Plan Year 2026 - 2027

EMPLOYEE BENEFITS **GUIDEBOOK**









Who To Contact

DIRECTORY

Refer to this list when you need to contact one of your benefit providers. For general information, please contact **Brown & Brown** or **Accounting Supervisor, Violet Reyes** at vreyes@poteetisd.org. You can also contact **Payroll Clerk, Rachel Hernandez** at rhernandez@poteetisd.org.

What's New 2026?	Benefit	Policy Number	Contact
• **New Dental Contribution Rates** • **New Vision Contribution Rates**	**Medical** Kempton	100022	(888) 820-6022 www.kemptongroup.com
	Flexible Savings Account **COBRA** NBS	N/A	(800) 274-0503 www.nbsbenefits.com
	Dental Guardian	00066581	(800) 627-4200 https://www.guardianlife.com/dental-insurance
	Vision Guardian - VSP	00066581	(877) 814-8970 https://www.guardianlife.com/vision-insurance
	Long-Term Disability **Basic Term Life and AD&D** **Supplemental Term Life** The Hartford	166284 166284 0449744	(888) 277-4767 (888) 563-1124 Claims https://www.thehartford.com/employee-benefits
	Accident **Critical Illness** **Hospital Indemnity** Voya	745871	(800) 955-7736 mybenefitshub.voya.com
Benefits Service Center	**SafetyNets Plus** SafetyNets Plus	N/A	(800) 787-3988 www.safetynetplus.com
	Universal LifeEvents with Long-Term Care Trustmark	N/A	(800) 918-8877 www.trustmarkbenefits.com
Benefits Service Center: **(866) 335-6368** **Monday - Friday:** 8:00 AM - 7:00 PM (CST)	**Employee Assistance Program** AllOne Health	N/A	(800) 451-1834 allonehealth.com/portal
	RediMD RediMD	N/A	(888) 733-4635 www.redimd.com
	Medical Transport MASA	N/A	https://getmasa.com

Staff Member	Email	Phone
Brown & Brown Insurance Services **Carolina Arias** Account Manager	carolina.arias@bbrown.com	(210) 524-7130

Here's What's Ahead

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About this Benefits Guidebook

This Benefits Guidebook describes the highlights of Poteet ISD's benefits program in nontechnical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents, and not the information in this Guidebook.

If there is any discrepancy between the description of the program elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. You should be aware that any and all elements of Poteet ISD's benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules, or otherwise as decided by Poteet ISD.

Take Note

If you fail to make your new hire or annual Open Enrollment benefit elections by the deadline given, you will not have the opportunity to enroll in until the next annual Open Enrollment, unless you experience a qualifying life event.

For more information about qualifying life event, visit page 6.

Your Employee Benefits

WELCOME

Each year, we remain committed to offering our employees a comprehensive, competitive, and thoughtfully designed benefits package. Our goal is to ensure that you and your family have access to meaningful coverage options that support your health, financial security, and overall well-being throughout the year.

In the following pages, you will find an overview of the benefit plans available for the **September 1st, 2026 to August 31st, 2027 Plan Year.** This Guidebook is intended to serve as a helpful resource as you evaluate your options and prepare to make your benefit elections for the upcoming Plan Year. We encourage you to review the information carefully so you can make informed decisions that best meet your personal and family needs.

To enhance your enrollment experience, Poteet ISD will be partnering with Accretive Enrollment Services (AES) for benefit communication and enrollment support. AES' team of highly trained Benefit Advisors will be available to guide you through every aspect of your benefit program.

During your one-on-one, confidential session, Benefit Advisors will:

- Provide a clear and detailed explanation of each benefit option
- Help you understand how the plans work and how they may apply to your individual circumstances
- Answer any questions you may have about coverage, costs, or eligibility
- Discuss personal or family situations that could influence your benefit choices
- Assist you in completing your enrollment accurately and efficiently

Our partnership with AES is designed to ensure that every employee receives personalized attention and support. Whether you are enrolling for the first time or reviewing your existing coverage, AES' Benefit Advisors are here to help you feel confident in the decisions you make for the year ahead.



2026-2027 Open Enrollment

Your 2025-2026 benefit elections will not automatically rollover to the 2026-2027 plan year. You must elect or waive benefits to be covered effective 9/1/2026.

Open Enrollment (OE) runs from
July 27th, 2026 - August 7th, 2026

Who Is Qualified?

ELIGIBILITY

Employee Eligibility

Group health coverage and all other benefits are available to full-time **(30 or more hours per week)** employees. The insurance plan year is from September 1st through August 31st.

Effective Dates of Coverage

In order for an employee's coverage to take effect, the employee must call in to the Benefits Service Center for coverage for the employee and any eligible dependents. If you are hired on the 1st day of the month your benefits would become effective that day. If you are hired in the middle of the month, your benefits would become effective 1st of the month following.

Dependent Eligibility

If you apply for coverage, you may include your dependents. All employees must ensure that only family members who meet the following requirements are enrolled in the Poteet ISD insurance and health care benefit programs.

You may also cover your eligible dependents, including:

- Legal spouse, Same Sex, Common Law Spouses, and Domestic Partners
- Your eligible children up to age 26 for medical, dental and vision coverage.
- "Children" are defined as your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian.
  Child means:
    - Your natural child; or
    - Your legally adopted child, including a child for whom the participant is a party in a suit in which the adoption of the child is sought; or
    - Your stepchild; or
    - A grandchild can be covered if:
        - Unmarried
        - Under age 25
        - Claimed as the employee's dependent for federal income tax purposes at the time the dependent coverage is applied for
    - A child for who a Participant has received a court order requiring that Participant to have financial responsibility for providing health insurance; or
    - A child not listed above:
        - Whose primary residence is your household; and
        - To who you are legal guardian or related by blood or marriage; and
        - Who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.
        - Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

Adjust Benefits When Life Shifts

QUALIFYING LIFE EVENTS

If you experience a Qualifying Life Event (for instance: getting married or having a baby), please contact HR; proof of the Qualifying Life Event must be submitted to your Human Resources within 31 days in order to change current benefit election.

- A change in the number of dependents (birth, adoption, death, guardianship);
- A change in marital status (marriage, divorce, death, legal separation);
- A dependent's loss of eligibility (attainment of limiting age or change in student status);
- A change in associate's, spouse's, or dependents' work hours;
- A termination or commencement of employment of associate's spouse or eligible dependent with coverage;
- Other events as the administrator determines to be permitted or any other applicable guidelines issued by the Internal Revenue Service.

An employee must ensure the change in coverage is consistent with the status change. For example, if the employee gets married, he/she has 30 calendar days to enroll the new spouse or drop coverage if the employee will be added to the spouse's plan.

Due to Texas Senate Bill 51 guidelines, **medical termination requests may be processed the first of the month following the date in which the Life Event is entered.** This may result in a modification to your medical termination and medical effective change dates.

If you have experienced a Qualifying Life Event and wish to update your benefits enrollment, you are required to complete the following task within 31 days:

Please notify HR for QLE changes by emailing HR.

Please do not hesitate to reach out to AES or your Human Resources with any questions/concerns.

It is our pleasure to assist!

After Your Change Has Been Processed

- ☐ Review your confirmation. Carefully review the changes and immediately advise AES of any discrepancies.
  - Proper address and contact information
  - Appropriate coverage, costs, and effective dates
  - Updated dependent and beneficiary information
- ☐ Plan for the financial impact. Updates to your deductions will be processed within 1-2 pay cycles. Double deductions to assess missed premiums may be required. You may review the Payroll Calendar to determine when your deduction changes will be processed.
- ☐ Review your paycheck stub(s). Premiums for the current month are paid on the last day of the month for salaried employees and on the 15th and the last day of the month for hourly employees. Ensure that any required adjustments to your pay appear as you expected and immediately notify Talent Management discrepancies.
- ☐ Watch for or Print new ID cards. Carrier updates will be processed within 5 business days from the date your enrollment is processed. You may print ID cards online no sooner than 10 business days after completing your enrollment. If you make changes that require new ID cards, the medical provider will issue new medical/Rx cards within 14 business days.

Options For You

WAYS TO ENROLL

How To Enroll

You have the option of **calling** one of our Benefits Advisors at the Benefits Service Center, meet with a Benefit Advisor **face to face** to learn more about your benefits and complete your enrollment process by either electing, changing, or waiving benefits. or enroll **online for self-service**.

Virtual Enrollment: 8/3/26 - 8/7/26
Scan the QR Code or click the link below to schedule your virtual enrollment session.
Link: https://calendly.com/poteet-isd

Face to Face Enrollment: 7/30/26 & 8/1/26
Location: Poteet High School Libary

For **Self-Service Instructions** visit page 8.

For **New-Hire Checklist** visit page 9.

Avoid Making Quick Decisions - Enroll Early!

The benefits plan year is September 1st through August 31st.

Benefits Effective Date

Generally, you cannot make any changes to your benefits during the year, unless you experience a Qualifying Life Event (QLE).

- **New Hires:** Your coverage begins the first of the month following your date of hire.
- **Current Employees:** Any changes you make during the annual open enrollment period will become effective on September 1st.

