EMPLOYEE BENEFITS PRESENTATION

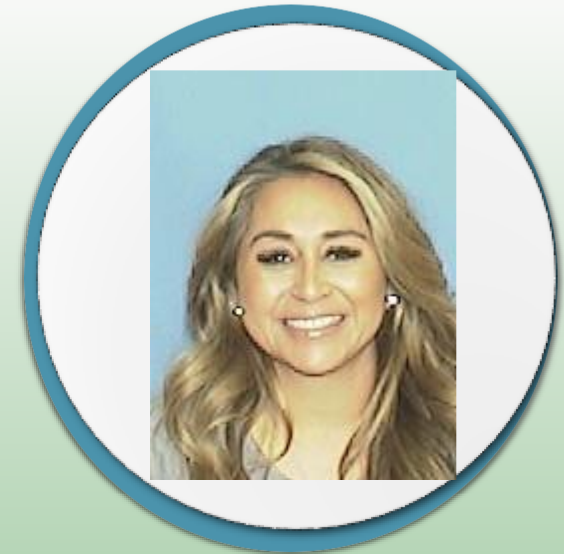
Benefits & Risk Management Team

YOLANDA GORDON

DIRECTOR

ESTELA VEJIL

RISK MANAGER



Erica Proaño

HEALTH

BENEFITS SPECIALIST

NOTICE

Enrollment is mandatory

31-day window from date of hire

Medical premiums are paid in advance

Payroll runs mid-month

Ector County ISD
Option I PPO Plan

MEDICAL BENEFIT SUMMARY
Effective Date: January 1, 2026

BlueCross BlueShield of Texas

BlueChoice PPO Network

This is a general summary of our proposed benefits. *Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses.* *Please carefully review the plan's limitations and exclusions.*

Overall Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)
Lifetime Maximum	*Unlimited*	
Medical Individual/Family Coverage Deductible		
Applies to all Eligible Medical Expenses, unless otherwise indicated.	*$ 2,250 Individual $4,500 Family*	*$4,500 Individual $9,000 Family*
Coinsurance	*25%*	*40%*
Individual/Family Medical Coverage Out-of-Pocket Expense (OPX) Limit		
Deductible and Copayment applies to Out-of-Pocket ** Copayment Amounts and per admission Deductibles are applied but will continue to be required after the benefit percentage increases to 100%.	*$6,750 Individual $13,500 Family*	*$12,500 Individual** $ 25,000 Family***

Physician Services	PPO (In-Network)	Non-PPO (Out-of-Network)
Physician Office Visits		
Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians	*$60 PCP Copay**	*40% of Allowable Amount after Deductible*
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider (Does not include Certain Diagnostic Procedures and surgical services). Copayment applies for each visit to the physician's office. Surgeries, therapies, and certain diagnostic procedures performed in a physician's office may be subject to the Deductible and/or coinsurance.	*$100 Specialist Copay**	*40% of Allowable Amount after Deductible*
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, and any other preventive health services as determined by USPSTF	*100% of Allowable Amount*	*Not Coverede*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount*	*Not Covered*
Medical / Surgical Services		
Physician inpatient hospital visits or surgical services performed in any setting	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*

Hospital Services- Inpatient and Outpatient	PPO (In-Network)	Non-PPO (Out-of-Network)
Penalty for failure to preauthorize services	*None*	*$1000*
For Inpatient Facility Services, Blue Cross Blue Shield of TX Participating Provider is required to obtain preauthorization. If preauthorization is not obtained, the Participating Provider will be sanctioned based on Blue Cross Blue Shield of TX contractual agreement with the Provider, therefore the member will be held harmless for the Provider sanction		
Hospital Admission Deductible		
Per admission, per individual	*None*	*$250 per admission deductible*
Inpatient Hospital Services		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units Room allowances based on the hospital's most common semi-private room rates.	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after per admission Deductible and medical deductible*
Outpatient Hospital Services		
Coverage for services performed in an outpatient facility or ambulatory surgical center. All other outpatient services and supplies Home Infusion Therapy *(Services must be preauthorized)*	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Lab/X-Ray in other Outpatient Facilities, excluding Certain Diagnostic Procedures	*25% of Allowable Amount*	*40% of Allowable Amount after Deductible*

