,507		
		$1,938			$2,841		

-Network Coverage Only	In-Network	Out-of-Network	In-Network	Out-of-Network
$1,200/$2,400	$3,300/$6,600	$6,600/$13,200	$1,000/$3,000	$2,000/$6,000
pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 40% after deductible
$6,900/$13,800	$8,300/$16,600	$20,500/$41,000	$7,900/$15,800	$23,700/$47,400
Statewide Network	Nationwide Network		Nationwide Network	
Yes	No		No	

$15 copay	You pay 30% after deductible	You pay 50% after deductible	$30 copay	You pay 40% after deductible
$70 copay	You pay 30% after deductible	You pay 50% after deductible	$70 copay	You pay 40% after deductible

$50 copay	You pay 30% after deductible	You pay 50% after deductible	$50 copay	You pay 40% after deductible
u pay 20% after deductible	You pay 30% after deductible		You pay a $250 copay plus 20% after deductible	
per medical consultation	$30 per medical consultation		$0 per medical consultation	
2 per medical consultation	$42 per medical consultation		$12 per medical consultation	

ble per participant (brand drugs only)	Integrated with medical	$200 brand deductible	
$15/$45 copay	You pay 20% after deductible; $0 coinsurance for certain generics	$20/$45 copay	
5% after deductible ($100 max)/ 25% after deductible ($265 max)	You pay 25% after deductible	You pay 25% after deductible ($40 min/$80 max)/ You pay 25% after deductible ($105 min/$210 max)	
pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible ($100 min/$200 max)/ You pay 50% after deductible ($215 min/$430 max)	
eligible; You pay 30% after deductible	You pay 20% after deductible	$0 if SaveOnSP eligible; You pay 30% after deductible ($200 min/$900 max)/ No 90-day supply of specialty medications	
-day supply; $75 for 61-90 day supply	You pay 25% after deductible	$25 copay for 31-day supply; $75 for 61-90 day supply	

Compare Prices for Common Medical Services

REMEMBER: Call a Personal Health Guide 24/7 to help you find the best price for a medical service. Reach them at **1-866-355-5999**.

Benefit	TRS-ActiveCare Primary	TRS-ActiveCare Primary+	TRS-ActiveCare HD		TRS-ActiveCare 2	
	In-Network Only	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Labs**	Office/Indpendent Lab: You pay $0 Outpatient: You pay 30% after deductible	Office/Indpendent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	Office/Indpendent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 40% after deductible
High-Tech Radiology	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible + $100 copay per procedure	You pay 40% after deductible + $100 copay per procedure
Outpatient Costs	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible ($150 facility copay per incident)	You pay 40% after deductible ($150 facility copay per incident)
Inpatient Hospital Costs	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible ($500 facility per day maximum)	You pay 20% after deductible ($150 facility copay per day)	You pay 40% after deductible ($500 facility copay per incident)
Freestanding Emergency Room	You pay $500 copay + 30% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 30% after deductible	You pay $500 copay + 50% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 40% after deductible
Bariatric Surgery	Facility: You pay 30% after deductible Professional Services: You pay $5,000 copay + 30% after deductible Only covered if rendered at a BDC+ facility	Facility: You pay 20% after deductible Professional Services: You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility	Not Covered	Not Covered	Facility: You pay 20% after deductible ($150 facility copay per day) Professional Services: You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility	Not Covered
Annual Vision Exam (one per plan year; performed by an ophthalmologist or optometrist)	You pay $70 copay	You pay $70 copay	You pay 30% after deductible	You pay 50% after deductible	You pay $70 copay	You pay 40% after deductible
Annual Hearing Exam (one per plan year)	$30 PCP copay $70 specialist copay	$15 PCP copay $70 specialist copay	You pay 30% after deductible	You pay 50% after deductible	$30 PCP copay $70 specialist copay	You pay 40% after deductible

***Pre-certification for genetic and specialty testing may apply. Contact a PHG at **1-866-355-5999** with questions.*

www.trs.texas.gov

Revised 05/30/25

Prescription Savings Program

Clever RX Benefits

Clever RX is a free prescription savings program designed to help individuals save up to 80% on medications, often outperforming standard insurance copays. Accepted at major pharmacies nationwide—including CVS, Walgreens, Walmart, and Kroger—it provides discounts on thousands of FDA-approved medications. Users can download the Clever RX app, enter their ZIP code to compare prices at nearby pharmacies, and present a digital voucher at checkout to access the lowest available price. The program is especially beneficial for those with high-deductible health plans, high copays, or no insurance, offering a practical solution to reduce prescription costs. Additionally, Clever RX facilitates easy sharing of savings with friends and family directly through the app.

Questions?

Call Clever RX Customer Service at **800-873-1195**.

BIN: 020529

PCN: CLEVR

Group Number: 1085

Member ID: 1720

Health Care Options

Becoming familiar with your options for medical care can save you time and money.

HEALTH CARE PROVIDER		SYMPTOMS	AVERAGE COST	AVERAGE WAIT
Non-Emergency Care				
 Telemedicine	Access to care via phone, online video, or mobile app whether you are at home, work, or traveling; medications can be prescribed 24 hours a day, 7 days a week	Allergies Cough/cold/flu Rash Stomachache	$	2-5 minutes
 Doctor's Office	Generally, the best place for routine preventive care; established relationship; able to treat based on medical history Office hours vary	Infections Sore and strep throat Vaccinations Minor injuries/sprains/strains	$	15-20 minutes
 Retail Clinic	Usually lower out-of-pocket cost than urgent care; when you can't see your doctor; located in stores and pharmacies Hours vary based on store hours	Common infections Minor injuries Pregnancy tests Vaccinations	$	15 minutes
 Urgent Care	When you need immediate attention; walk-in basis is usually accepted Generally includes evening, weekend and holiday hours	Sprains and strains Minor broken bones Small cuts that may require stitches Minor burns and infections	$$	15-30 minutes
Emergency Care				
 Hospital ER	Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility 24 hours a day, 7 days a week	Chest pain Difficulty breathing Severe bleeding Blurred or sudden loss of vision Major broken bones	$$$$	4+ hours
 Freestanding ER	Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher 24 hours a day, 7 days a week	Most major injuries except trauma Severe pain	$$$$$$	Minimal

Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

Health Savings Account

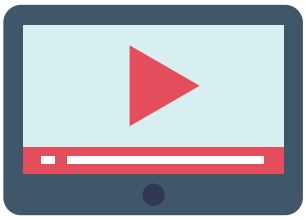
We offer a Health Savings Account (HSA) to offset your HDHP medical costs, reduce your taxes, and offer a long-term tax-advantaged savings account.