For enrollment completion, please have the following information ready:

- Dependents' names
- Birth dates
- Social security numbers
- Addresses
- Phone numbers



Call Center Enrollment

Benefits Service Center[1]: (866) 335-6368
Monday - Friday: 8:00 AM - 7:00 PM (CST)

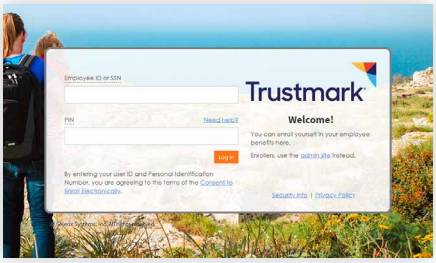
[1]Para hablar con un consejero en Español, presione 2 cuando se le solicite.

Enrolling Online

SELF SERVE INSTRUCTIONS

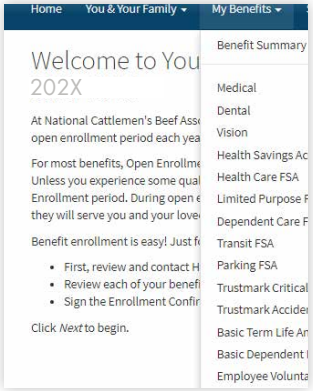
Register for the portal by logging on to:

www.trustmark.benselect.com/enroll



Employee ID or SSN: Your SSN
PIN: Last 4 digits of your SSN and the last 2 digits of your birth year

- ☐ Follow the prompts to complete the registration process. Please review the personal demographic data and update as needed. Then ***click next*** to advance through each screen.
- ☐ Next, you will be asked to enter Dependent / Beneficiary information. To add a dependent, please ***click the + sign*** and enter the dependent's information. To edit an existing dependent, please ***click the pencil icon*** on the right side of the dependent. After making any changes, please click save on the bottom of the page. Once you are finished with this section, ***click next.***
- ☐ Once you are at the medical screen, verify your medical plan election or waive the coverage. When you ***click next,*** you will advance to any coverage that you have not previously enrolled in.



- ☐ If you would like to make changes to existing coverage, you may click on the individual coverage options listed under ***"My Benefits"*** or by choosing the coverage under the ***"My Benefits"*** menu at the top of the screen.
- ☐ Once you select the coverage you would like to change, ***click on "Unlock"*** to access the options. Once you make a decision, please ***click next*** to go to the review page.
- ☐ Once on the ***"Sign and Submit"*** page, you will be able to review your elections. If you need to make changes, please click on the link for that coverage. You will then unlock, make your change, and click next. This returns you to the ***"Sign and Submit"*** page. If everything is correct, please click next.
- ☐ On the ***"Confirmation"*** page, enter your PIN / Password used to log in. ***This will finalize your enrollment.*** You can print the confirmation form, save it as a downloadable PDF, and e-mail a confirmation summary to the e-mail address on file.

Essentials to Start Strong

NEW HIRE CHECKLIST

Welcome to Poteet ISD! We are honored to offer a competitive benefits package designed to meet the needs of you and your family. You have 31 days from your date of hire (printed on your offer letter) to complete your New Hire Enrollment elections.

Whether this is your first time accepting benefits from an employer or your 10th, there are many things to consider prior to and after enrollment. We have created the following checklist of tasks to guide you through the enrollment process.

Please do not hesitate to reach out to AES or your Human Resources with any questions/ concerns.

It is our pleasure to assist!

Within 31 days from your Date of Hire:

- ☐ Review the Benefits Guidebook and Benefits Website for plan details, eligibility, premiums, required notices, and reference materials. The website also includes detailed plan documents and links to carrier resources. Make sure to read all documents for any plan you plan to enroll in.
- ☐ Review any current insurance policies you hold outside of Poteet ISD. Comparing your existing coverage to Poteet ISD's plan documents may help you determine the best fit. Our Benefits Advisors can help ensure your benefits package aligns with your family's needs.
- ☐ Ask questions about any of the material that you have reviewed and contact the **Benefits Service Center at (866) 335-6368.**
- ☐ Gather dependent and beneficiary information. You will be required to provide the name, date of birth, SSN, and address for any dependents you enroll in coverage along with accurate contact information for your beneficiaries.
- ☐ Visit the Benefits Enrollment website or call the Benefits Service Center at (866) 335-6368 for questions to process your enrollment. You have two options for enrollment:
  - Enroll online at **www.trustmark.benselect.com/enroll**
    (In addition to enrolling in benefits, you may add/update dependent and beneficiary, access enrollment confirmations, insurance applications and other important plan documents.)
  - Contact the Benefits Service Center.
    Phone: (866) 335-6368
    Hours: Monday - Friday: 8AM - 7 PM (CST)
- ☐ Review your elections in [Platform]. Make any corrections or contact the Benefits Service Center for assistance.
  - Proper address and contact information
  - Appropriate coverage, costs, and effective dates
  - Updated dependent and beneficiary information
- ☐ Plan for the financial impact. Updates to your deductions will be processed within 1-2 pay cycles. Double deductions to assess missed premiums may be required. You may review the Payroll Calendar to determine when your deduction changes will be processed.
- ☐ Review your paycheck stub(s). Premiums for the current month are deducted on the last day of the month for salaried employees and on the 15th and last day of the month for hourly employees. Confirm that all adjustments appear as expected and notify HR immediately if anything looks incorrect.
- ☐ Watch for or print new ID cards. Carrier updates are processed within 5 business days of your enrollment. ID cards can be printed online about 10 business days after you enroll. If your changes require new cards, your medical provider will issue updated medical/Rx cards within 14 business days.



The AllOne Health App and Member Portal— **Instant Access to Your Assistance Program**

Taking care of your mental health should be simple, supportive, and always within reach. That's why we created the AllOne Health app and member portal—to make it easier than ever for you to access the care you need, when you need it.

Whether you're navigating life's challenges, looking for resources, or just need someone to talk to, we're here to help.

WHAT YOU'LL FIND

Virtual Counseling Made Easy
Self-schedule virtual counseling sessions directly through the app.

Izzy, Your AI Mental Health Navigator
Receive guidance and personalized support in real time.

On-Demand Self-Help Resources
Explore self-guided therapy (iCBT), articles, videos, assessments, and tools.

Family Care and Lifestyle Support Referrals
Request referrals for childcare, eldercare, legal, financial consultation, personal assistant and medical advocacy.

Real Human Support
24/7 live assistance is always just a tap away when you want to speak to someone.

HOW IT WORKS

1. **Download the AllOne Health App** from the Apple App Store or Google Play Store or visit allonehealth.com/portal.
2. **Sign Up** using your member portal and app code. The email address and password used to create your account will work for both the app and the member portal.
3. **Start Exploring** – Book sessions, chat with Izzy, and discover resources that support your whole health.



Download the App and Take the First Step
No matter where you are in your journey, support is here—because your mental health deserves care that's easy to access, always available, and built around you.

Download on the App Store | GET IT ON Google Play

Contact AllOne Health
Call: 800-451-1834
Visit: allonehealth.com/portal
Member Portal and App Code: poteetisd

ALLONE HEALTH

Strong Support for a Healthier Future

MEDICAL

Carrier: *Kempton Group*

The medical program, administered by The Kempton Group, helps individuals and families manage the rising costs of medical care by providing financial protection and coverage for a wide range of health services. To better meet the varying needs of our employees, Poteet ISD offers the following medical plan.

Coverage	Medical Plan	
	In-Network	*Out-of Network*
Deductible Individual Family	 $5,000 $6,000	 $1,000 $2,000
Out of Pocket Maximum Individual Family	 $9,800 $19,600	 $8,400 $16,800
Annual Maximum	Unlimited	
Coinsurance (participant pays)	80%	20%
Office Visits Preventative Services Primary Care Specialist Urgent Care	 No charge $15 copay $50 copay $50 copay	
Emergency Room	80% after deductible	
Hospital Services Inpatient	80% after deductible	
Outpatient X-Ray & Lab Services	100% deductible waived	
Major Lab MRI, PET Scan and CAT Scan	80% after deductible	
Enhanced Benefits	100% deductible waived	
Prescription Drug Retail Order (30 day) / Mail Order (90 day) Generic Preferred Non-Preferred RX Mail Order - 90 Day Supply	 Walmart & HEB $5 $30 $50 2X	 Other Pharmacies $15 $50 $70 2x

Medical Deductions	Medical Plan	
	Monthly	*Semi-Monthly*
Employee	$330.99	$165.50
Employee + Spouse	$1,282.28	$641.14
Employee + Child(ren)	$917.69	$458.85
Family	$1,614.40	$807.20

Medical Plan Effective: September 1st, 2026 - August 31st, 2027

Network

A provider "network" is a group of doctors, hospitals, and facilities that offer care at discounted, pre-negotiated rates. Using in-network providers typically lowers your out-of-pocket costs. Out-of-network providers have not agreed to these rates and may charge more, which can result in higher out-of-pocket costs for you.

To find providers in your plan's network, visit the insurance carrier's website or contact their customer service line for assistance.

Network Provider:
HealthSmart Physician

Website:
https://providerlookup.healthsmart.com/SearchProviders.aspx

OPEN ENROLLMENT INFORMATION

Pharmacy Benefits with SmithRx

Welcome to pharmacy benefits with SmithRx. Our mission is to reduce the complexity and cost of your pharmacy benefits.

What is a Pharmacy Benefits Manager?