	PPO (In-Network)	Non-PPO (Out-of-Network)
Certain Diagnostic Procedures such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Extended Care Services	**PPO (In-Network)**	**Non-PPO (Out-of-Network)**
Skilled Nursing *(60 visits per benefit period)*	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Home Health Care *(100 visits per benefit period)*	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Hospice Services	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*

Special Provisions Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Mental Health & Chemical Dependency Treatment Services ***Penalty for failure to preauthorize services***	*Same as any other illness* *Same as Inpatient Penalty (None INN / $1000 OON)*	
Emergency Room/Treatment Room		
Facility Charges	*$200 Copayment plus 25% of Allowable Amount after deductible*	
Physician Charges	*25% of Allowed Amount after Deductible*	
Urgent Care Services Urgent Care center visit *(Copayment does not include Certain Diagnostic Procedures and surgical services)*	*$60 Copayment, deductible does not apply*	*40% of Allowed Amount after Deductible*
Ground and Air Ambulance Services	*25% of Allowable Amount after Deductible*	
Physical Medicine Services – Occupational, Physical, Speech and Chiropractic		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy) Coverage for services provided by a physician or therapist. Includes Physical, Occupational, and Speech Services. *Limited to a combine 100 visits for Physical, Occupational and Speech services per benefit period*		
Physical Medicine Services in the Physician's Office	*$60 PCP Copay $100 Specialist Copay*	*40% of Allowable Amount after Deductible*
Physical Medicine Services in an Outpatient Facility	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Chiropractic Care (limited to 24 visits per benefit period)	*$60 PCP Copay $100 Specialist Copay*	*40% of Allowable Amount after Deductible*
Hearing Aid Maximum	*Hearing Aids are limited to 1 per ear every 36 months*	
Organ and Tissue Transplant Services	*Covered same as any other illness if treatment provided at a Blue Distinction Center*	
Bariatric Surgery/Treatment of Morbid Obesity	*Medical/Surgical covered same as any other sickness if treatment is provided at a Blue Distinction Center*	

Ector County ISD
Option II PPO Plan

BlueCross BlueShield of Texas

MEDICAL BENEFIT SUMMARY
Effective Date: January 1, 2026

BlueChoice PPO Network

This is a general summary of our proposed benefits. *Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.*

Overall Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)
Lifetime Maximum	*Unlimited*	
Medical Individual/Family Coverage Deductible		
Applies to all Eligible Medical Expenses, unless otherwise indicated.	*$ 3,000 Individual $6,000 Family*	*$6,000 Individual $12,000 Family*
Coinsurance	*25%*	*40%*
Individual/Family Medical Coverage Out-of-Pocket Expense (OPX) Limit		
Deductible and Copayment applies to Out-of-Pocket ** Copayment Amounts and per admission Deductibles are applied but will continue to be required after the benefit percentage increases to 100%.	*$6,000 Individual $12,000 Family*	*$16,000 Individual** $30,000 Family***

Physician Services	PPO (In-Network)	Non-PPO (Out-of-Network)
Physician Office Visits		
Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider (Does not include Certain Diagnostic Procedures and surgical services). Copayment applies for each visit to the physician's office. Surgeries, therapies, and certain diagnostic procedures performed in a physician's office may be subject to the Deductible and/or coinsurance.	*25% of Allowable Amount after Deductible **	*40% of Allowable Amount after Deductible*
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, and any other preventive health services as determined by USPSTF	*100% of Allowable Amount*	*Not Coverede*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount*	*Not Covered*
Medical / Surgical Services		
Physician inpatient hospital visits or surgical services performed in any setting	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*

