



26
27



EMPLOYEE BENEFITS GUIDE

for a healthy you



Welcome

We are pleased to offer a full benefits program to you and your eligible dependents. Read this guide to know what benefits are available.

Availability of Medical Plan Benefits Information

Coverage details for each medical plan offered are available in a Summary of Benefits and Coverage (also referred to as an SBC), which can be viewed at www.mybenefitshub.com/georgetownisd.



Your Benefits Are in Effect

**September 1, 2026
through
August 31, 2027**

Contents

Important Contacts.....	3	Dental Coverage	20
Eligibility	4	Vision Coverage.....	22
How to Enroll.....	5	Life and AD&D Insurance.....	24
Enrollment Frequently Asked Questions.....	6	Permanent Life Insurance	26
Medical.....	7	Educator Disability Insurance	27
Next Level Prime	10	Hospital Indemnity Insurance.....	28
\$0 Cost Care	11	Cancer Insurance.....	29
Alternative Pharmacy Services	12	Critical Illness Insurance	31
Your Care Roadmap	13	Accident Insurance.....	32
Health Care Options	14	Financial Planning.....	33
Health Savings Account.....	15	Emergency Medical Transport.....	37
Flexible Spending Accounts.....	16	Identity Theft Protection	39
HSA and FSA Comparison	18	Glossary of Terms	40
Qualified HSA and FSA Expenses	19	Important Legal Notices.....	44

FLIP TO ...

HOW TO ENROLL

5



ENROLLMENT FAQ

6



MEDICAL

7



Important Contacts

Georgetown ISD Benefits

Higginbotham Public Sector
972-776-6518
georgetownisd@hps.higginbotham.net

Accident

Chubb
888-499-0425
educatorclaims@chubb.com

Cancer

Chubb
888-499-0425
educatorclaims@chubb.com

Critical Illness

Unum
800-445-0402
www.unum.com

Dental

Blue Cross Blue Shield of Texas
800-521-2227
www.bcbstx.com

Educator Disability

The Hartford
866-547-4205
www.thehartford.com

Flexible Spending Account(s)