Pharmacy benefits managers (or PBMs) coordinate the interaction between your employer, physician, health plan, and pharmacy. Your PBM powers your pharmacy experience by:

- Making sure you're charged the correct copay at the pharmacy
- Setting up your medications to be covered according to your plan design
- Managing clinical requirements related to your prescriptions

Since your PBM benefits are closely related to your health coverage, you're automatically covered when you enroll in your health plan.

Will my pharmacy experience change?

You will receive a new Member ID card in the mail. Present this new card at the pharmacy to ensure you're using your current plan and not overpaying for your prescriptions. PBMs like SmithRx cover medications based on lists of preferred drugs called formularies. The formulary with SmithRx may differ from your prior PBM. We'll notify you if a change is required for your medication(s).

Can I go to my usual pharmacy?

We have over 83,000 pharmacies in our network including retail pharmacies like CVS, Walgreens, RiteAid, Walmart, Costco and more.

Mail order pharmacies like Amazon Pharmacy and Walmart Mail Order, and specialty pharmacies like Senderra and Kroger.

What if I need assistance?

The SmithRx Member Services team is available: Monday to Friday, 8 am to 8 pm (MT):

- Phone: 844.454.5201
- Email: help@smithrx.com
- Chat: On our website www.smithrx.com

In addition, we have onsite clinical staff and after-hours answering to ensure you can always get the assistance you need.

You can also create an account on our member portal at portal.mysmithrx.com to find documentation, tools and your ID card.

Connecting you to the lowest cost prescription solutions

SmithRx Connect 360

SmithRx can help lower your drug costs.

SmithRx's Connect 360 programs identify and help you navigate various cost savings programs. Many of these programs can help patients obtain medications for little or no co-payment. Connect 360 is constantly evolving and adding programs to ensure members are always getting their medications at the best possible price.

Here is the growing list of Connect 360 Programs:

Access	Capture manufacturer coupon savings on traditional and specialty medications. Members have a low or $0 copay on prescriptions while also helping employers save on pharmacy benefit costs.
Access Plus	Leverages advocacy foundations and grant programs to reduce cost when a high-cost specialty medication is not covered under the pharmacy benefit. We assist members in navigating and applying to these different programs.
Assist	No more pre-shopping for the best price or printing coupons! Your member ID has all the information that your pharmacy needs to find the best deals for you at the point of sale.
International Sourcing	SmithRx offers the option to connect members with an independent international sourcing vendor to obtain select drugs at a lower cost (if requested by the plan).
Mark Cuban Cost Plus Drugs	Mark Cuban Cost Plus Drugs is building an innovative pharmacy model that delivers medications at cost, plus a straightforward 15% markup, along with a $3 dispensing fee and shipping. Mark Cuban Cost Plus Drugs carries over 1,000 medications and is continuing to expand their drug list weekly
Autoimmune (Mark Cuban Cost Plus Drugs)	Yusimry, a biosimilar for Humira, is now available to SmithRx members at Mark Cuban Cost Plus Drugs. Yusimry offers a more affordable option for members with autoimmune diseases
Multiple Sclerosis (MS) (at Mark Cuban Cost Plus Drugs)	The lowest-cost Multiple Sclerosis products on the market through Cost Plus Drugs. Generics offer substantial upfront savings.
Low-Cost Insulin	The lowest-cost insulin products on the market; typically a generic or biosimilar insulin, offering upfront savings to the health plan instead of having to wait for rebates.
Diabetes Non-Insulin (DNI)	Eli Lilly and Company's low-cost insulin biosimilar products (and more), are now preferred on the SmithRx formularies.



Welcome to Your 24/7 Online Benefits Connection!

Review your personal details and health benefits from the privacy of your home or while on-the-go.

View deductible and out-of-pocket balances. Download details into CSV file.

View claims status, claim history, and Explanation of Benefits.

Print a temporary ID card and request a new ID card.

Ask questions, verify coverage, and more!

View FAQs, flyers, plan details, benefits, and forms.

Creating Your Account is Simple!

1. Visit www.kemptongroup.com
2. Choose the “For Members” button, then "Secure Login."
3. Click “Create a New Login.”
4. Follow the simple steps on your screen. Use your member ID card to help you answer the questions.

Need help or have questions?

Call us at (888) 820-6022.

EASY AS 1-2-FREE!

When you choose KPP*Free*™, your medical service is covered at **100%**, with **no cost to you**! With more than 200 provider locations, and thousands of procedures, tests, imaging, and other services, using KPP*Free*™ is an easy choice!

Call us! Call our Kempton Care Advocate team at **(888) 820-6022** to find out if your procedure is available through KPP*Free*™, discuss your benefits, and see if using KPP*Free*™ is your best option.

Our team will assist you every step of the way. Remember, reasonable travel expenses can be reimbursed, including hotel, mileage, etc.
mileage, etc.

After your appointment is scheduled, you will be provided with a KPP*Free*™ Voucher to present to the provider at the time of service.

Services Available

There are thousands of medical services that can be performed through the KPP*Free*™ program.

Examples of services available:

- General Surgeries
- Diagnostic Imaging
- Orthopedics
- Gastrointestinal
- Ear, Nose, & Throat
- Cardiac
- Oncology
- Gynecological
- Ophthalmological/Ocular
- Kidney
- Sleep Disorders

Don't forget your Preventive Services!
Many of your preventive screenings can be done through the KPP*Free*™ program. If a diagnosis is found, you can be confident that you won't receive surprise bills, and you may be able to get treatment from the same high-value provider.

KPP*Free*™ Locations



Don't have a KPP*Free*™ option near you or want to use your current medical provider? Ask us about how any provider can "price match" and be reimbursed at 100% with a Cash Price Agreement!

KPP*Free*™ Savings

KPP*Free*™ providers often charge 50-80% less than a traditional network provider. Since 2011, our clients have saved **$61 million** over network discounts, while reducing or eliminating participant out-of-pocket cost.

To learn more:
Call us your dedicated Kempton Care Advocate at (888) 820-6022

TALKING TO YOUR DOCTOR...

KPP*Free*™ is a new type of enhanced benefit, which means your current doctor may not be familiar with the process.

Here are some talking points and a worksheet to assist you in discussing the program and getting the information you need.

If you are enrolled in a Qualified High Deductible Health Plan, or have other primary insurance, please review the information included at the bottom of this page and your Summary Plan Description.

Talking Points...

- "I am enrolled in a self-funded plan and I am cost conscious."
- "I have an enhanced benefit that reduces or eliminates my out-of-pocket costs."*
- "If this is a diagnostic test or procedure, I will need a copy of the physician's orders to start the KPP*Free*™ process."
- "Can you tell me the exact type of surgery or procedure I need?"
- "What is the name or CPT code for this procedure?"

Ask Your Doctor...

What type of procedure do I need?

☐ Imaging ☐ Diagnostic Test ☐ Surgery ☐ Other: _____

Are physician's orders required for this procedure? If so, will you provide me with a copy of the orders so that I can begin the process?

Physician's orders are necessary for procedures that are diagnostic in nature.

☐ Yes, they are required, and I have received a copy. ☐ No, they are not required.

What is the exact name of the procedure or the CPT code(s)?

CPT codes are used to describe the procedure(s) or service(s) a patient needs to receive. More than one code may be utilized.

Procedure Name: _____

CPT Code 1: _____ CPT Code 2: _____ CPT Code 3: _____

What is the urgency level?

The KPP*Free*™ program is intended for voluntary and elective procedures that are not urgent in nature. If your medical service is urgent or time sensitive, we encourage you to consider using regular plan benefits.

☐ Not time-sensitive ☐ Time-sensitive; not urgent ☐ Urgent; consider using regular plan benefits

24-48 HOURS PRIOR TO APPOINTMENT

24-48 hours prior to your appointment, confirm that you have received the following information.

Have I received and printed my KPP*Free*™ voucher?	☐ Yes ☐ No	If you have not received your Voucher, please call our Kempton Care Advocates at (888) 820-6022, Monday - Friday 8:00 a.m. - 5:00 p.m. CST.
Do I know the location of my appointment?	☐ Yes ☐ No	Please confirm the location of your appointment with the KPP*Free*™ provider. For example, your consultation may be scheduled at a different location than your procedure.
I am traveling, do I have the details and reservation information?	☐ Yes ☐ No	If you have not received this information, please call our Kempton Care Advocates at (888) 820-6022, Monday - Friday 8:00 a.m. - 5:00 p.m. CST.

AFTER YOUR PROCEDURE

Check with your KPP*Free*™ provider to find out if you will need follow-up care or services and reach out to us to review the benefit available.

Do I need post-operative care or follow-up appointments?	☐ Yes ☐ No	Post-operative or follow-up appointments may not be included under KPP*Free*™ and may be covered under regular plan benefits.
Do I need any durable medical equipment?	☐ Yes ☐ No	Durable Medical Equipment (DME), such as crutches, walkers, and other equipment prescribed by your surgeon, may not be included for your specific procedure under the KPP*Free*™ benefit and may be covered under regular plan benefits.
Do I need physical therapy?	☐ Yes ☐ No	Physical therapy may not be included for your specific procedure under the KPP*Free*™ benefit and may be covered under regular plan benefits. Our Kempton Care Advocates can assist you in finding the best benefit for physical therapy.
Do I need any other continuing care or medical services?	☐ Yes ☐ No	These services may not be included for your specific procedure under the KPP*Free*™ benefit and may be covered under regular plan benefits. Our Kempton Care Advocates can assist you in finding the best benefit.