An HSA is like a personal savings account that allows you to pay for current or future health care expenses with pre-tax dollars or save the funds for retirement. An HSA is always yours to keep, even if you change health plans or jobs.

HSA Eligibility

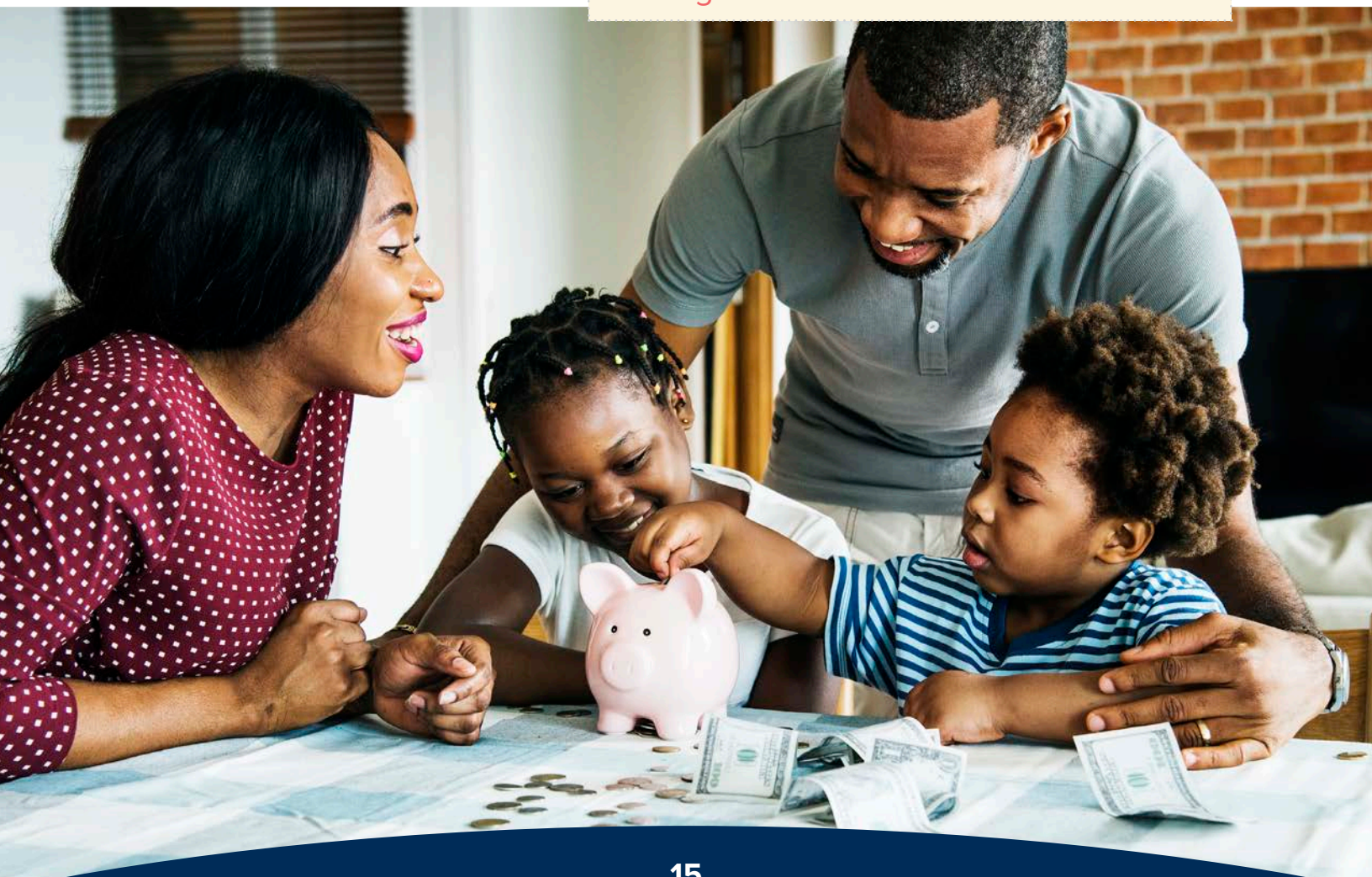
You are eligible to open and contribute to an HSA if you are:

- Enrolled in an HSA-eligible HDHP
- 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
- Not eligible to be claimed as a dependent on someone else's tax return
- Not enrolled in Medicare, Medicaid, or TRICARE
- Not receiving Veterans Administration benefits



Watch and learn more!

Having an HSA is a smart financial move!



Health Savings Account

MAXIMUM HSA CONTRIBUTIONS
2025
$4,300 Individual
$8,550 Family
If you are age 55 or older, you can contribute an extra $1,000.

Two Ways to Use Your HSA Funds

Use it Now

- Make annual HSA contributions.
- Pay for eligible medical costs.
- Keep HSA funds in cash.

Let it Grow

- Make annual HSA contributions.
- Pay for medical costs with other funds.
- Invest HSA funds.

Important HSA Information

- Have your doctor file your claims and use your HSA debit card to pay any balance due.
- Keep ALL your records and receipts for HSA reimbursements in case of an IRS audit.
- Only HSA accounts opened through our plan administrator are eligible for automatic payroll deductions.

HSA Contacts

- Have your doctor file your claims and use your HSA debit card to pay any balance due.
- Keep ALL your records and receipts for HSA reimbursements in case of an IRS audit.
- Only HSA accounts opened through our plan administrator are eligible for automatic payroll deductions.

HSA contributions are tax-deductible and grow tax-deferred.

Withdrawals for qualifying medical expenses are tax-free.

Have a question?

We're here for you! Connect with us your way. Online/Mobile: Log in for 24/7 account access to check your balance, pay bills and more.

Call/Text: **817-882-0800**. Our dedicated member service representatives are available to assist you with any questions.

Monday - Friday from 8:00 a.m. – 7:00 p.m. CT

Saturday 9:00 a.m. – 1:00 p.m. CT

Lost/Stolen Debit Card: Call our 24/7 debit card hotline at **800-333-9934**.

Stop by: a local EECU financial center for in-person assistance; find EECU locations & service hours at **www.eecu.org/locations**.

Flexible Spending Accounts

Higginbotham™

A Flexible Spending Account (FSA) allows you to set aside pretax dollars from each paycheck to pay for certain IRS-approved health and dependent care expenses.