National Benefit Services
855-399-3035
www.nbsbenefits.com

Urgent Care Services

Next Level Prime
832-957-6200
www.nextlevelurgentcare.com

Emergency Medical Transport

MASA
800-643-9023
www.masamts.com

Health Savings Account

EECU
817-882-0800
www.eecu.org

Hospital Indemnity

Lincoln Financial Group
800-423-2765
www.lfg.com

Identity Theft Protection

Experian
855-797-0052
www.experian.com

Permanent Life

Texas Republic Life
512-330-0099
www.texasrepubliclife.com

Life and AD&D

Chubb
972-776-6518
educatorclaims@chubb.com

Medical

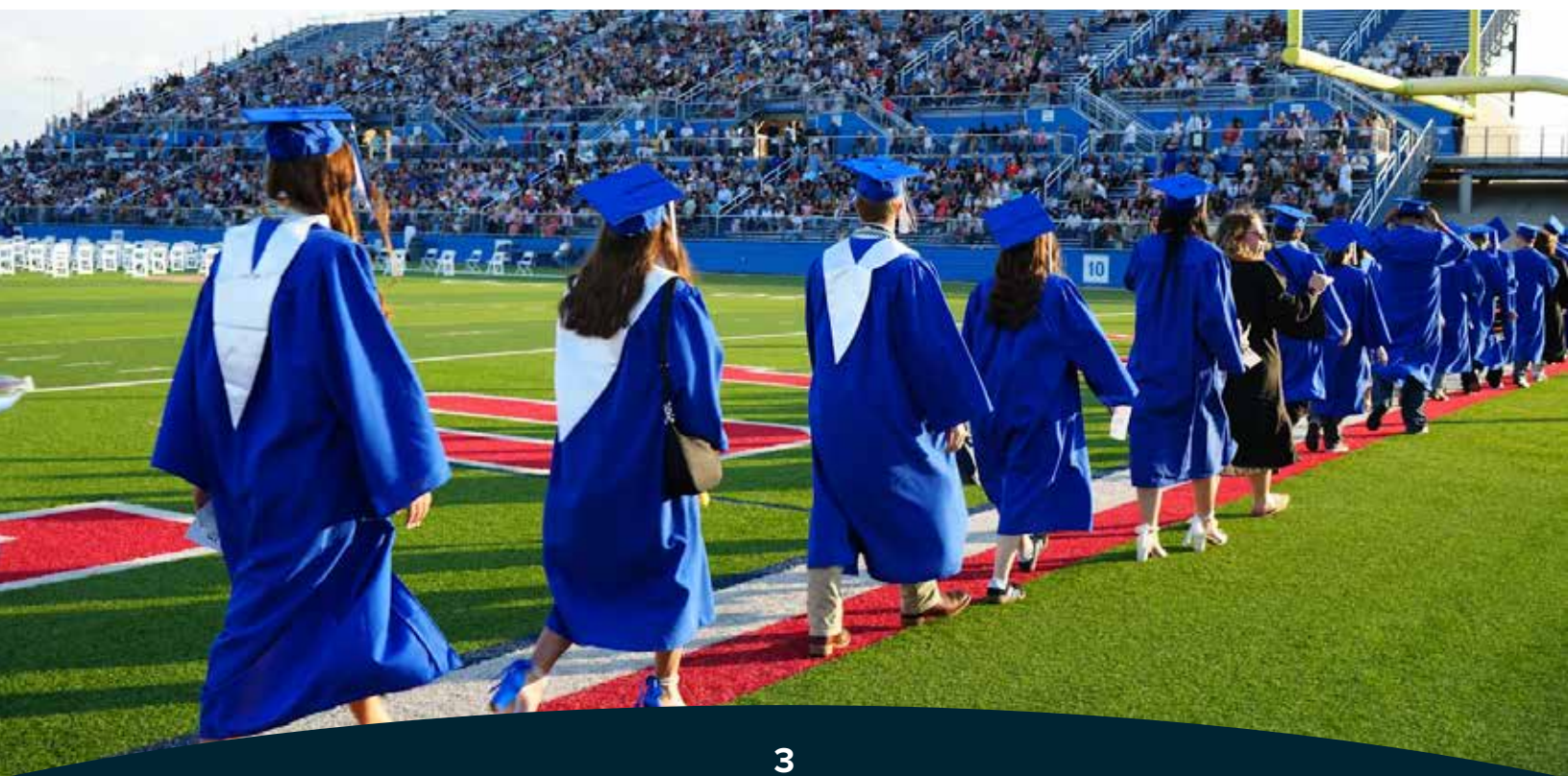
Blue Cross Blue Shield of Texas
800-521-2227
www.bcbstx.com

Retirement Plan

Trusted Capital Group (TCG)
800-943-9179
<https://tcgservices.com>

Vision

Blue Cross Blue Shield of Texas
800-521-2227
www.bcbstx.com



Eligibility

OE: Open Enrollment

QLE: Qualifying Life Event

Who is Eligible for Benefits

NEW HIRE

Who is Eligible

- A regular, full-time employee working an average of 20 hours or more per week

When to Enroll

- By the deadline given by the Benefits Office

When Coverage Starts

- First of the month following date of hire

EMPLOYEE

Who is Eligible

- A regular, full-time employee working an average of 20 hours or more per week

When to Enroll

- During OE or for a QLE

When Coverage Starts

- OE: Start of the plan year, September 1, 2026
- QLE: Consult the Benefits Department

DEPENDENT(S)

Who is Eligible

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

When to Enroll

- During OE or for a QLE
- When covering dependents, you must enroll for and be on the same plans

When Coverage Starts

- Ask the Benefits Office

MAXIMUM DEPENDENT ELIGIBILITY AGE BY PLAN

TO AGE 26

Medical/Dental/Vision/Life/Accident/
Hospital Indemnity/Critical Illness/Cancer

Qualifying Life Events

You may only enroll for or make changes to coverage during the plan year if you are a new hire or if you have a QLE, such as:



Marriage

.....

Divorce

.....

Annulment

.....

Death of spouse

.....



Birth

.....

Adoption/placement
for adoption

.....

Change in benefits
eligibility

.....

Death of child

.....



FMLA, COBRA event,
judgment, or decree

.....

Becoming eligible for
Medicare, Medicaid,
or TRICARE

.....

Receiving a Qualified
Medical Child
Support Order

.....



Gain or loss of
benefits coverage

.....

Change in
employment status
affecting benefits

.....



You have **30 days** from the event to **notify** the Benefits Department and **complete your changes**. You may need to provide documents to verify the change.