FREQUENTLY ASKED QUESTIONS

What is KPP*Free*™?

KPP*Free*™ is a program that encourages self-funded employers to work directly with medical providers who believe in charging a fair price for high quality care.

Under KPP*Free*™, you can receive high quality care at an enhanced benefit, often with no out-of-pocket cost.* To encourage you to use this benefit, reasonable travel expenses are included.

Providers who are part of KPP*Free*™ are paid quickly, often at 100%.* They are reimbursed from a simple invoice rather than filing a claim through the PPO network.

What services are available through KPP*Free*™?

Medical services available through KPP*Free*™ are non-emergency procedures such as surgeries, tests, and diagnostic imaging. The up-front transparent prices for KPP*Free*™ services are bundled. This means the price includes all relevant items, such as surgeon, facility, and anesthesia.

What is a KPP*Free*™ Cash Price Agreement?

A KPP*Free*™ Cash Price Agreement enables participants to get the same enhanced KPP*Free*™ benefit with the medical provider they choose.

If your provider agrees to match, or closely approximate, the *bundled* price of a current KPP*Free*™ provider for a particular service or procedure, it can be covered under the KPP*Free*™ benefit.

All services required for the service or procedure are bundled under KPPFree™. These same services must also be included in the Cash Price Agreement.

Is a KPP*Free*™ Cash Price Agreement the best option for me?

Cash Price Agreements are consumer-driven. This means that you, as a smart consumer, are responsible for working with your provider(s) independently, and "owning" the process.

The relationship you have with your provider is very important to this process. There is a much higher possibility of success when the patient, you, leads the discussion.

However, this process is not for everyone.

If you are uncomfortable having this discussion with your provider, or you do not want to devote the time to the process, this option is not a good fit for you.

For medical issues that are urgent or time sensitive, we recommend using a current KPP*Free*™ provider, or your regular plan benefits for care.

Even if a Cash Price Agreement is not the best option for you, the enhanced benefit is still available by choosing a current KPP*Free*™ provider. You may also choose to use the regular plan benefits available to you.

Are all providers willing to do a KPP*Free*™ Cash Price Agreement?

No. Not all providers are willing, or able, to participate in this option.

If your provider is not willing or able to sign a Cash Price Agreement, you still have an enhanced benefit available if you choose to use a current KPP*Free*™ provider. You may also choose to use the regular plan benefits available to you.

What is the process?

1. Call the Kempton Care Advocates to find out if your medical service is available through the KPP*Free*™ program and discuss whether a Cash Price Agreement is your best option.
2. Talk to your provider about the enhanced benefit available to you. If they are willing to match, or closely approximate, the KPP*Free*™ bundled price, you can request a Cash Price Agreement to share with them.
3. The Kempton Care Advocate will provide you with a Cash Price Agreement to present to your provider for them to sign.
4. Once your provider has signed the agreement return it to the Kempton Care Advocate for review.
5. After the agreement is reviewed, and our team confirms that all necessary services are included in the bundled price, the Kempton Care Advocate will send an executed copy of the agreement to you.
6. Once the process is complete, you may schedule your appointment and your medical services will be covered under the enhanced KPP*Free*™ benefit!

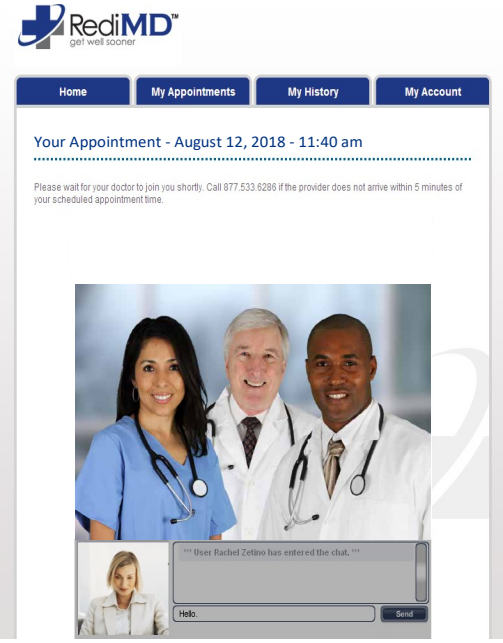
Talking Points

- "How much will this treatment cost? I would like to know what the total cost will be, not just my out-of-pocket cost."
- "My health plan is self-funded. I want to keep costs in mind when I am making this decision."
- "I have an enhanced benefit that saves me significant money on my out-of-pocket costs."
- "We have the option of working together so that I can still have my out-of-pocket costs reduced or waived, while not having to use a different provider."
- If you are willing to work with me and match the bundled price of a provider who participates in KPP*Free*™, I get the enhanced benefit, but there are also benefits for you too. Can we discuss this option?"

Have Questions?

For assistance please call our Kempton Care Advocates at **(888) 820-6022**, Monday – Friday 8:00 a.m. - 5:00 p.m. CST.

*Code To Register = Poteet ISD



RediMD™ get well sooner

RediMD gives you the option to have a regular doctor's visit online or by phone. No copay or payment required. Visit us at www.redimd.com

- *Any time you need to see or speak with a doctor*
- *We are "Always Open"*

RediMD provides primary medical care online via webcam, smart phone, or by telephone. You can see and speak with a physician or other medical professional who can diagnose, recommend treatment and prescribe medications if needed.

RediMD service is available for you and your family.

REDIMD TREATS MOST PRIMARY CARE AILMENTS INCLUDING, BUT NOT LIMITED TO:

STRAINS	*HIGH BLOOD PRESSURE*	*INFECTIONS*	*Colds*
CONTUSIONS	*UTI*	*DIABETES*	*SINUS INFECTIONS*

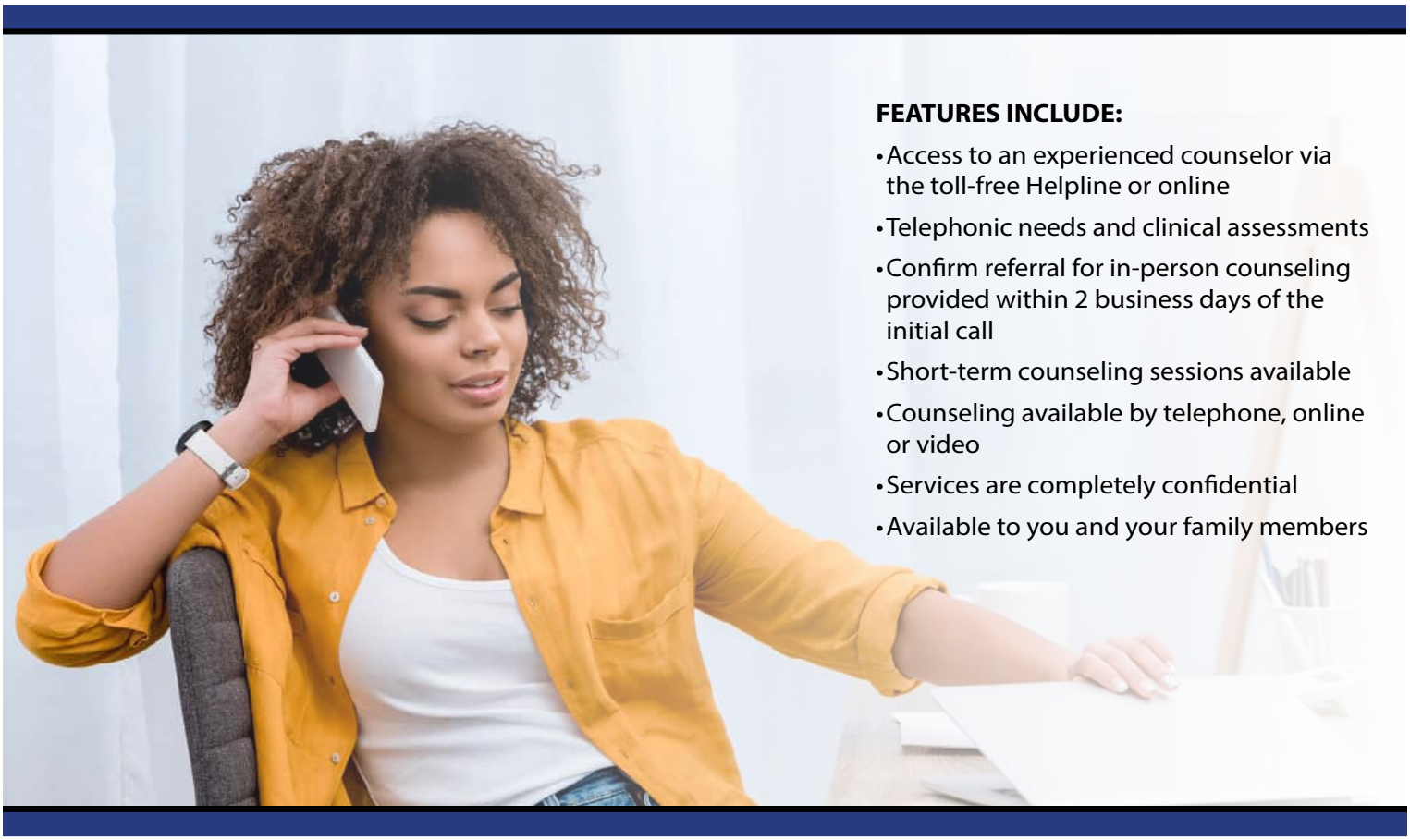
- A computer with internet connection and web camera, or a smart phone or iPad with internet connection is required for all face-to-face visits.
- Visit us at www.RediMD.com for more information and to register

www.redimd.com

Para Ayuda Llamar / For help, call RediMD at 866-989-CURE or 866-989-2873

RediMD™ get well sooner

RediMD visits available from work or home 24/7 by telemedicine or phone



FEATURES INCLUDE:

- Access to an experienced counselor via the toll-free Helpline or online
- Telephonic needs and clinical assessments
- Confirm referral for in-person counseling provided within 2 business days of the initial call
- Short-term counseling sessions available
- Counseling available by telephone, online or video
- Services are completely confidential
- Available to you and your family members

We understand that life can be hectic and demanding. We also understand that issues such as anxiety, depression, career stressors and marital/family stressors can add further stress to your already busy life.