Health Care FSA

The Health Care FSA covers qualified medical, dental, and vision expenses for you or your eligible dependents. 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 enrolled in a High Deductible Health Plan (HDHP) and contribute to a Health Savings Account (HSA).

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 daycare or babysitter expenses for your children under age 13 and qualifying older dependents, such as dependent parents. Reimbursement from your Dependent Care FSA is limited to the total amount deposited in your account at that time. To be eligible, you (and your spouse, if married) must be gainfully employed, looking for work, a full-time student, or incapable of self-care.

Dependent Care FSA Guidelines

- Overnight camps are not eligible for reimbursement (only day camps can be considered).
- If your child turns 13 mid-year, 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.

Access Your FSA Funds in Two Ways:

- Use your FSA debit card to pay for qualified expenses, doctor visits, and prescription copays.
- Pay out-of-pocket and submit your receipts for reimbursement:
  - » Visit **https://flexservices.higginbotham.net**.
  - » Email **flexclaims@higginbotham.net**.
  - » Fax **817-882-9267**.

Note: You may file claims incurred during the plan year for another 75 days.

Flexible Spending Accounts

Higginbotham™

ANNUAL MAXIMUM FSA CONTRIBUTIONS		
2025	Health Care FSA Limited Purpose FSA	Dependent Care FSA
Maximum	$3,300	$5,000 if filing jointly or head of household and $2,500 if married filing separately.
Grace Period	75 d ays	No carryover — use it or lose it

You are entitled to the full election from day one of the plan year.

Higginbotham Portal

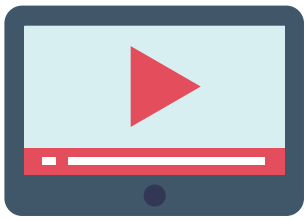
The Higginbotham Portal provides information and resources to help you manage your FSAs to:

- Access plan documents and account information.
- Update your personal information.
- Look up qualified expenses.
- Submit claims.

Register on the Higginbotham Portal

Visit **https://flexservices.higginbotham.net** click *Get Started* and follow the instructions.

- Enter your Social Security number with no dashes or spaces as your Employee ID.
- Follow the prompts to navigate the site.
- If you have any questions or concerns, contact Higginbotham:
  - » Visit **https://flexservices.higginbotham.net**.
  - » Email **flexclaims@higginbotham.net**.
  - » Fax 817-882-9267.



Watch and learn more!

Higginbotham Flex Mobile App

Download the Higginbotham app to easily access your Health Care FSA information.

- View your account balance
- View debit card activity
- File a claim and upload receipts
- Set up notifications

Register on the Higginbotham Portal first to access the mobile app, and use the same username and password for both.

The Higginbotham Health Care FSA debit card gives you immediate access to your Health Care FSA funds. You do not need to file a claim when you make a purchase with your debit card. **You can only use this debit card for qualified health care expenses.** If you use the debit card to pay for anything other than a copay amount, you must submit an itemized receipt or an Explanation of Benefits (EOB). If you do not submit a receipt, you will be asked to do so. You have 60 days to submit a receipt before your debit card is suspended.

HSA and FSA Comparison

Knowing the difference between a Health Savings Account (HSA) and Health Care Flexible Spending Account can help you choose the best option for you and your family.

	HEALTH SAVINGS ACCOUNT (HSA)	FLEXIBLE SPENDING ACCOUNT (FSA)
Internal Revenue Code	Section 223	Section 125
Description	An HSA is an actual bank account in your name that allow you to save and pay for unreimbursed qualified medical expenses tax-free.	An FSA allows you to pay out-of-pocket expenses tax-free for: • copays, deductibles, and certain services not covered by medical plan
Employer Eligibility	A qualified High Deductible Health Plan	All employers
Contribution Source	You and/or your employer	You and/or your employer
Account Owner	Individual	Employer
Underlying Insurance Requirement	High Deductible Health Plan	None
Insurance Plan Minimum Deductible	**2025** • $1,650 single • $3,500 family	N/A
Maximum Contribution	**2025** • $4,300 single • $8,550 family • $1,000 age 55+ catch-up	$3,300
Permissible Use of Funds	Use any way you wish. If used for non-qualified medical expenses, funds are subject to the current tax rate plus a 20% penalty.	Reimbursement for qualified medical expenses as defined in Section 213(d) of the Internal Revenue Code.
Cash-Outs of Unused Amounts (if no medical expenses)	Permitted, but subject to current tax rate plus 20% penalty (waived after age 65).	Not permitted
Year-to-year rollover of account balance?	Yes, it 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 2½-month grace period.
Does the account earn interest?	Yes	No
Portable?	Yes, it is portable year-to-year and between jobs.	No

FLIP TO... 15 HSA 17 FSA

Qualified HSA and FSA Expenses

The products and services listed below are examples of medical expenses eligible for payment under your Health Care FSA or HSA. This list is not all-inclusive; additional expenses may qualify, and the items listed are subject to change in accordance with IRS regulations. Please refer to IRS *Publication 502 Medical and Dental Expenses* at **www.irs.gov** for a complete description of eligible medical and dental expenses.

Abdominal supports

Acupuncture

Ambulance

Anesthetist

Arch supports

Artificial limbs

Blood tests

Braces

Cardiographs

Chiropractor

Crutches

Dental treatment

Dentures

Dermatologist

Diagnostic fees

Eyeglasses

Gynecologist

Healing services

Hearing aids and batteries

Hospital bills

Insulin treatment

Lab tests

Metabolism tests

Neurologist

Nursing

Obstetrician

Operating room costs

Ophthalmologist/Optician/Optometrist

Orthopedic shoes

Orthopedist

Osteopath

Physician

Postnatal treatments

Prenatal care

Prescription medicines

Psychiatrist

Therapy equipment

Wheelchair

X-rays

Dental Coverage

Renaissance
DENTAL · VISION · LIFE · DISABILITY

Our dental plans help you maintain good oral health through affordable options for preventive care, including regular checkups and other dental work.

Find an In-Network Provider

Visit **www.myrenproviders.com**.

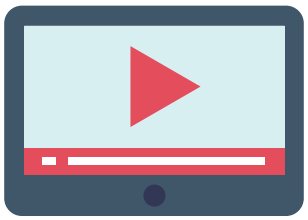
Call **800-894-4532**.

DPPO Plan

Two levels of benefits are available with the DPPO plan: in-network and out-of-network. You may select any dental provider for care, but you will pay less and get the highest level of benefits with in-network providers. You could pay more if you use an out-of-network provider.