How to Enroll



Enrolling in benefits is simple through **THEbenefitsHUB**.

1	Go to www.mybenefitshub.com/georgetownisd or scan the QR code.
2	Click <i>Login</i> .
3	Enter your: » Last name » Date of birth » Social Security number (last four digits only)
4	Once confirmed, the Additional Security Verification page will list contact options. Select either the <i>Text</i> , <i>Email</i> , <i>Call</i> , or <i>Ask Admin</i> option to receive a code for completing final verification.
5	Enter the code, and click <i>Verify</i> to begin your enrollment.
6	Review your personal information and verify covered dependents. Contact your employer with any discrepancies.
7	After dependent information is confirmed, you may select the benefits shown. To make your selections, click the drop-down list next to the plan name. Once the desired coverage amount is selected, your contribution amount will be displayed. Click <i>Save & Continue</i> . Repeat for each benefit. You may be asked to provide evidence of insurability for certain benefits.
8	If enrolling in life insurance coverage, you must identify your beneficiary(ies). » Select your beneficiary designation. » Click <i>Sign & Continue</i>. » Review and confirm your information. » Click <i>Finished</i>.



Benefits Questions?

Employee benefits can be complicated. The **Higginbotham Public Sector** benefits team is available to help you with the following:

- Enrollment
- Benefits
- Eligibility
- Claims and Billing

Call **972-776-6518** Monday through Friday from 7:00 a.m. to 6:00 p.m. CT. If you leave a message after 3:00 p.m. CT, your call or text will be returned the next business day. You can also email georgetownisd@hps.higginbotham.net.

Bilingual representatives are available.

SECTION 125 CAFETERIA PLAN GUIDELINES

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

Changes in benefit elections can occur only if you experience a QLE. You must present proof of the QLE to your Benefits Department within 30 days of the event. Meeting with the Benefits Department to complete and sign the necessary paperwork is also required to make benefit election changes effective. Changes must be consistent with the QLE.

Enrollment Frequently Asked Questions

What if I miss the enrollment deadline?

Contact your Benefits Office for guidance if you miss a benefits enrollment deadline. Under normal circumstances, you may only enroll for or make changes to coverage during OE, if you have a QLE, or if you are a new hire.

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

Yes. See **Eligibility** on page 4 for details.

Where can I find benefits summaries and forms?

To access medical plan Summary of Benefits and Coverage (SBC) documents, plan documents for other coverages, and forms, go to the **Benefit Information** section at www.mybenefitshub.com/georgetownisd. Click on each benefit (e.g., medical, vision, etc.) for details.

How can I find in-network providers?

Go to www.mybenefitshub.com/georgetownisd and click on the *Provider Search* link, where you will see all available plan provider searches.

When will I get my ID cards?

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

You may not need or receive an ID card for dental and vision plans. Simply share the carrier name and phone number with your health care provider to have benefits verified.

Benefits Questions?



Call the Higginbotham Public Sector benefits team at **972-776-6518**.

Can I cover family members (a spouse and/or dependent) as dependents on my benefits if I and my spouse work for the same employer?

Some benefits may not allow for this type of coverage if you both work for the same employer. Review the benefit plan documents, contact Higginbotham Public Sector, or contact the carrier for eligibility details.

Are there FSA and HSA limitations for married couples?

Yes, generally. Married couples may not enroll in both a Health Care Flexible Spending Account (FSA) and a Health Savings Account (HSA) at the same time. If your spouse is covered under a Health Care FSA that reimburses for qualified health care expenses, then you and your spouse are not HSA-eligible – even if you do not use your spouse's Health Care FSA to reimburse your expenses. However, there are some exceptions to the general limitation for other types of FSAs (e.g., Limited Purpose Health Care FSA; Dependent Care FSA). Contact the FSA and/or HSA administrator before you enroll, or consult your tax advisor for further guidance.

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

Medical



Our medical plans protect you and your family from major financial hardship in the event of illness or injury.

You have a choice of three plans:

- **High Deductible PPO Plan** – This HDHP plan has a \$3,500 Individual and a \$7,000 Family in-network deductible.
- **Standard HMO Plan** – This HMO plan has a \$5,000 Individual and a \$10,000 Family in-network deductible.
- **Enhanced HMO Plan** – This HMO plan has a \$2,250 Individual and a \$4,500 Family in-network deductible.