Hospital Services- Inpatient and Outpatient	PPO (In-Network)	Non-PPO (Out-of-Network)
Penalty for failure to preauthorize services	*None*	*$1000*
For Inpatient Facility Services, Blue Cross Blue Shield of TX Participating Provider is required to obtain preauthorization. If preauthorization is not obtained, the Participating Provider will be sanctioned based on Blue Cross Blue Shield of TX contractual agreement with the Provider, therefore the member will be held harmless for the Provider sanction		
Hospital Admission Deductible		
Per admission, per individual	*None*	*$250 per admission deductible*
Inpatient Hospital Services		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units Room allowances based on the hospital's most common semi-private room rates.	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after per admission Deductible and medical deductible*
Outpatient Hospital Services		
Coverage for services performed in an outpatient facility or ambulatory surgical center. All other outpatient services and supplies Home Infusion Therapy *(Services must be preauthorized)*	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Lab/X-Ray in other Outpatient Facilities, excluding Certain Diagnostic Procedures	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*

Ector County ISD
Option II PPO Plan

BlueCross BlueShield of Texas

	PPO	Non-PPO
Certain Diagnostic Procedures such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*

Extended Care Services	PPO (In-Network)	Non-PPO (Out-of-Network)
Skilled Nursing *(60 visits per benefit period)*	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Home Health Care *(100 visits per benefit period)*	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Hospice Services	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*

Special Provisions Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Mental Health & Chemical Dependency Treatment Services	*Same as any other illness*	
Penalty for failure to preauthorize services	*Same as Inpatient Penalty (None INN / $1000 OON)*	
Emergency Room/Treatment Room		
Facility Charges	*$200 Copayment plus 25% of Allowable Amount after deductible*	
Physician Charges	*25% of Allowed Amount after Deductible*	
Urgent Care Services Urgent Care center visit *(Copayment does not include Certain Diagnostic Procedures and surgical services)*	*25% of Allowable Amount after Deductible*	*40% of Allowed Amount after Deductible*
Ground and Air Ambulance Services	*25% of Allowable Amount after Deductible*	
Physical Medicine Services – Occupational, Physical, Speech and Chiropractic		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy) Coverage for services provided by a physician or therapist. Includes Physical, Occupational, and Speech Services. *Limited to a combine 100 visits for Physical, Occupational and Speech services per benefit period*		
Physical Medicine Services in the Physician's Office	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Physical Medicine Services in an Outpatient Facility	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Chiropractic Care (limited to 24 visits per benefit period)	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Hearing Aid Maximum	*Hearing Aids are limited to 1 per ear every 36 months*	
Organ and Tissue Transplant Services	*Covered same as any other illness if treatment provided at a Blue Distinction Center*	
Bariatric Surgery/Treatment of Morbid Obesity	*Medical/Surgical covered same as any other sickness if treatment is provided at a Blue Distinction Center*	

BlueCross BlueShield of Texas

MEDICAL BENEFIT SUMMARY
Effective Date: January 1, 2026

BlueChoice PPO Network

This is a general summary of our proposed benefits. *Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.*

Overall Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)
Lifetime Maximum	*Unlimited*	
Medical Individual/Family Coverage Deductible		
Applies to all Eligible Medical Expenses, unless otherwise indicated.	*$ 2,000 Individual $4,000 Family*	*$6,500 Individual $13,000 Family*
Coinsurance	*25%*	*40%*
Individual/Family Medical Coverage Out-of-Pocket Expense (OPX) Limit		
Deductible and Copayment applies to Out-of-Pocket ** Copayment Amounts and per admission Deductibles are applied but will continue to be required after the benefit percentage increases to 100%.	*$6,000 Individual $12,000 Family*	*$15,000 Individual** $30,000 Family***

Physician Services	PPO (In-Network)	Non-PPO (Out-of-Network)
Physician Office Visits		
Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider (Does not include Certain Diagnostic Procedures and surgical services). Copayment applies for each visit to the physician's office. Surgeries, therapies, and certain diagnostic procedures performed in a physician's office may be subject to the Deductible and/or coinsurance.	*25% of Allowable Amount after Deductible **	*40% of Allowable Amount after Deductible*
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, and any other preventive health services as determined by USPSTF	*100% of Allowable Amount*	*Not Covered*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount*	*Not Covered*
Medical / Surgical Services		
Physician inpatient hospital visits or surgical services performed in any setting	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*