Dental Benefits Summary

DENTAL PLAN		
	DPPO High Plan	DPPO Low Plan
Calendar Year Deductible • Individual • Family	$50 $150	$t50 $150
Plan Year Benefit Maximum Per Individual	$1,000	$750
	You Pay	
Diagnostic & Preventive Services • Exams, cleanings, fluoride, and space maintainers • Brush biopsy to detect oral cancer • Bitewing radiographs • X-rays, sealants	$0	20% after deductible
Basic Services • Emergency palliative treatment • All other X-rays • Other basic services • Periodontal maintenance • Fillings • Simple extractions	20% after deductible	50% after deductible
Major Services • All other periodontic services to treat gum disease • Endodontic services (root canals) • Oral surgery • Crowns and veneers • Relines and repairs to bridges and dentures • Bridges, implants, and dentures	50% after deductible	25% after deductible
Orthodontia Orthodontic services - braces (no age limit)	50% $1,000 lifetime maximum	50% $750 lifetime maximum
Employee Monthly Contributions		
Employee Only	$30.72	$21.42
Employee and One Dependent	$59.84	$42.60
Employee and Two or More Dependents	$108.06	$83.69



Watch and learn more!

Vision Coverage

Our vision plan offers quality care to help preserve your health and eyesight. Regular exams can detect certain medical issues such as diabetes and high cholesterol, in addition to vision and eye problems.

You may seek care from any vision provider, but the plan will pay the highest level of benefits when you see in-network providers.

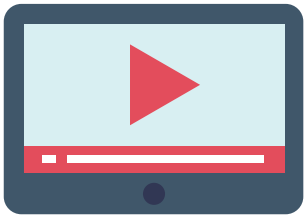
Vision Benefits Summary

VISION PLAN	
	In-Network You Pay
Exam	$10 copay
Lenses • Single vision • Lined bifocals • Lined trifocals • Lenticular	 $25 copay $25 copay $25 copay $25 copay
Frames	$0 Co-pay; $130 allowance; 20% off balance over $130
Contacts In lieu of frames and lenses • Fitting and follow-up • Elective • Medically necessary	 Up to $55 $0 Copay; $130 allowance; 15% off balance over $130 Covered in full
Benefit Frequency	
Exam	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 24 months
Contacts	Once every 12 months
Employee Monthly Contributions	
Employee Only	$5.78
Employee and One Dependent	$10.97
Employee and Two or More Dependents	$16.11

Find an In-Network Provider

Visit **www.eyemed.com**.

Call **866-804-0982**.

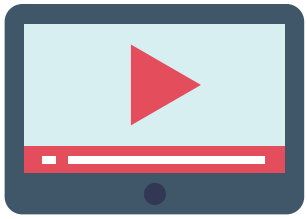


Watch and learn more!

Life and AD&D Insurance

Life and Accidental Death and Dismemberment (AD&D) insurance is important to your financial security, especially if others depend on you for support or vice versa.

With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts such as credit cards, loans, and bills. AD&D coverage provides specific benefits if an accident causes bodily harm or loss (e.g., the loss of a hand, foot, or eye). If death occurs from an accident, 100% of the AD&D benefit would be paid to you or your beneficiary(ies).



Watch and learn more!

Basic Term Life and AD&D

Basic Term Life and AD&D insurance are provided at no cost to you. **You are automatically covered at $10,000 for each benefit.**

Supplemental Term Life

If you need more coverage than Basic Term Life and AD&D, you may buy Supplemental Term Life for yourself and your dependent(s). If you do not elect Supplemental Term Life insurance when first eligible, or if you want to increase your benefit amount at a later date, you may need to show proof of good health.

Designating a Beneficiary

A beneficiary is the person or entity you elect to receive the death benefits of your Life and AD&D insurance policies. You can name more than one beneficiary, and you can change beneficiaries at anytime. If you name more than one beneficiary, you must identify how much each beneficiary will receive (e.g., 50% or 25%). The total must add up to 100%.

Life and AD&D Insurance

THE HARTFORD

Supplemental AD&D

Supplemental AD&D coverage is separate and apart from your Basic and Supplemental Term Life insurance coverage. It provides benefits beyond your disability or life insurance 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 — such as loss of sight, speech or hearing; coma; or paralysis — are payable as a predetermined percentage of the full amount.

Supplemental AD&D Coverage Amounts

Your Supplemental AD&D amount is equal to your Supplemental Term Life amount. You can also cover your dependent spouse and child(ren). Dependent coverage amounts will be equal to their Dependent Term Life coverage amounts.

Supplemental Coverage Highlights

- **Portable** – keep your supplemental coverage if you leave your current employer
- **Convertible** – convert your group term life insurance benefits to an individual whole life policy if your coverage ends
- **Accelerated Benefits Option** – get up to 80% of your life insurance benefit if you (or your spouse) are terminally ill and have less than 24 months to live. Note: this benefit is not the same as long term care insurance.

Some limitations and exclusions apply, so see the plan documents for details.

VOLUNTARY LIFE COVERAGE AMOUNT	
Employee	• Increments of $10,000 up to $500,000 • New Hire Guaranteed Issue $250,000
Spouse	• Increments of $5,000 up to $250,000 not to exceed 100% of Employee's election • New Hire Guaranteed Issue $50,000
Child(ren)	• $10,000 not to exceed 100% of Employee's election • New Hire Guaranteed Issue $10,000

Voluntary Life Rates per $10,000	
Age	Employee/Spouse[1]
<25	$0.30
25-29	$0.30
30-34	$0.40
35-39	$0.70
40-44	$1.00
45-49	$1.60
50-54	$2.40
55-59	$3.70
60-64	$5.50
65-69	$9.30
70-74	$16.50
75+	$33.70
Child(ren)	
To age 26	$1.75

[1] Spouse rate is based on employee's age.

VOLUNTARY AD&D COVERAGE AMOUNT	
Employee	• Increments of $10,000 up to $500,000 • Guaranteed Issue $500,000
Spouse	• Increments of $5,000 up to $250,000 not to exceed 100% of Employee's election • Guaranteed Issue $250,000
Child(ren)	• $10,000 not to exceed 100% of Employee's election • Guaranteed Issue $10,000

Telemedicine

The telemedicine and behavioral health plan offered through **Recuro Health** provides 24/7 virtual access to board-certified physicians for acute care needs, by phone, web, or desktop. This service allows patients to receive personalized treatment plans and follow-up consultations at no additional cost.