Find an In-Network Provider



Visit www.bcbstx.com.



Call **800-521-2227**.



Download the **BCBSTX app**.

High Deductible Health Plan

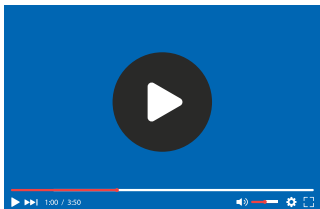
A High Deductible Health Plan (HDHP) allows you to see any provider when you need care, and you will pay less when you go to in-network providers. In exchange for a lower per-paycheck cost for medical benefits, you must satisfy a higher plan deductible that applies to almost all health care expenses, including prescription drugs. If you enroll in the HDHP, you may be eligible to open a Health Savings Account (HSA).

Health Maintenance Organization

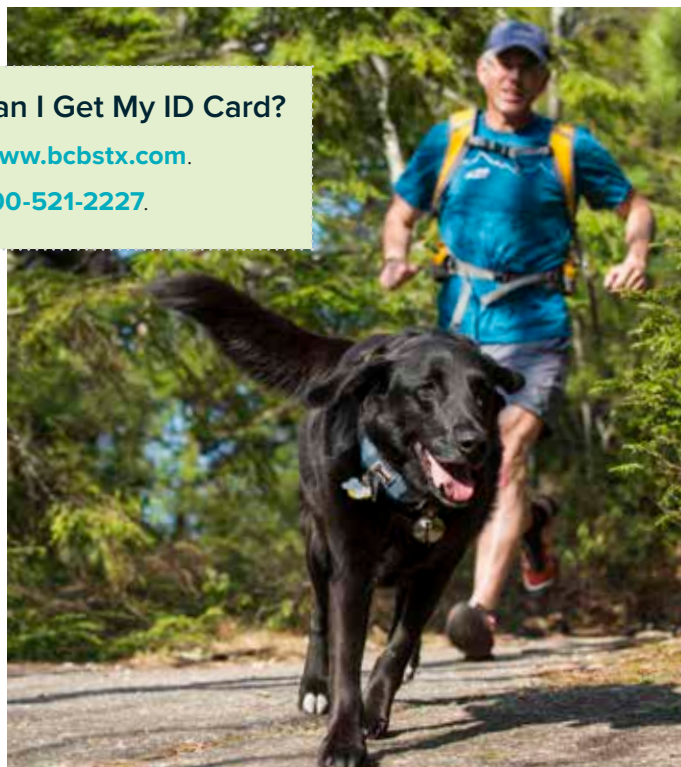
With a Health Maintenance Organization (HMO) plan, you must seek care from in-network providers in the HMO network. The selection of a primary care physician is required, and you need a referral to see a specialist. Always confirm that your doctors and specialists are in-network before seeking care. **Network is Texas only.**

How Can I Get My ID Card?

- Visit www.bcbstx.com.
- Call **800-521-2227**.



Watch and learn more!



Medical



Medical Benefits Summary

BCBSTX	HIGH DEDUCTIBLE PPO PLAN		STANDARD HMO PLAN	ENHANCED HMO PLAN
Type of Network	Nationwide: In-Network and Out-of-Network Coverage		Statewide: In-Network Coverage Only	Statewide: In-Network Coverage Only
MEDICAL	BCBSTX PPO In-Network	BCBSTX PPO Out-of-Network	BCBSTX HMO In-Network	BCBSTX HMO In-Network
Annual Deductible • Individual • Family	\$3,500 \$7,000	\$10,500 \$21,000	\$5,000 \$10,000	\$2,250 \$4,500
Annual Out-of-Pocket Maximum • Individual • Family	\$8,500 \$17,000	\$24,150 \$48,300	\$10,000 \$20,000	\$9,000 \$18,000
Coinsurance Percentage	70%	50%	70%	80%
Health Savings Account Eligible	Yes	Yes	No	No
Primary Care Provider Required	No	No	Yes	Yes
Primary Care Provider Referral to Specialist Required	No	No	Yes	Yes
PHYSICIAN SERVICES	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Preventive Care	\$0	50% ¹	\$0	\$0
Primary Care	30% ¹	50% ¹	\$25 copay	\$40 copay
Specialist	30% ¹	50% ¹	\$75 copay	\$75 copay
Urgent Care	30% ¹	50% ¹	\$100 copay	\$100 copay
Virtual Visit	30% ¹	50% ¹	\$25 primary \$75 specialist	\$40 primary \$75 specialist
OTHER SERVICES				
Simple Lab & X-Ray	30% ¹	50% ¹	30% ¹	20% ¹
Hospital Admission	30% ¹	50% ¹	30% ¹	20% ¹
Outpatient Surgery	30% ¹	50% ¹	30% ¹	20% ¹
Emergency Room Care Freestanding and hospital	\$750 copay then 30% after deductible	\$750 copay then 30% after deductible	\$750 copay then 30% after deductible	\$750 copay then 20% after deductible
Emergency Medical Transportation	30% ¹	30% ¹	30% ¹	20% ¹
Complex Imaging	30% ¹	50% ¹	30% ¹	20% ¹