Hospital Services- Inpatient and Outpatient	PPO (In-Network)	Non-PPO (Out-of-Network)
Penalty for failure to preauthorize services	*None*	*$1000*
For Inpatient Facility Services, Blue Cross Blue Shield of TX Participating Provider is required to obtain preauthorization. If preauthorization is not obtained, the Participating Provider will be sanctioned based on Blue Cross Blue Shield of TX contractual agreement with the Provider, therefore the member will be held harmless for the Provider sanction		
Hospital Admission Deductible		
Per admission, per individual	*None*	*$250 per admission deductible*
Inpatient Hospital Services		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units Room allowances based on the hospital's most common semi-private room rates.	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after per admission Deductible and medical deductible*
Outpatient Hospital Services		
Coverage for services performed in an outpatient facility or ambulatory surgical center. All other outpatient services and supplies Home Infusion Therapy *(Services must be preauthorized)*	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Lab/X-Ray in other Outpatient Facilities, excluding Certain Diagnostic Procedures	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*

BlueCross BlueShield of Texas

	PPO (In-Network)	Non-PPO (Out-of-Network)
Certain Diagnostic Procedures such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*

Extended Care Services	PPO (In-Network)	Non-PPO (Out-of-Network)
Skilled Nursing *(60 visits per benefit period)*	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Home Health Care *(100 visits per benefit period)*	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Hospice Services	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*

Special Provisions Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Mental Health & Chemical Dependency Treatment Services	*Same as any other illness*	
Penalty for failure to preauthorize services	*Same as Inpatient Penalty (None INN / $1000 OON)*	
Emergency Room/Treatment Room		
Facility Charges	*$200 Copayment plus 25% of Allowable Amount after deductible*	
Physician Charges	*25% of Allowed Amount after Deductible*	
Urgent Care Services Urgent Care center visit *(Copayment does not include Certain Diagnostic Procedures and surgical services)*	*25% of Allowable Amount after Deductible*	*40% of Allowed Amount after Deductible*
Ground and Air Ambulance Services	*25% of Allowable Amount after Deductible*	
Physical Medicine Services – Occupational, Physical, Speech and Chiropractic		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy) Coverage for services provided by a physician or therapist. Includes Physical, Occupational, and Speech Services. *Limited to a combine 100 visits for Physical, Occupational and Speech services per benefit period*		
Physical Medicine Services in the Physician's Office	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Physical Medicine Services in an Outpatient Facility	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Chiropractic Care (limited to 24 visits per benefit period)	*25% of Allowable Amount after Deductible*	*40% of Allowable Amount after Deductible*
Hearing Aid Maximum	*Hearing Aids are limited to 1 per ear every 36 months*	
Organ and Tissue Transplant Services	*Covered same as any other illness if treatment provided at a Blue Distinction Center*	
Bariatric Surgery/Treatment of Morbid Obesity	*Medical/Surgical covered same as any other sickness if treatment is provided at a Blue Distinction Center*	

2026 PRESCRIPTION BENEFITS

Benefits at a Glance

At LucyRx, we recognize that school employees are the light guiding our success. That's why we're proud to support your health and well-being.

Ector ISD Plan Option 1

30-day Generic	$0 deductible waived
30-day Preferred Brand	$100 after Deductible
30-day Non-Preferred Brand	$175 after Deductible
90-day Generic	$0 deductible waived
90-day Preferred Brand	$200 after Deductible
90-day Non-Preferred Brand	$350 after Deductible
Specialty	Lesser of $1,500 or 25% after Deductible
Deductible	$500 per Person for Brand /Specialty only
Out of Pocket Maximum	$2,750 Individual $5,500 Family

Ector ISD Plan Option 2

30-day Generic	$0 deductible waived
30-day Preferred Brand	$100 after Deductible
30-day Non-Preferred Brand	$175 after Deductible
90-day Generic	$0 deductible waived
90-day Preferred Brand	$200 after Deductible
90-day Non-Preferred Brand	$350 after Deductible
Specialty	Lesser of $1,500 or 25% after Deductible
Deductible	$500 per Person for Brand /Specialty only
Out of Pocket Maximum	$2,500 Individual $5,000 Family