For behavioral health, the plan includes comprehensive services such as therapy, counseling, psychiatry, and medication management, all delivered virtually. A key feature is the use of pharmacogenetic (PGx) testing to ensure the most effective behavioral health medications are prescribed from the outset. Additionally, primary care and behavioral health providers collaborate to create coordinated treatment plans, offering a holistic approach to patient care.

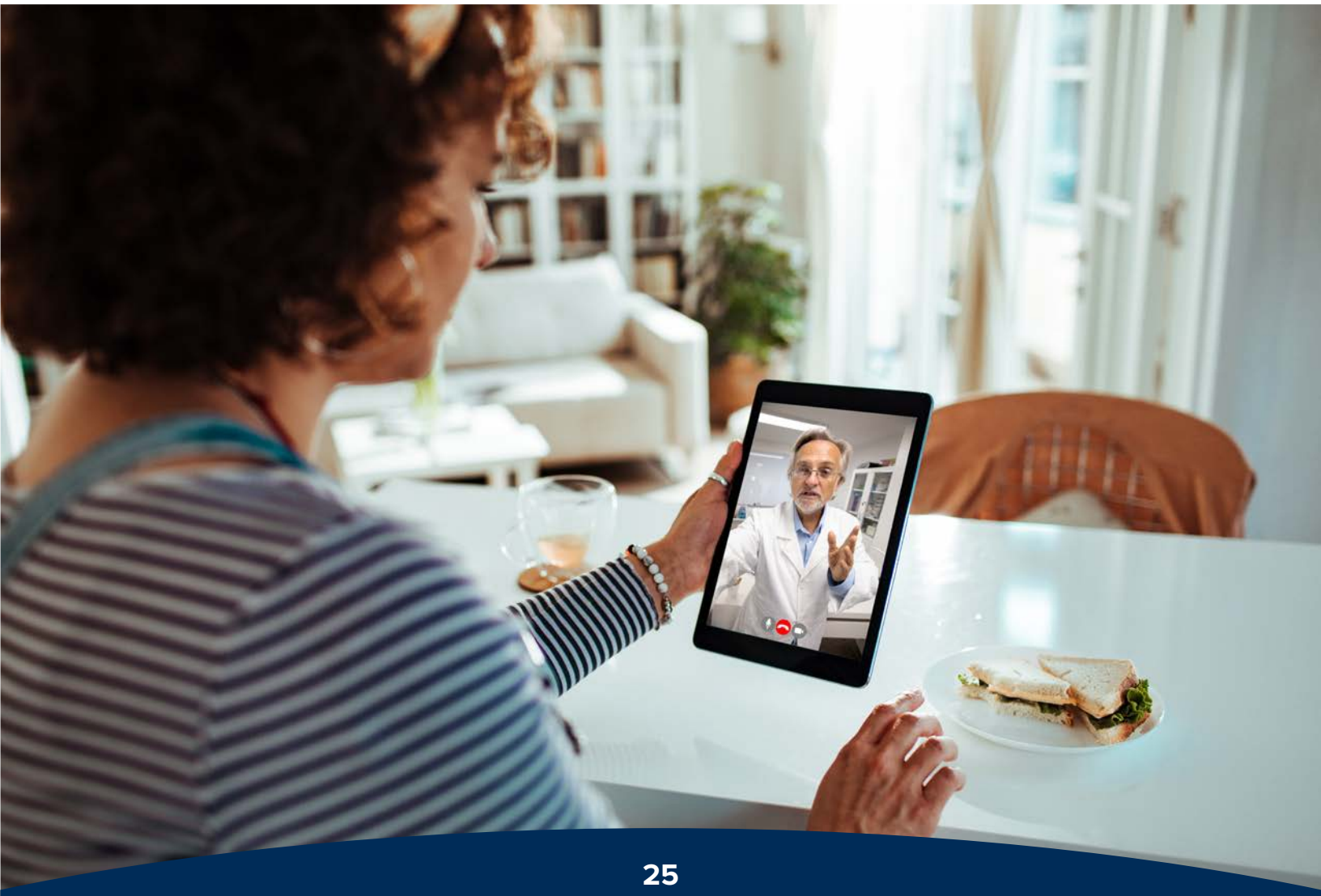
Registration is Easy

Register today so you are ready to use this valuable service when and where you need it.

Visit **www.recurohealth.com**.

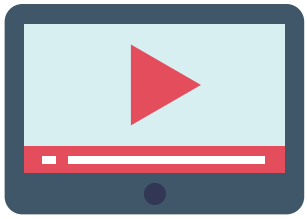
Call **855-673-2876**.

EMPLOYEE MONTHLY CONTRIBUTIONS	
Employee and Family	Paid for by Red Oak ISD



Educator Disability Insurance

Educator Disability insurance combines features of short-term and long-term disability into one plan. Disability insurance protects part of your income if you are unable to work due to a covered accident, illness, or pregnancy. We offer Educator Disability insurance for you to purchase and allow you to choose the coverage amount and waiting period that best suits your needs.



Watch and learn more!

EDUCATOR DISABILITY	
Percentage of Earnings You Receive	66.67%
Maximum Monthly Benefit	$8,000
Maximum Benefit Period Prior to 63 Age 63 Age 64 Age 65 Age 66 Age 67 Age 68 Age 69 and older	 To Normal Retirement Age or 48 months if greater To Normal Retirement Age or 42 months if greater 36 months 30 months 27 months 24 months 21 months 18 months
Pre-existing Condition Exclusion	6/12[2]
Accident/Sickness Elimination Period[1]	0/7 14/14 30/30 60/60 90/90 180/180

[1] If your elimination period is 30 days or less and you are confined to a hospital for 24 hours or more, the elimination period will be waived, and benefits will be payable from the first day of hospitalization.

[2] Benefits may not be paid for any condition treated within six months prior to your effective date until you have been covered under this plan for 12 months. If your disability is a result of a pre-existing condition, benefits will be paid for a maximum of one month.

Educator Disability FAQ

What is disability insurance?

Disability insurance protects one of your most valuable assets: your paycheck. This insurance replaces part of your income if you are physically unable to work due to sickness or injury for an extended period of time. The Educator Disability plan is unique in that it includes both short- and long-term coverage in one convenient plan.

Does this plan have pre-existing condition limitations?

Yes. However, 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 (including your initial new hire enrollment). Review the plan documents for full details.

Will I get all of my disability benefit?

Your disability 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 Insurance

THE HARTFORD

What is the best way to choose which disability plan option to enroll in?