You may speak with one of our professional counselors by calling the toll-free Helpline. The counselor will access your needs, provide a clinical assessment if appropriate and make recommendations for assistance.

We encourage you to call RediMD today for free, confidential counseling and work/life referrals for you and your family. Let us help you regain your balance.

888.RediMD5 or 888.733.4635

RediMD.com

RediMD™
get well sooner

Tax-Free Savings and Smarter Spending

FLEXIBLE SAVINGS ACCOUNT (FSA)

Carrier: NBS

Using a Flexible Spending Account (FSA) is great way to stretch your benefit dollars. You use before-tax dollars in your FSA to reimburse yourself for eligible out-of-pocket health (Healthcare FSA) and dependent care (Dependent Care FSA) expenses. That means you can enjoy tax savings and increased take-home pay—all with the convenience of a benefits card. You are also covered with a 75-day grace period in case you couldn't use all of your allotted funds by the end of the year.

WHAT IS AN FSA?

With an FSA, you elect to have your annual contribution (up to $3,400* for a Healthcare FSA and $7,500* for a Dependent Care FSA) deducted from your paycheck each pay period, in equal installments throughout the year, until you reach the yearly maximum you have specified. The amount of your pay that goes into an FSA will not count as taxable income, so you will have immediate tax savings. FSA dollars can be used during the plan year to pay for qualified expenses and service.

- A Healthcare FSA allows reimbursement of qualifying out-of-pocket health expenses.
- A Dependent Care FSA allows reimbursement of dependent care expenses, such as daycare) incurred by eligible dependents.

**The entire elected Healthcare FSA contribution amount is front loaded to the benefits card and available for immediate use. The elected Dependent Care contribution amount is loaded each pay period.*

ACCESSING MY FSA:

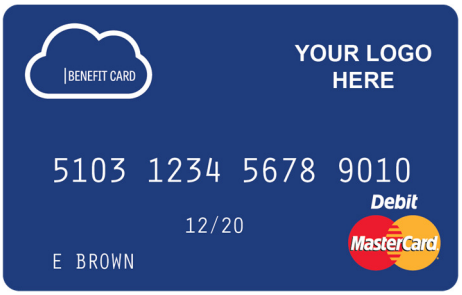
With all FSA account types, you'll receive access to a secure, easy-to-use web portal where you can track your account balance, view your claims history and submit requests for reimbursements.

In addition, you'll receive a convenient benefits card to make it easy to pay for eligible services and products. When you use the card, payments are automatically withdrawn from your account. Just swipe the card and go. Most expenses can be validated through the card transaction but you may be prompted to provide a copy of the itemized receipt for certain transactions in accordance to IRS regulations. When required, itemized receipts can be easily uploaded to either the consumer portal online or, through the mobile app.

WITH AN FSA YOU CAN:

An FSA is a great way to pay for expenses with pre-tax dollars.

- Enjoy significant tax savings with pre-tax deductible contributions and tax-free reimbursements for qualified plan expenses
- Quickly and easily access funds using the prepaid benefits card at point of sale, or request to have funds directly deposited to your bank account via online or mobile app
- Reduce filing hassles and paperwork by using your prepaid benefits card
- Enjoy secure access to accounts using a convenient Consumer Portal available 24/7/365
- Manage your FSA "on the go" with an easy-to-use mobile app
- File claims easily online (when required) and let the system determine approval based on eligibility and availability of funds
- Stay up to date on balances and action required with automated email alert and convenient portal and mobile home page messages
- Get one-click answers to benefits questions
- Use it or Roll It Over. Up to $680 of your unused Healthcare FSA balance can be carried over into the next plan year instead of you "losing it" - making enrollment in an FSA much less risky. This gives you more flexibility to spend your FSA money when you need it. You can use it for necessary out-of-pocket healthcare expenses, rather than feeling pressured to engage in last minute and potentially unnecessary spending at the end of the year.



Bright Smiles and Healthy Lives

DENTAL

Carrier: *Guardian Dental*

Guardian Dental gives you the freedom to choose whether you would like to visit a participating dentist or an out-of-network dentist. There are considerable cost savings when using a dentist who is in network. The following is a brief summary of the major plan provisions.

Network Provider: Guardian
Website: https://www.guardianlife.com/dental-insurance

Coverage	Guardian Dental Value Plan		NAP Plan	
	In-Network	*Out-of Network*	*In-Network*	*Out-of Network*
Calendar Year Deductible Period Family Limit Waived For	$50 Calendar Year 3 per family Preventive			
Benefit Year Maximum (per calendar year. Includes Class A, B, and C services)	$1,500 per person		$1,500 per person	
Class A - Preventive Services Oral Exams (twice/12 mos.) Cleanings (twice/12 mos.) X-Rays (Full-mouth series once/36 mos.) Fluoride Treatment (to age 16, twice/12 mos.) Sealants (to age 16, once/36 mos.) Space Maintainers/Harmful Habit Appliances	100%		100%	
Class B - Basic Services Amalgam Fillings Root Canal Surgery Periodontal Scaling Simple Extraction	100%		80%	
Class C - Major Services Simple Extractions Complex Extractions Space Maintainers Restorative Amalgams Restorative Composites (anterior and posterior teeth) Fillings	60%		50%	
Orthodontics *(dependent child to age 19 only)* *Waiting Period: None*	50% for children (Orthodontia in Progress - covered)		50% for children (Orthodontia in Progress - covered)	

Dental Deductions	Value Plan		NAP Plan	
	Monthly	*Semi-Monthly*	*Monthly*	*Semi-Monthly*
Employee	$31.45	$15.73	$31.45	$15.73
Employee + Spouse	$62.00	$31.00	$62.00	$31.00
Employee + Child(ren)	$68.76	$34.38	$68.76	$34.38
Family	$89.66	$44.83	$89.66	$44.83

Enhance your Vision for a Clearer Future

VISION

Carrier: *Guardian*

VSP Network is pleased to offer vision benefits designed to provide you and your covered family members with the care, value, and service needed to support healthy vision and overall well-being.

It's our goal to make it easier for you to access quality vision care and enjoy the peace of mind that comes with comprehensive coverage.

Network Provider: VSP

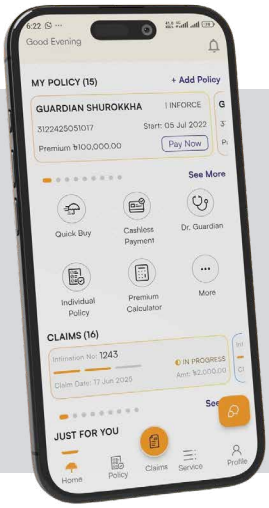
Website: https://www.guardianlife.com/vision-insurance



Coverage	Guardian VSP Plan	
	In-Network	*Out-of Network*
Exams (once per 12 months)	$10 copay	Up to $39
Materials	$25 copay	
Standard Plastic Lenses (once per 12 months)** Single Vision Bifocal Trifocal Lenticular	 $25 copay $25 copay $25 copay $25 copay	 Up to $23 Up to $37 Up to $49 Up to $64
Contact Lenses (once per 12 months) *** Fit & Follow Up Exams * Elective Medically Necessary	 15% discount on the fee $130 allowance (copay waived) Covered in full (after copay)	 Included in the contact lens allowance Up to $100 (copay waived) Up to $210
Frames (once per 24 months)	$130 retail allowance + 20% off balance	Up to $46

*Choice plans offer 20% off any additional pairs of glasses purchased within 12 months of the exam. Members also receive 20% off the amount exceeding the copay and allowance on frames purchased as well as 15% off providers' professional services for prescription contact lenses.
These discounts only apply to services from an in network provider.
**Lenses is the not in the same year as contacts. 40% off additional pair of glasses.
***In lieu of eyeglass lenses and/or frames

Vision Deductions	Guardian VSP Plan	
	Monthly	*Semi-Monthly*
Employee	$9.38	$4.69
Employee + Spouse	$14.97	$7.49
Employee + Child(ren)	$15.27	$7.64
Family	$24.67	$12.34



Download the Guardian app Today!

Your go to place anything related to your plan. Download from the Apple® App Store, Google Play, or Amazon Appstore.