Ector ISD Plan Option 3 - HSA

30-day Generic	0% after Deductible
30-day Preferred Brand	25% after Deductible
30-day Non-Preferred Brand	25% after Deductible
90-day Generic	25% after Deductible
90-day Preferred Brand	25% after Deductible
90-day Non-Preferred Brand	25%
Specialty	25%
Deductible	$1,700 Individual $3,400 Family
Out of Pocket Maximum	$2,500 Individual $5,000 Family

Connect with us!

Call us anytime at 877-860-8846.

Visit **www.lucyrx.com/ubc** for your formulary, welcome guide, FAQs and more.

Getting Started with Your LucyRx Benefit

Here's how to start using your benefit and access support:

1. **Check your ID card**
   Look for the LucyRx logo on the prescription insurance card you received to confirm your prescription coverage. If you're unsure, ask your employer or contact our 24/7 Prescription Care team.

2. **Show your card at the pharmacy**
   When filling a prescription, show your insurance card at the pharmacy so they can process your coverage correctly.

3. **Register online**
   Visit www.lucyrx.com/members to create your digital account and view your plan details.

4. **Download the app**
   Use the LucyRx app (available in the App Store and Google Play) to manage your prescriptions anytime, anywhere.

We're proud to be on your care team.
Let's make this easier—together.

Questions? We're here 24/7 at 877-860-8846 or online at www.lucyrx.com/members.

Plan Definitions & Coverage Conditions

- **Eligible Employee – full-time employee (spouse & dependent children up to the age of 26)**
- **District plans do not provide coverage to dependents of covered dependents.**
- **Waiting Period – coverage will be effective the first of the month following the date of hire, unless an employee is hired on the first working day of the month at which the effective date will be the first day of the month**
- **Medical premiums are paid in advance-for example., January pays for February, February pays for March and so on…….**
- **Open Enrollment Period – starts in the Fall – schedule will be emailed and posted on the benefits web page (open enrollment changes are effective in January of the proceeding year. *New Hires of a given year must participate in Open Enrollment regardless of their start date.***

Available services at no cost to participants of Option I & II.
Participants of Option III HSA pay a $25.00 co-pay

ECISD Health & Wellness Center

- Monday – Friday 8:00am to 5:00pm
- All services provided are at no cost to employees on Option I or II (visits, lab work, shots, etc.)
- Employees on Option III with an HSA will have a $25.00 co-pay
- Excluded: Employees on the Hospital Indemnity Plan

Preventative Care

- Adult Immunizations
- Annual Physicals
- Health Screenings
- Lab Work/Tests
- Men's Health
- Well Women Exams

Urgent Care

- Colds/Flu/Congestion
- Diarrhea/Constipation
- Headaches/Migraines
- Muscle/Joint Pain
- Nausea/Vomiting
- Seasonal Allergies
- Sinus Infection
- Sore Throat
- Sprain/Strains
- Skin Cuts/Rashes
- Urinary Tract Infections

Chronic Condition Care

- Asthma/Emphysema
- Depression/Anxiety
- Diabetes Treatment
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Thyroid Conditions
- Weight Management

Mental & Behavioral Health

You have access to a mental Health professional!
Schedule with Eliana Brito, LPC
By calling the Health & Wellness Center.

Eliana's Hours

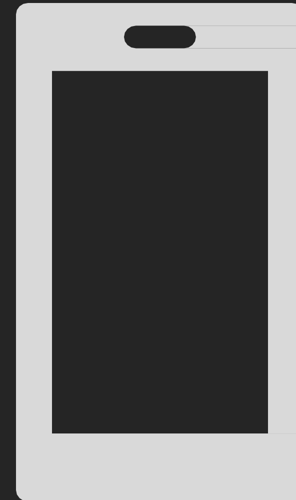
Tuesday/Wednesday	8:00-5:00pm
Friday	8:00am-12:00pm

Three easy ways to schedule an appointment:

RECURO Telehealth

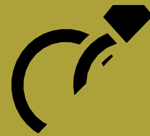
Members and covered dependents have access to care for non-emergency medical issues through RECURO. They will be able to request a consultation 24/7/365 by web, mobile app, or calling RECURO's Patient Care Center.