Your disability plan selection should be a two-step approach.

Step One

Choose your elimination period, or waiting period. This is how long you are disabled and unable to work before your benefit will begin. It will be displayed as two numbers, such as 0/7, 14/14, 60/60, 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, determine how long you could go without a paycheck. Choose your elimination period based on your answer.

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. Review your plan details to see if this feature is available to you.

Step Two

Choose your benefit amount. This is the maximum amount of money you would get from the carrier on a monthly basis once your disability claim is approved by the carrier.

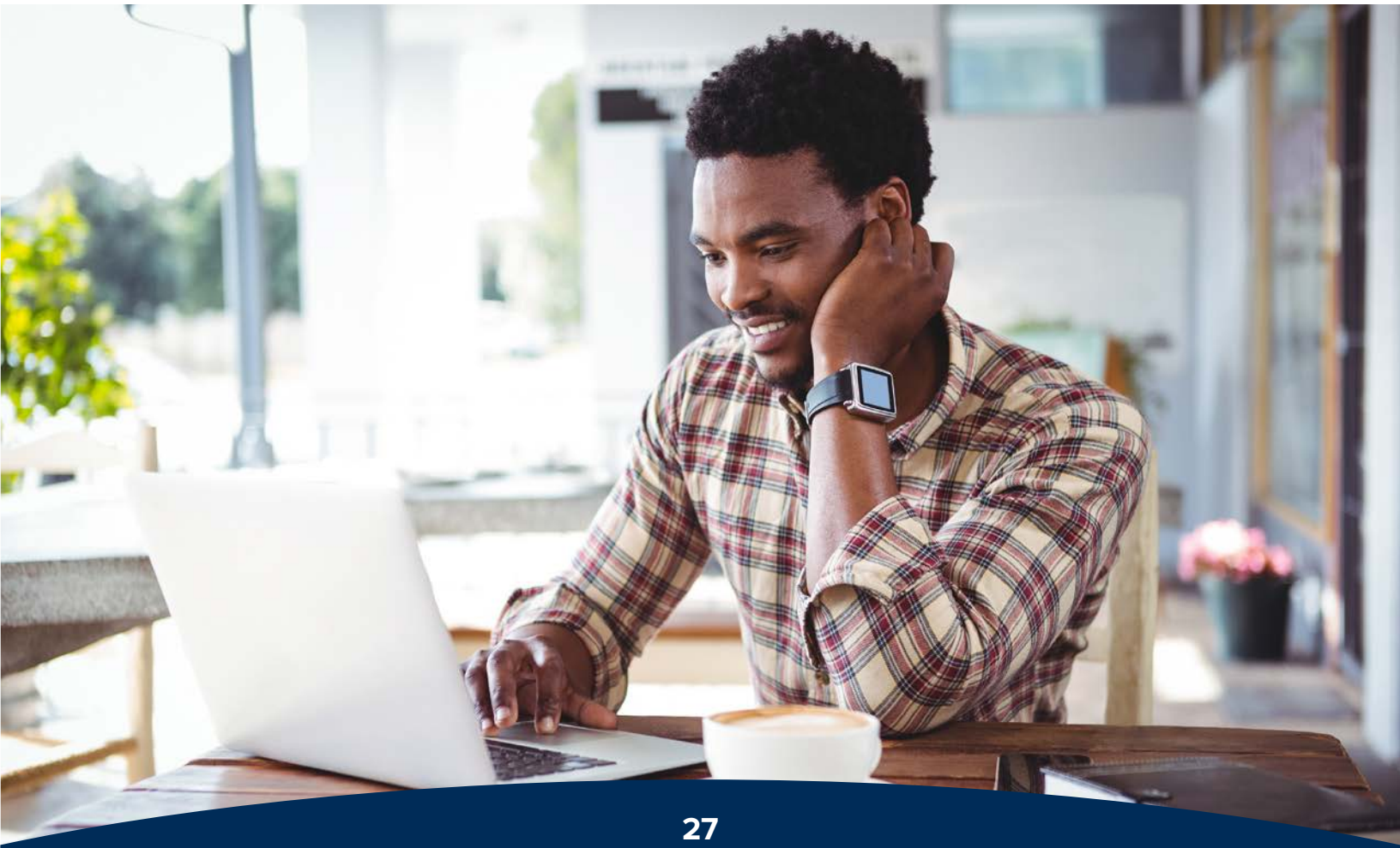
When choosing your monthly benefit, consider how much money you need to pay your monthly bills. Choose your monthly benefit amount based on your answer.

Visit **www.mybenefitshub.com/redoakisd** for rates.

File a Disability Claim

Visit **www.thehartford.com**.

Call **866-574-9124**.



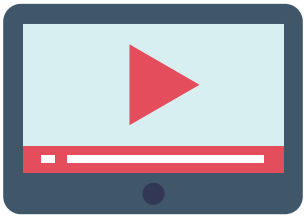
Accident Insurance

Lincoln Financial Group®

Accident insurance provides affordable protection against a sudden, unforeseen accident. This benefit helps offset the direct and indirect expenses resulting from an accident such as copayments, deductible, ambulance, physical therapy, childcare, rent, and other costs not covered by traditional health plans. See the plan documents for full details.

ACCIDENT INSURANCE		
	Low Plan	High Plan
Ambulance • Ground • Air	 $150 $750	 $225 $1,125
Emergency Room	$100	$150
Admission • Hospital • ICU	 $500 $1,000	 $1,000 $1,500
Confinement • Hospital	 $100 per day	 $200 per day
Specific Sum Injuries Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, and more	$50 - $500	$100-$1,000
Accidental Death & Dismemberment[1] • Employee • Spouse • Child(ren)	 $25,000 $10,000 $5,000	 $50,000 $20,000 $10,000
***Percentage of benefit paid for dismemberment is dependent on type of loss.**	5%-25%	10%-50%
Employee Monthly Contributions		
Employee Only	$6.24	$9.70
Employee and Spouse	$10.84	$16.54
Employee and Child(ren)	$12.48	$18.56
Employee and Family	$16.88	$25.18

[1] Percentage of benefit paid for dismemberment is dependent on type of loss.



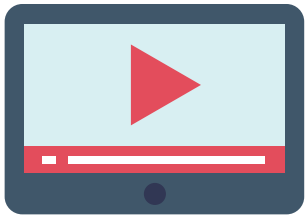
Watch and learn more!

Visit **www.mybenefitshub.com/redoakisd** for rates.