¹ The amount paid after the deductible is met.

Medical



BCBSTX	HIGH DEDUCTIBLE PPO PLAN		STANDARD HMO PLAN	ENHANCED HMO PLAN
Type of Network	Nationwide: In-Network and Out-of-Network Coverage		Statewide: In-Network Coverage Only	Statewide: In-Network Coverage Only
MEDICAL	BCBSTX PPO In-Network	BCBSTX PPO Out-of-Network	BCBSTX HMO In-Network	BCBSTX HMO In-Network
PHARMACY BENEFITS				
Rx Deductible	Combined with medical deductible	50% ¹	\$500	\$500
Generic	30% ¹	50% ¹	\$0	\$0
Preferred	30% ¹	70% after deductible/ 50% additional charge	\$75 after Rx deductible	\$75 after Rx deductible
Non-Preferred Brand Name	30% ¹	70% after deductible/ 50% additional charge	\$200 after Rx deductible	\$200 after Rx deductible
MENTAL HEALTH SERVICES				
Outpatient Services	Covered / Same as any other illness			
Inpatient Services	Covered / Same as any other illness			
MATERNITY SERVICES				
Office Visits	30% ¹	50% ¹	\$25/\$75 copay	\$40/\$75 copay
Childbirth/Delivery Facility Fees	30% ¹	50% ¹	30% ¹	20% ¹
Childbirth/Delivery Professional Services Fees	30% ¹	50% ¹	30% ¹	20% ¹
EMPLOYEE MONTHLY RATES				
Employee Only	\$85.51		\$85.40	\$258.94
Employee and Spouse	\$1,182.32		\$1,186.98	\$1,427.23
Employee and Child(ren)	\$561.27		\$572.42	\$746.41
Employee and Family	\$1,519.80		\$1,535.48	\$1,890.09

¹ The amount paid after the deductible is met.

Next Level Prime



When you enroll in a medical plan, you and your covered dependents automatically receive access to **Next Level Urgent Care (NLUC)** at no additional cost. If you do not enroll in the district's medical plan, you may elect this coverage for an additional monthly cost. There are no copays, deductibles, or additional fees for covered NLUC services.

What Is Covered

- Primary and urgent care (details below)
- 24/7 telemedicine visits
- Care navigation and wellness coaching
- Labs, vaccines, and DME

Hours and Locations

NLUC offers in-person and virtual care with locations throughout Houston, Dallas, Austin, and San Antonio. Care is available seven days a week from 9:00 a.m. to 9:00 p.m. CT.



For most everyday health care needs, start with NLUC.

Primary Care Services

- Annual physical and wellness exams
- Preventive screenings and vaccinations
- Diabetes and hypertension management
- Depression and anxiety support
- Blood draws and specialist referrals
- Weight management and GLP-1 programs (if for weight loss only, at employee's expense)

Urgent Care Services

- Respiratory infections and flu symptoms
- Urinary tract infections and rashes
- Sprains, strains, and minor injuries
- X-rays, splints, and stitches
- Ear infections, headaches, and back pain
- IV fluids and dehydration treatment

Your Annual Checkup

1. Complete a virtual visit with an NLUC provider
2. Schedule your in-person exam and labs
3. Review results and create a wellness plan

Get More Information or Submit Receipts



Visit www.nextlevelurgentcare.com.



Call **832-957-6200**.



Email navigator@nextlevelurgentcare.com.



Download the **Next Level Urgent Care app**.

\$0 Cost Care



By working directly with providers to secure fair, transparent pricing, **ZERO Health** helps lower health care costs for everyone – allowing your employer to cover the full cost of many eligible services.