- 24/7 access to board-certified doctors for treatment of common medical concerns with ongoing communication with your doctor, free of change.
- Comprehensive behavioral health care from therapy and counseling to psychiatry and medication management. Our Behavioral Health platform is always accessible at no additional cost to you. When you would like to setup a secure virtual session with one of our licensed counselors or psychiatrist, your cost is minimal.



Qualifying Events

You have the option to change your coverage outside of Open Enrollment if you experience a qualifying life event. Qualifying life events must be reported to the Benefits Department within 31 days of the life event, otherwise you must wait until the next Open Enrollment Period to make any changes.



Examples: Birth, Marriage/ Divorce, Lost/Gained other coverage

Important Message: You have 31 days from the date of birth to add a new baby.

Family Medical Leave Act - FMLA

Leave Reason:

- Birth/Adoption
- Bond with child
- Care for the employee's spouse, child or parent who has a qualifying heath condition
- Employee's own qualifying serious health condition

Eligibility Requirements:

- Have at least 1,250 hours of service in the 12 months before taking leave; and
- Work at a location where the employer has at least 50 employees within 75 miles of employees' worksite

MetLife Dental

Type	In-Network	Out-of-Network
Type A - Preventive	100%	100%
Type B- Basic	80%	80%
Type C - Major	50%	
Type D - Orthodontia	Dependent children to the age of 19 only Maximum $1,000 per person	

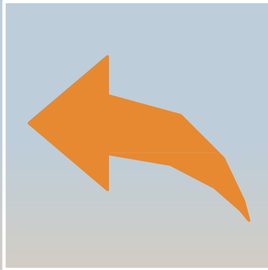
Superior by MetLife Vision

Service	Frequency	High Plan	Low Plan
Exam	Once every 12 months	Covered in full	$10 Co-pay
Frame	Once every 12 months	$150 Allowance	$125 Allowance
Corrective Lenses	Once every 12 months	Covered in full	$20 Co-pay
Lens Enhancements	Once every 12 months	Covered in full	Covered in full

Optional Benefits

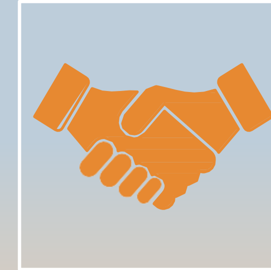
- Accident Insurance - MetLife
- Cancer - American Fidelity
- Cancer, Heart & Stroke Insurance - Allstate
- Critical Illness - MetLife
- Disability - The Standard
- Hospital Indemnity Insurance
- HSA- Health Saving Account - First Financial
- FSA– Flexible Spending Account – First Financial
- ilock - Identity Theft Shield
- Legal Shield
- Life Benefits - Allstate - Group Whole Life Insurance
- Life Benefits - Standard Life
- Life Benefits - Texas Life
- Long-Term-Care-- -Genworth
- MASA- Medical Transport

403(b) or 457(b) Contributions



As an employee of the district, you are eligible to contribute to a 403(b) or a 457(b)-retirement account.

The contributions are taken before federal income taxes



Contract First Financial:

800-523-8422

The Standard Life Basic Group Life

ECISD provides all full-time employees with $10,000 Basic Life insurance through the Standard Life. Employees are automatically enrolled when they complete a medical plan enrollment. This $10,000 Policy is at ***NO COST to you!***

Completing Your Enrollment

After viewing this presentation, you must email the Benefits Department at **Benefits@ectorcountyisd.org** so that your record in the FFenroll Portal can be activated. Activation of your record gives you access to complete your enrollment. Instructions and the link to the FFenroll site will be emailed to you once your email is received.

Note: **Include your full name and ID number in your email.**

Benefits Office Number: 432-456-9789
Office Hours: 8:00 AM to 5:00 PM

ECISD