Protection that Lasts

LIFE AND AD&D

Carrier: *The Hartford*

Group Basic Life & AD&D Insurance

Poteet ISD provides a guaranteed issue amount of Basic Life insurance at **no cost to you during your employment. Please call the Benefits Service Center to designate or update beneficiary information.**

The AD&D insurance provides a monetary benefit to an employee or beneficiary when the employee experiences certain bodily injuries or death resulting from a covered accident while insured. The company provides a guaranteed issue amount equal to the basic life insurance amount.

Note: *Basic Life and AD&D benefit reduces by 65% at age 65 and to 50% at age 70.*

$10,000
maximum amount for Basic Life and Accidental Death and Dismemberment (AD&D) Insurance coverage

Supplemental Life and AD&D Insurance - *The Hartford*

In addition to the company paid life insurance, you have the opportunity to elect additional life insurance through The Hartford. AD&D amount will reflect the Voluntary Life insurance amount.

Employee	Spouse	Dependent
Benefit Amount: You may choose to purchase benefits in increments of $10,000 not to exceed 5X your annual salary	**Benefit Amount:** You may choose to purchase benefits in increments of $5,000	**Benefit Amount:** You may choose to purchase benefits up to $10,000 (children live birth to 6 months is $1,000)
New Hire Guarantee Issue: $200,000	**New Hire Guarantee Issue:** $30.000	**New Hire Guarantee Issue:** $10,000
Overall Maximum: The lesser of 5X your salary, or $500,000	**Overall Maximum:** Lesser of 100% employee coverage or $100,000	**Overall Maximum:** $10,000
AD&D Coverage Maximum: The lesser of 5X your salary,or $500,000	**AD&D Coverage Maximum:** Lesser of 100% employee coverage or $100,000	**AD&D Coverage Maximum:** $10,000

Note: *Supplemental Term Life and AD&D reduces to 65% at age 65 and to 50% at age 70.*

Your Income, Protected

DISABILITY

Carrier: *The Hartford*

Long-Term Disability

Long Term Disability Insurance provides income replacement benefits for you and your family in the event you are unable to work due to injury or illness. This covers injuries and illnesses that are both work-related and non-work related.

You are eligible for LTD coverage if you are an active, full-time employee working a minimum of 30 hours per week. **You can purchase a monthly benefit in $100 increments (minimum $200) up to 66-2/3% of your monthly earnings (rounded to the nearest $100) not exceeding $8,000.**

There is a 3/12 pre-existing conditions clause. This means a 3-month look-back period to see if you were treatment-free prior to the effective date of your coverage. If you weren't treatment-free, the pre-existing condition is excluded from coverage if you were disabled within 12 months of your coverage effective date.Pre-exemption applies to: decreases in the elimination period, increases in the maximum benefit period, and late applicants.

Please speak with your Plan Administrator for the definition of monthly earnings and any other questions.

MOST COMMON CAUSES OF LONG TERM DISABILITY[1]

25%
musculoskeletal disorders

13%
injuries such as fractures, sprains, and strains of muscles and ligaments

12%
cancer

10%
mental health issues

8%
circulatory (heart attack, stroke)

[1]*thecdia.org/disability-statistics/*

Long-Term Disability Plan						
Duration of Benefit	SS ADEA					
Pre-Existing Limitation	3/12					
Elimination Period (Days)						
Injury	0*	14*	30*	60	90	180
Sickness	7*	14*	30*	60	90	180
Rate Per Increment of $100	$2.71	$2.29	$1.97	$1.59	$0.91	$0.64

* If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.

You may choose one of the six injury & illness Benefit Waiting periods shown above. These are the periods of time in which an employee ***must be continuously disabled before any benefits are paid.***

Care When It Matters Most

UNIVERSAL LIFEEVENTS WITH LTC

Carrier: *Trustmark*

Universal LifeEvents with Long-Term Care

Financial security even after a loss

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income. Universal LifeEvents can help.Universal LifeEvents provides a higher death benefit during your working years, when your needs and responsibilities are the greatest. (See reverse for more on how Universal LifeEvents works.) You can choose a benefit amount that provides the right protection for you. Universal LifeEvents insurance can mean those left behind can still pursue their own dreams, and help ensure that the ending of one story won't stop the beginning of another.

Solving the long-term care issue

At any point in your life, you may need long-term care services, which could cost hundreds of dollars per day. Universal LifeEvents includes a long-term care (LTC)* benefit that can help pay for these services at any age. This benefit never reduces due to age, so the full amount is always available when you most need it.

- **Here's how it works** - You can collect 4% of the face amount of your Universal LifeEvents policy per month for up to 25 months to help pay for long-term care services.
- **Flexible features available** - PLUS: If you collect a benefit for LTC, your full death benefit is still available for your beneficiaries, as much as doubling your benefit
- **How Universal LifeEvents Works** - A higher death benefit during working years. Full LTC benefits when you're most likely to need them.

Need additional Information?

Trustmark

Phone: (800) 918-8877

Monday – Friday: 8:00am – 7:00pm CST
Saturday: 9:00am – 3:00pm CST

Please note: *Employee must apply for and maintain coverage on themselves to have coverage on the spouse and eligible dependents.*

*The LTC Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance (except in LA, where the LTC benefit is Long-Term Care Insurance.) It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. Pre-existing condition limitation may apply. Benefits may not be available in all states or may be named differently.Your policy will contain complete details.

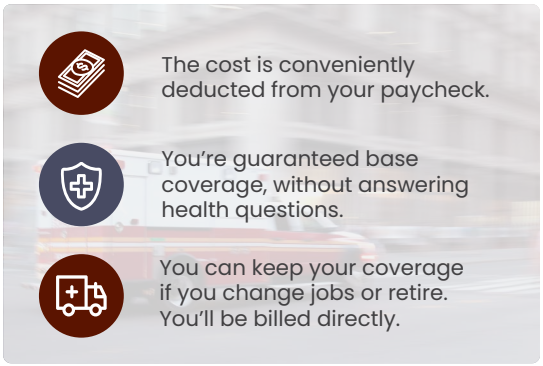


Safeguard Against the Unexpected

CRITICAL ILLNESS WITH CANCER

Carrier: *Voya*

You have responsibilities - to yourself and to your family. Critical Illness with Cancer Insurance protects you and your family in the event of a serious illness or other medical condition with coverage that is portable (meaning you can take it with you, if you leave!) Payments are made directly to the employee, and can be applied to claims, household bills, or other expenses as needed.



The cost is conveniently deducted from your paycheck.

You're guaranteed base coverage, without answering health questions.

You can keep your coverage if you change jobs or retire. You'll be billed directly.

$75 WELLNESS BENEFIT

for both employee and spouse per calendar year.
Children receive 100% of your benefit amount per child.

Coverage	Critical Illness with Cancer Plan *Initial Benefit Amount*
Benefit Amount Employee (Guaranteed Issue - $30,000) Spouse (Guaranteed Issue - $30,000) Child (Guaranteed Issue - $15,000)	$15,000 or $30,000 100% of Employee Benefit 50% of Employee Benefit
Covered Conditions	
Invasive Cancer (including all Breast Cancer) **Heart Attack*** **Major Organ Transplant** (major organ failure) **Benign Brain Tumor** **Coma** **Loss of Hearing, Sight or Speech** **Dementia - Other causes** **Permanent Paralysis**	100%
Systemic Lupus Erythematosus (SLE) **Myasthenia Gravis** **Coronary Artery Bypass**	50%
Bone Marrow Transplant **Infectious Disease** (hospitalization requirement)** **Stem cell transplant**	25%
Coronary Angioplasty **Skin Cancer** **Pacemaker Placement** **Addison's Disease**	10%
Additional Conditions for your Children	
Cerebral Palsy **Multiple Sclerosis (MS) - Advance stage** **Congenital birth defects** **Cystic Fibrosis** **Down Syndrome** **Sickle Cell Anemia**	100%

*A sudden cardiac arrest is not in itself considered a heart attack.
**Diagnosis of a severe infectious disease by a Doctor, including COVID-19, when a diagnosis occurs on or after the group's coverage effective date; AND Confinement to a Hospital for 5 or more consecutive days, or in a transitional facility for 14 or more consecutive days.
Please speak to a licensed Benefits Advisor for personalized rates.

Your Shield Against the Unexpected

ACCIDENT

Carrier: *Voya*

$7,500
cost of a broken leg[1]

60 %
of Americans can't cover an unexpected $1,000 expense[2]

43 m
ER visits each year are due to injuries[3]

It's comforting to know you have help to manage the medical costs associated with accidental injuries, both on and off the job. Voya's Accident insurance pays a scheduled cash benefit upon diagnosis of covered accident injuries.

$75 WELLNESS BENEFIT

Accident Deductions	Accident Plan	
	Monthly	*Semi-Monthly*
Employee	$14.38	$7.19
Employee + Spouse	$25.16	$12.58
Employee + Child(ren)	$32.11	$16.06
Family	$42.89	$21.45

Coverage	Accident Plan
Accidental Death Benefit Rider Employee Spouse Children	 $100,000 $50,000 $20,000
Accidental Death Benefit Rider – Common Carrier Employee Spouse Children	 $200,000 $100,000 $50,000
Ambulance	Ground $600 | Air $2,500
Prosthetic Device - one/two or more	$1,500 - $2,400
Burns	Up to $22,000
Cuts/Lacerations	$60 - $960
Induce Coma (up to 14 days)	$250
Dislocations	Up to $10,000
Emergency Care	$350
Fractures	Up to $12,000
X-rays	$100
Physical or Occupational Therapy (per treatment up to 10)	$75
Stitches (for lacerations, up to 2 inches)	$150
Tendon, Ligament, Rotator Cuff	Up to $1,520
Surgery (open abdominal, thoracic)	Up to $2,500
Emergency Dental Repair	$180-$480
Lodging (per night)	$225
Physical Therapy (10 per accident)	$75
Hospital Admission (per accident)	$2,000
Hospital Daily Stay	$350/day – up to 1 year
Hospital ICU Admission (per accident)	$2,000
Critical Care Unit Confinement (per day up to 30 days)	$500/day – up to 30 days
Be Well Benefit (per covered person per calendar year)	$75

[1] *www.healthcare.gov*
[2] *www.bankrate.com*
[3] *www.cdc.gov*

HOSPITAL INDEMNITY NOTICE

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized.