ZERO Health helps you receive high-quality health care from participating providers for:

- \$0 out-of-pocket for eligible services
- Personalized support every step of the way
- Access to quality, pre-screened providers
- Simple scheduling and care coordination
- No surprise bills for covered services

Follow These Steps

- 1. Contact Your Personal Health Assistant.** Use the contact information to contact ZERO Health first to confirm your needed services are covered.
- 2. Get Matched with a Provider.** ZERO Health will help you find a participating provider and coordinate your care.
- 3. Receive Your Care.** Schedule your appointment and receive eligible services for \$0.

Get More Information



Visit <https://zero.health>.



Call **855-816-0001**.



Email help@zero.health.



Chat <https://my.zero.health>.



Alternative Pharmacy Services



If you take a high-cost medication (typically \$300 or more for a 30-day supply), **National Integrative Health (NIH) Clinical Pharmacy Services** can help you transition to a mail-order pharmacy that provides your medication at no cost.

How It Works

- 1. Watch for Your Invitation.** You'll receive a text message and email from the NIH Clinical Pharmacy Services team inviting you to enroll.
- 2. Complete Enrollment.** Follow the enrollment instructions. The team will guide you through the process and work with your physician to obtain your prescription as quickly as possible.
- 3. Receive Your Medication.** Your eligible medication will be shipped directly to your home at no cost.

Enrolled in the HDHP?

If you're enrolled in the High Deductible Health Plan, your medication will be sourced after you've met your deductible. To avoid delays, contact the Pharmacy Services team as you get close to meeting your deductible so the enrollment process can begin.

Enrollment Takes About 10 Minutes



Call **515-518-6654**.



Email **pharmacyservices@nihclinical.com**.



Your Care Roadmap

Three ways to get care and what it costs you. Visit www.mybenefitshub.com/georgetownisd for complete benefit details.

Your BCBSTX Medical Plan Copay / Coinsurance Applies

High Deductible PPO, Standard HMO, or Enhanced HMO. Use for anything — primary care, specialists, ER, imaging, surgery. Your normal plan cost-share applies.

Next Level Prime

next level

\$0 — FREE, district-paid

(if enrolled in a GISD medical plan.
Pricing if not enrolled — \$30 Employee Only, \$60 Family)

Urgent care, primary care, preventive visits, telemedicine, labs, immunizations, and health and emotional wellness services — at \$0 to you, any time. Starts 9/1/2026. *New location coming to Georgetown soon.*

Zero Health

zero

\$0 for Imaging, Surgery & PT

HMO plan members: \$0, no deductible required. High Deductible PPO members: \$0 once your deductible is met. Zero arranges \$0 imaging, surgical procedures, and physical therapy with partner providers. Starts 9/1/2026.

If you need...	Your Medical Plan (BCBSTX)	Next Level Prime	Zero Health (HMO: \$0, no deductible; PPO: \$0 after deductible — starts 9/1/26)
Annual physical / well visit	\$0 (preventive care, all plans)	\$0 — free comprehensive annual physical	N/A
Sick visit / primary care	\$25 (Standard HMO) / \$40 (Enhanced HMO) copay, or 30% after deductible (PPO)	\$0 — unlimited visits, 45+ TX locations, 7 days/wk, 9am–9pm	N/A
Urgent care	\$100 copay (HMO), or 30% after deductible (PPO)	\$0 — walk in, or reserve your spot in the app	N/A
Telemedicine / virtual visit	\$25 (Standard HMO) / \$40 (Enhanced HMO) copay, \$75 for a specialist telehealth visit, or 30% after deductible (PPO)	\$0 — via the Next Level app	N/A
Routine labs & immunizations	20–30% coinsurance after deductible	\$0 — CBC, A1C, lipid panel, thyroid, STI screens & more included	N/A
Specialist visit	\$75 copay (HMO), or 30% after deductible (PPO)	— Prime can refer you in	N/A
X-ray / complex imaging (MRI, CT, etc.)	20–30% coinsurance after deductible	\$0 — includes X-rays, basic imaging, splints, and stitches	\$0 — Zero coordinates provider & scheduling
Outpatient / surgical procedure	20–30% coinsurance after deductible	N/A	\$0 — Zero coordinates provider & scheduling
Physical therapy	\$75 copay (HMO), or 30% after deductible (PPO)	N/A	\$0 — Zero coordinates provider & scheduling
Emergency room (true emergency)	\$750 copay + coinsurance after deductible — use for true emergencies	— Use Prime for non-emergency needs instead	N/A