Hospital Indemnity Insurance

CHUBB

The Hospital Indemnity plans help you with the high cost of medical care by paying you a cash benefit when you have an inpatient hospital stay. Unlike traditional insurance which pays a benefit to the hospital or doctor, this plan pays you directly. It is up to you how you want to use the cash benefit. These costs may include meals, travel, childcare or eldercare, deductibles, coinsurance, medication, or time away from work. See the plan document for full details.



Watch and learn more!

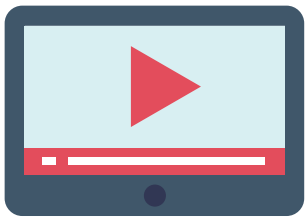
HOSPITAL INDEMNITY INSURANCE		
	Plan 1	Plan 2
Hospital Admission	$1,500	$2,500
Hospital Confinement	$100 per day up to 31 days	$250 per day up to 31 days
Intensive Care Unit Admission	$1,500	$2,500
Intensive Care Unit Confinement	$150 per day up to 31 days	$250 per day up to 31 days
Newborn Nursery	$150 per day up to 5 days	$250 per day up to 5 days
Observation Unit	$200 per day up to 2 days	$200 per day up to 2 days
Employee Monthly Contributions		
Employee Only	$17.26	$30.05
Employee and Spouse	$38.36	$66.72
Employee and Child(ren)	$31.90	$55.60
Employee and Family	$53.00	$92.26

Visit **www.mybenefitshub.com/redoakisd** for rates.

Cancer Insurance

CHUBB

Treatment for cancer is often lengthy and expensive. While your health insurance helps pay the medical expenses for cancer treatment, it does not cover the cost of non-medical expenses, such as out-of-town treatments, special diets, daily living, and household upkeep. In addition to these non-medical expenses, you are responsible for paying your health plan deductibles and/or coinsurance. Cancer insurance helps pay for these direct and indirect treatment costs so you can focus on your health.



Watch and learn more!

CANCER INSURANCE		
	Low Plan	High Plan
First Cancer Benefit	$100 paid upon receipt of first covered claim for cancer; only one payment per covered person per certificate per calendar year	$100 paid upon receipt of first covered claim for cancer; only one payment per covered person per certificate per calendar year
Diagnosis of cancer	Employee or spouse: $5,000 Child(ren): $7,500 Waiting period: 0 days Benefit reduction: none	Employee or spouse: $10,000 Child(ren): $15,000 Waiting period: 0 days Benefit reduction: none
Hospital confinement	$100 per day – days 1 through 30 Additional days: $100 Maximum days per confinement: 31	$200 per day – days 1 through 30 Additional days: $200 Maximum days per confinement: 31
Hospital confinement ICU	$600 per day – days 1 through 30 Additional days: $600 Maximum days per confinement: 31	$600 per day – days 1 through 30 Additional days: $600 Maximum days per confinement: 31
Radiation therapy, chemotherapy, immunotherapy	Maximum per covered person per calendar year 12-month period: $10,000	Maximum per covered person per calendar year 12-month period: $20,000
Alternative care	$75 per visit Maximum visits per calendar year: 4	$75 per visit Maximum visits per calendar year: 4
Medical imaging		
	Low Plan	High Plan
Employee Only	$14.64	$22.94
Employee and Spouse	$28.42	$43.60
Employee and Child(ren)	$18.06	$28.12
Employee and Family	$30.68	$46.04

Visit **www.mybenefitshub.com/redoakisd** for rates.

Emergency Transport Services

MASA MTS membership provides the ultimate peace of mind at an affordable rate for emergency ground and air transportation service within the U.S. and Canada, regardless of whether the provider is in or out of a given group health care benefits network. After the group health plan pays its portion, MASA MTS works with providers to deliver no cost emergency transport services to you.

Emergent Air Transportation

In the event of a serious medical emergency, you have access to emergency air transportation into a medical facility or between medical facilities.

Emergent Ground Transportation

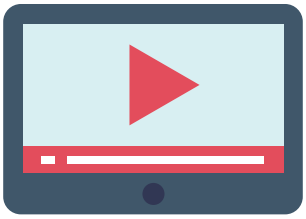
In the event of a serious medical emergency, you have access to emergency ground transportation into a medical facility or between medical facilities.

Non-Emergency Inter-Facility Transportation

If you are in stable condition in a medical facility but require a heightened level of care that is not available at your current medical facility, you have access to non-emergency air or ground transportation between medical facilities.

Repatriation/Recuperation

Suppose you or a family member is hospitalized more than 100-miles from your home. In that case, you have benefit coverage for air or ground medical transportation into a medical facility closer to your home for recuperation.



Watch and learn more!

For More Information

Visit **www.masamts.com**.

Call **800-423-3226**.

EMPLOYEE MONTHLY CONTRIBUTIONS	
Employee and Family	$14.00

ID Theft Protection

Identity theft is one of the fastest-growing crimes in the country. Millions of people have their identity stolen each year.

Protect yourself and restore your identity with coverage that includes:

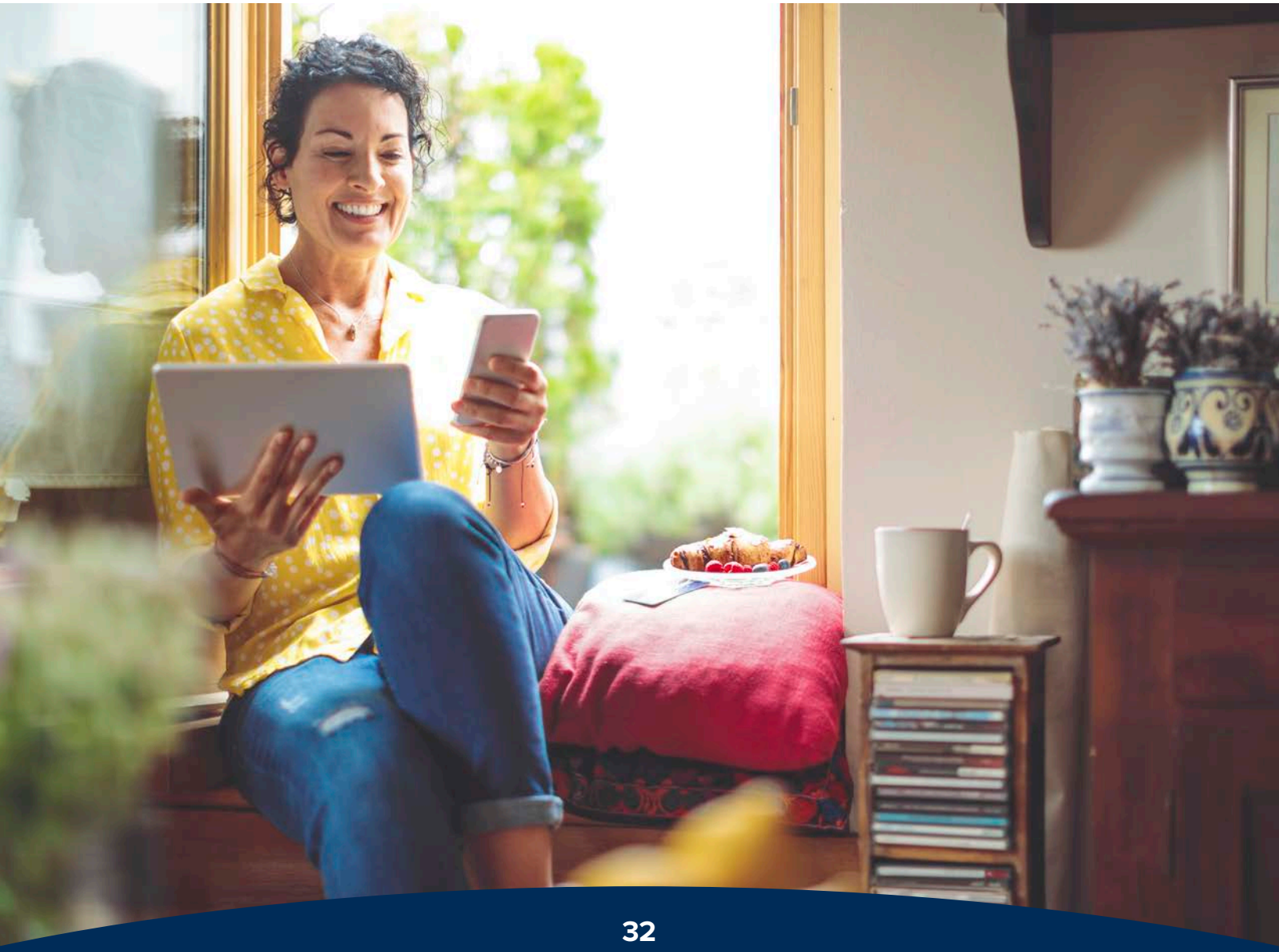
- Identity consultation and advice
- Licensed private investigators
- Identity and credit monitoring
- Social media monitoring
- Identity restoration
- Threat and credit alerts
- 24/7 emergency ID protection access
- Mobile app

EMPLOYEE MONTHLY CONTRIBUTIONS	
Employee Only	$7.50
Employee and Family	$14.00

For More Information

Visit **www.experian.com**.

Call **855-797-0052**.



Glossary of Terms

Beneficiary – Who will receive a benefit in the event of the insured's death. A policy may have more than one beneficiary.

Coinsurance – Your share of the cost of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for health care services received.

Deductible – The amount you owe for health care services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you meet your $1,000 deductible for covered health care services. The deductible may not apply to all services, including preventive care.

Employee Contribution – The amount you pay for your insurance coverage.

Employer Contribution – The amount your employer contributes to the cost of your benefits.

Explanation of Benefits (EOB) – A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, what portion of the claim is your responsibility, and information on how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Flexible Spending Account (FSA) – An option that allows participants to set aside pretax dollars to pay for certain qualified expenses during a specific time period (usually a 12-month period).

Health Savings Account (HSA) – A personal savings account that allows you to pay for qualified medical expenses with pretax dollars.

High Deductible Health Plan (HDHP) – A medical plan with a higher deductible in exchange for a lower monthly premium. You must meet the annual deductible before any benefits are paid by the plan.

In-Network – Doctors, hospitals, and other providers that contract with your insurance company to provide health care services at discounted rates.

Out-of-Network – Doctors, hospitals, and other providers that are not contracted with your insurance company. If you choose an out-of-network provider, you may be responsible for costs over the amount allowed by your insurance carrier.

Out-of-Pocket Maximum – Also known as an out-of-pocket limit. The most you pay during a policy period (usually a 12-month period) before your health insurance or plan begins to pay 100% of the allowed amount. The limit does not include your premium, charges beyond the Reasonable and Customary (R&C) Allowance, or health care your plan does not cover. Check with your health insurance carrier to confirm what payments apply to the out-of-pocket maximum.

Preventive Care – The care you receive to prevent illness or disease. It also includes counseling to prevent health problems.

Reasonable and Customary (R&C) Allowance – Also known as an eligible expense or the Usual and Customary (U&C). The amount your insurance company will pay for a medical service in a geographic region based on what providers in the area usually charge for the same or similar medical service.

SSNRA – Social Security Normal Retirement Age.

Important Legal Notices

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for, such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Red Oak ISD
109 W. Red Oak Road
Red Oak, TX 75154
972-617-2941

Important Legal Notices

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Red Oak ISD and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Red Oak ISD has determined that the prescription drug coverage offered by the Red Oak ISD medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. The HSA plan is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting Red Oak ISD at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current Red Oak ISD prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at **972-617-2941**.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

Important Legal Notices

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov.**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

September 1, 2025
Red Oak ISD
109 W. Red Oak Road
Red Oak, TX 75154
972-617-2941

Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of Notice: September 23, 2013

Red Oak ISD's Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1 – Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Important Legal Notices

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.
6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In which case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

Important Legal Notices

9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2 – Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

Important Legal Notices

Protected Health Information (PHI)

Includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set

Includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Important Legal Notices

Section 3 – The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted, you will also receive a copy of the Notice or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4 – Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5 – Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at:

Red Oak ISD
109 W. Red Oak Road
Red Oak, TX 75154
972-617-2941

Important Legal Notices

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of March 17, 2025. Contact your State for more information on eligibility.

Texas – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493

To see if any other States have added a premium assistance program since **March 17, 2025**, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Continuation of Coverage Rights Under COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you are covered under the Red Oak ISD group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the Red Oak ISD plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan Contact Information

Red Oak ISD
109 W. Red Oak Road
Red Oak, TX 75154
972-617-2941

Important Legal Notices

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- Emergency services – If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Certain services at an in-network hospital or ambulatory surgical center – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact your insurance provider. Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

Notes

for a healthy you

Higginbotham™ Public Sector

This brochure highlights the main features of the Red Oak ISD employee benefits program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Red Oak ISD reserves the right to change or discontinue its employee benefits plans at anytime.