- You're still responsible for paying the cost of your care.
- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.

Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Peace of Mind on Life's Unexpected Moments

HOSPITAL INDEMNITY

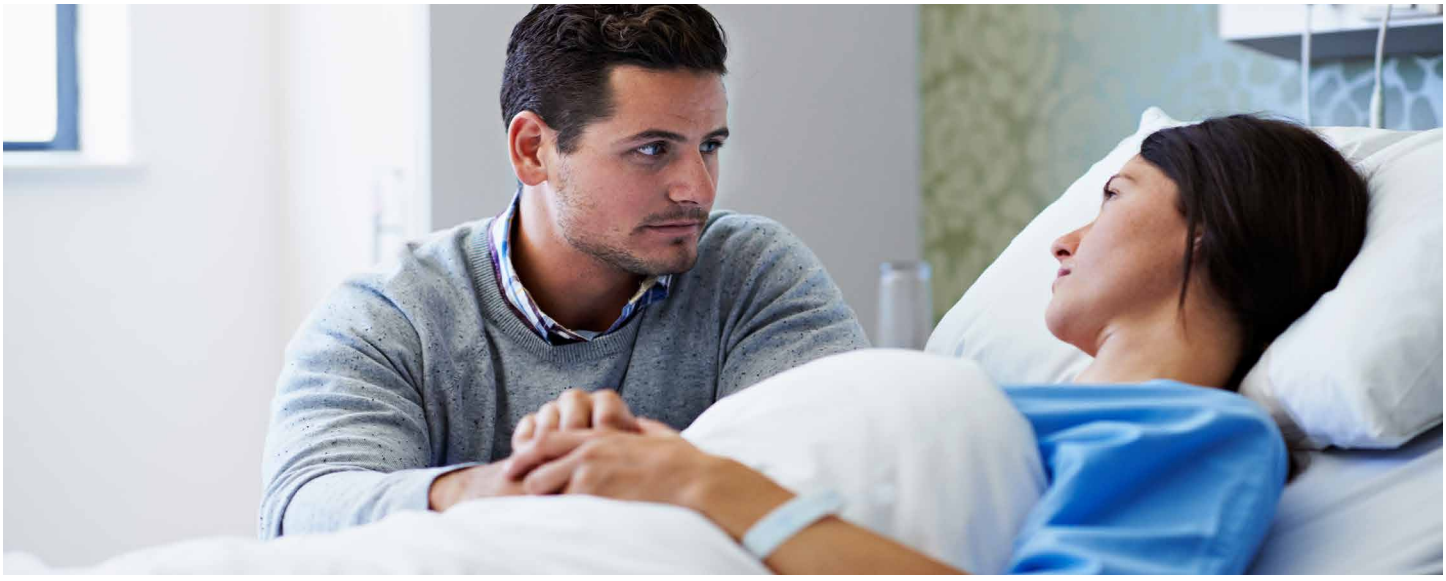
Carrier: *Voya*

Voya's Hospital Indemnity plan complements your medical insurance by providing a cash benefit to help cover the costs associated with a hospital stay. These funds can be used for out-of-pocket expenses your medical plan may not fully cover, such as deductibles, copays, and coinsurance.

$75 WELLNESS BENEFIT

Benefits	Hospital Indemnity Plan	
	High Plan	*Low Plan*
Admission (once per calendar year)	$1,000	$500
ICU Supplemental Admission (once per calendar year)	$2,000	$1,000
Daily Stay (per day up to 365 days)	$200	$100
ICU Daily Stay (per day up to 30 days)	$400	$200
Pre-Existing Conditions	12/12 exclusion	

Hospital Indemnity Deductions	High Plan		Low Plan	
	Monthly	*Semi-Monthly*	*Monthly*	*Semi-Monthly*
Employee	$27.47	$13.74	$11.74	$5.87
Employee + Spouse	$52.94	$26.47	$22.59	$11.30
Employee + Child(ren)	$37.71	$18.86	$16.11	$8.06
Family	$63.18	$31.59	$26.96	$13.48



SafetyNets plus provides 3 Benefits For You and Your Immediate Family

All For $14.95 Per Month + Free Student Loan Analysis

Powered by GotZoom!

How long are you waiting for medical care?

+20 million members **95% member satisfaction**
$0 visit fee **92% issues resolved after 1st visit**



Feel better now! 24/7 access to a doctor is only a call or click away—anytime, anywhere with a **$0 visit fee**. With Teladoc, you can talk to a doctor by phone, online video or mobile app to get a diagnosis, treatment options and prescription if medically necessary. Save time and money by avoiding crowded waiting rooms in the doctor's office, urgent care clinic or ER. Simply use your phone, computer, smartphone or tablet to request a visit with a U.S. physician licensed in your state. Teladoc doctors respond on average within 10 minutes to treat non emergency medical issues such as the following:

- cold & flu symptoms
- sinus problems
- gastroenteritis
- pink eye
- constipation
- allergies
- respiratory infection
- pharyngitis
- urinary tract infection
- diarrhea
- bronchitis
- rash & other skin eruptions

TELADOC®

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Available with no age restrictions.

Allstate IDENTITY PROTECTION

InfoArmor has joined the **Allstate family of companies.** Their mission is to help protect more digital lives and continue to deliver impeccable customer service. PrivacyArmor is now known as Allstate Identity Protection Pro.

InfoArmor

Identity & Credit Monitoring. Proactive identity monitoring utilizing data sources and proactive alerts including account applications for credit cards, wireless carriers, loans, utility accounts, and even non-credit accounts. PrivacyArmor monitors high-risk identity activity such as password resets, fund transfers, unauthorized account access, compromised credentials, address changes, public record alerts, and more. Uncover and resolve issues early to help minimize damages.

Digital Identity Report. Take control of your privacy and reputation. Our deep internet search creates a snapshot of your exposed information online.

Three Year Rolling History. InfoArmor monitors your identity for past adverse events to make sure that you are not only protected moving forward but we also fix anything in the past (pre-existing conditions).

Internet Surveillance. By scanning an ever-evolving network of compromised machines, we detect information misuse and compromised credentials in the Underground Internet and alert consumers with unparalleled accuracy.

Privacy Advocate Remediation. An expert is on your side to guide you through the identity restoration process and fight back against identity thieves.

$1,000,000 Identity Theft Insurance Policy. If you are a victim of fraud, we will reimburse your out of pocket costs to reinforce your financial security.†

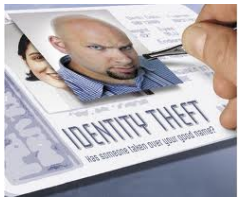
Solicitation Reduction and IdentityMD. Reduce unwanted calls, mail and preapproved credit offers and receive guidance on how to limit exposure to fraud.

Did You Know?

49 million American consumers were victims of identity fraud in 2020 costing those victims **56 billion**[1].

It takes most businesses over **6 months** to notice a data breach.[2]

More than **60%** of fraud comes from mobile devices.[3]



*Network provides comprehensive coverage, although no solution can detect all suspicious activity. Nonetheless, our Privacy Advocates will work tirelessly to restore your identity regardless of when or how the damage was done.
†Identity theft insurance underwritten by insurance company subsidiaries or affiliates of AIG. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies describe. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

1 "2021 Identity Fraud Study", independent study by Javelin Strategy & Research. 2 Ponemon Institute. "Fifth Annual Benchmark Study on Privacy & Security of Healthcare Data," May 2015. 3 RSA. "Q1 2018 Fraud Report," May 2018

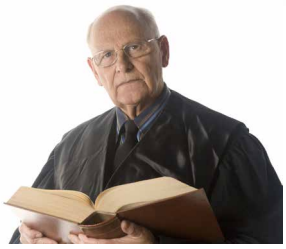
Disclosures: **This plan is not insurance.** This discount card program contains a 30-day cancellation period. The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under the Affordable Care Act. Available only to TX residents.

SafetyNets® plus

Save time, money and stress. Protect yourself and your family with the SafetyNets plus package of benefits.

Family Legal Protection Plan

7 out of 10 families had a need for an attorney in the past year.



This plan is so much more than just an online do-it-yourself legal plan. Members have access to face-to-face or phone consultations with licensed network attorneys and so much more. There are no caps or limitations to how many times members can utilize the plan fro new legal matters.

Four great ways to save:

1. No-Cost Services
2. Exclusive Flat Fee Services
3. Low Hourly Plan Discount Rate Services
4. Discounted Contingency Fees

Legal Access

No-Cost services including :

- Free Simple Will with free annual updates
- Free Living Will substitution for Free Simple Will
- One-on-one consultations for new legal matters
- Unlimited phone consultations (for each new legal matter)
- Phone calls made and letters written on your behalf
- Attorney review of legal documents (6 page max per new matter)
- Helpful advice on representing yourself in small claims court
- Assistance in solving your problems with government programs

Available to member, spouse or domestic partner, unmarried dependent children up to age 26. Also available to member and spouse's elder parents, step parents, adoptive parents and grandparents, even if not residing in member's household.

gotzoom Your Path to Student Loan Relief

Reduce your Student Loan Debt by up to 80% without refinancing.

Educators and Public Service employees enjoy special status with the Department of Education (DOE). The Public Service Loan Forgiveness program (PSLF) helps make Educators among the highest loan forgiveness recipients.

- Gotzoom is the premier "White Glove" Financial Wellness company whose sole focus is on reducing the financial stress overtaking the workforce Please
- visit www.safetynetsplus.com/poteetisd and select the GotZoom benefit under the Products tab. Then simply follow the instructions. Your benefit will be effective 9/1/2021
- All administrative details are managed by GotZoom for the employee
- GotZoom monitors DOE programs and reviews the employee's status annually to find any additional debt reduction options
- **Employee's loan analysis and Benefits Summary are free (no obligation)**
- Service fees apply only after the employee has reviewed and approved repayment/forgiveness programs
- Application Fee: $407; Monthly Fee: $32.95

Participants can realize savings with both reduced monthly payments and shorter loan terms.

We have helped participants save an average of ***$468*** in monthly payments or ***$5,616*** per year for up to ten years. A total savings of ***$56,160***.

PLEASE NOTE: InfoArmor account **must be activated** direct with InfoArmor *and* **Teladoc** account **must be registered** direct with Teladoc upon becoming effective. Instructions for both will be sent to your home address upon becoming effective, along with your SafetyNets plus ID cards.
All other benefits do not require activation and are ready to use upon becoming effective.

SafetyNets plus is provided by National Benefit Plans, Ltd. • San Antonio, TX • (800) 787-3988

SafetyNets plus

EMERGENCY TRANSPORTATION COSTS

MASA MTS is here to protect its members and their families from the shortcomings of health insurance coverage by providing them with comprehensive financial protection for lifesaving emergency transportation services, both at home and away from home.

Many American employers and employees believe that their health insurance policies cover most, if not all ambulance expenses. The truth is, they DO NOT!

Even after insurance payments for emergency transportation, you could receive a bill up to $5,000 for ground ambulance and as high as $70,000 for air ambulance. The financial burdens for medical transportation costs are very real.

HOW MASA IS DIFFERENT

Across the US there are thousands of ground ambulance providers and hundreds of air ambulance carriers. ONLY MASA offers comprehensive coverage since MASA is a PAYER and not a PROVIDER!

ONLY MASA provides over 1.6 million members with coverage for **BOTH ground ambulance and air ambulance transport, REGARDLESS of which provider transports them.**

Members are covered ANYWHERE in all 50 states and Canada!

Worldwide coverage is also available with our Platinum Membership.

Additionally, MASA provides a repatriation benefit: if a member is hospitalized more than 100 miles from home, MASA can arrange and pay to have them transported to a hospital closer to their place of residence.

MASA Medical Transport Solutions™

Any Ground. Any Air. Anywhere.™

OUR BENEFITS

Benefit*	Platinum $39/Month	Emergent Plus $14/Month
Emergent Ground Transportation	U.S./Canada	U.S./Canada
Emergent Air Transportation	U.S./Canada	U.S./Canada
Non-Emergent Air Transportation	Worldwide	U.S./Canada
Repatriation	Worldwide	U.S./Canada
Escort Transportation	Worldwide	
Mortal Remains Transportation	Worldwide	
Visitor Transportation	BCA**	
Minor Children/Grandchildren Return	BCA**	
Vehicle Return	BCA**	
Pet Return	BCA**	
Organ Retrieval	U.S./Canada	
Organ Recipient Transportation	U.S./Canada	

** Please refer to the MSA for a detailed explanation of benefits and eligibility,*

*** Basic Coverage Area (BCA) includes U.S., Canada, Mexico, and Caribbean (excluding Cuba).*



A MASA Membership prepares you for the unexpected and gives you the peace of mind to access vital emergency medical transportation no matter where you live, for a minimal monthly fee.

- One low fee for the entire family
- NO deductibles
- NO health questions
- Easy claim process

For more information, please contact Jaran Floyd or Brice Calahan

830-377-8637 | Jfloyd@masamts.com
956-252-6818 / Bcalahan@masamts.com

EVERY FAMILY DESERVES A MASA MEMBERSHIP

GLOSSARY

In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, health plans, and health care providers.

Affordable Care Act and Patient Protection (ACA): Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Benefits: The amount of money payable by an insurance company to a claimant under the insurance policy.

Brand Name Drug: The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

Children's Health Insurance Program (CHIP): The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people and goes by different names in some states.

Claim: A request by an individual (or his/her provider) for the insurance company to pay for services obtained.

COBRA (Consolidated Omnibus Budget Reconciliation Act): COBRA allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Co-insurance: The money that an individual is required to pay for services, after deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20% of the charges while the health plan pays 80%

Comprehensive Coverage: A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Co-payment: An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered.

Deductible: A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual or contract year basis.

Exclusions and Limitations: Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).

Explanation of Benefits (EOB): A summary of claims processed which will be provided to you after a claim is processed for you or for a dependent. This statement outlines year-to-date deductible and out-of-pocket amounts met during the year. This statement will be mailed unless it is turned off on the website.

Formulary: A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug: Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

Health Savings Account (HSA): An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.

Important Notices

9/1/2026

Poteet ISD

Mailing Address 1100 School Dr
Poteet , TX 78065

Contact Name Violet Reyes

Contact Title Accounting Supervisor

Contact Email: vreyes@poteetisd.org

Contact Phone: 830-742-3567

Your Medicare Part D Notice is the first section of this packet. Some other key notices include CHIPRA, HIPAA Privacy, and Notice of Coverage Options (Marketplace Notice). If you have any questions, please reach out to the contact listed above.

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Important Notice from Poteet ISD About Your Prescription Drug Coverage and Medicare, Creditable Coverage, Poteet ISD Medical Plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Poteet ISD and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1) Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare 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) Poteet ISD has determined that the prescription drug coverage offered by the Kempton Group is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back at the next annual enrollment opportunity or qualified life event.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with this plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare 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 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, 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, therefore, whether or not you are required to pay a higher premium (a penalty).

Or contact the person listed below.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Poteet ISD** changes. You also may request a copy of this notice at any time.

Effective Date: 9/1/2026

Employer Name: Poteet ISD

Contact Name/Title: Violet Reyes
Accounting Supervisor

Address: 1100 School Dr
Poteet , TX 78065

Phone: 830-742-3567

Email: vreyes@poteetisd.org

Notice of Special Enrollment Rights

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

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to 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 request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 request enrollment within 30 days after the marriage, birth, or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact the plan administrator (see cover page for contact information).

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother of her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

Mental Health Parity & Addiction Act

The Mental Health Parity and Addiction Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (see cover page for contact information).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: 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; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema.

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact your plan administrator (see cover page for contact information).

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

For additional information, contact your plan administrator (see cover page for contact information).

Patient Protections

Poteet ISD generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members

You do not need prior authorization from Poteet ISD Medical Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator (see cover page for contact information).

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra/main.htm

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http;//www.dol.gov/vets
An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually, see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage**.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage**. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact *Yolanda Herrera 830-742-3567 or yherrera@poteetisd.org*.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name **Poteet ISD**		**4. Employer Identification Number (EIN)** **74-6001936**
5. Employer address **1100 School Dr**		**6. Employer phone number** **830-742-3567**
7. City **Poteet**	**8. State** **TX**	**9. Zip Code** **78065**
10. Who can we contact about health coverage at this job? Violet Reyes		
11. Phone number (if different from above)	**12. Email address** **vreyes@poteetisd.org**	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are: [fill in eligibility rules if applicable]
  - ☑ Some employees. Eligible employees are: [full-time, working 30 hours/week or more]

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: [your legal spouse, regardless of gender, and your natural, step or adopted children until the end of the month in which they reach age 26]
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends this coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Your Information. Your Rights. Our Responsibilities.

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: 9/1/2026

Privacy Officer: Violet Reyes
Title: Accounting Supervisor
Email: vreyes@poteetisd.org
Phone: 830-742-3567

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
- In these cases we *never* share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
- *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide

whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- *Example: We use health information about you to develop better services for you.*

Pay for your health services
- We can use and disclose your health information as we pay for your health services.
- *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan
- We may disclose your health information to your health plan sponsor for plan administration.
- *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

- How else can we use or share your health information?
- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
- We can use or share your information for health research.

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

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 January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
Option 4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid.1-877-267-2323, Menu

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

POTEET INDEPENDENT SCHOOL DISTRICT

Brown & Brown INSURANCE®

EMPLOYEE BENEFITS **GUIDEBOOK**

This document is designed to provide basic information regarding benefit plans and programs available to eligible employees. This document merely summarizes the employee benefit plans and programs and does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the "plan documentation") for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former employee, or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual's rights under any employee benefit plan or program. Your employer reserves the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.