Zero Health is available at \$0 with no deductible required for members enrolled in a BCBSTX HMO plan (Standard or Enhanced). High Deductible PPO members can also use Zero Health at \$0, but only after their deductible is met; coverage begins 9/1/2026. Next Level Prime starts 9/1/2026 for all members enrolled in any medical plan, at no cost. This flyer highlights common services; it is not a complete list of covered services or costs. Refer to your BCBSTX Summary of Benefits and Coverage and each program's plan documents for full details.

Your Medical Plan — BCBSTX

800-521-2227 | bcbstx.com
GISD Benefits Dept: 512-943-5000 ext. 6092
Benefits@georgetownisd.org

Next Level Prime

Download the Next Level Urgent Care app (App Store / Google Play)
Austin-area locations | Open 7 days, 9am–9pm

Zero Health

Chat: my.zero.health | 855-816-0001
help@zero.health | zero.health

A Few Real-Life Examples

Your Medical Plan	Next Level Prime	Zero Health
You have chest pain and need the ER. → True emergency: \$750 copay + coinsurance	Your child spikes a fever on a Saturday night. → Walk in, \$0 You're due for your annual well visit. → Free comprehensive physical, \$0	Your doctor orders an MRI for a knee injury. → \$0, Zero schedules it for you You're referred to physical therapy after a sprain. → \$0, Zero coordinates the provider

Health Care Options

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

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

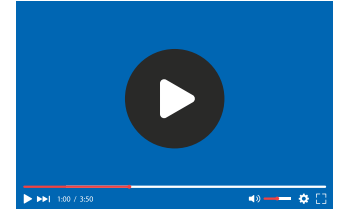
Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

Health Savings Account



Offset your HDHP health care costs, reduce your taxes, and get a long-term tax-advantaged savings account.

A Health Savings Account (HSA) is like a personal savings account that allows you to pay for current or future health care expenses with pretax dollars or save the funds for retirement. The funds can also be used for your dependents, even if they are not covered by the HDHP. An HSA is always yours to keep, even if you change health plans or jobs.



Watch and learn more!

HSA Eligibility

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

- Enrolled in an HSA-eligible HDHP
- Not covered by another plan that is not a qualified HDHP (e.g., spouse's health plan)
- Not enrolled in a Health Care Flexible Spending Account
- Not eligible to be claimed as a dependent on someone else's tax return
- Not enrolled in Medicare, Medicaid, or TRICARE
- Not receiving Veterans Administration benefits

Note: You may have an HSA at the financial institution of your choice, but only accounts opened through **EECU** are eligible for automatic payroll deductions.

How to Pay or Get Reimbursed

- Use your HSA debit card to pay for qualified expenses.
- Pay out-of-pocket and submit your receipts for reimbursement online or through the app.

Contributions

You may contribute up to the IRS annual maximum.

2026 MAXIMUM HSA CONTRIBUTIONS	
Individual	\$4,400
Family	\$8,750

If you are age 55 or older, you can contribute an extra \$1,000.

Two Ways To Use Your HSA

Use it Now

Pay for qualified out-of-pocket medical, dental, and vision expenses as they are incurred.

Invest Over Time

Invest and grow your HSA dollars tax-free. You can use the funds to pay for qualified expenses later.



Triple Tax Savings

Tax-free contributions

Tax-free growth

Tax-free withdrawals

Get More Information or Submit Receipts



Visit www.eecu.org.



Call **817-882-0800**.



Download the **EECU Mobile Banking app**.

Flexible Spending Accounts



Set aside pretax dollars from each paycheck to pay for certain IRS-approved health and dependent care expenses. We offer the following Flexible Spending Accounts (FSAs).

Health Care FSA

The Health Care FSA covers qualified medical, dental, and vision expenses for you and your eligible dependents. Eligible expenses include:

- Deductibles, copays, and coinsurance
- Prescription drugs
- Braces, glasses, and contacts
- Hearing aids and batteries

If you enrolled in an HDHP and contribute to an HSA, you may not contribute to a Health Care FSA.

Important Reminders!

FSAs are generally considered “use it or lose it” accounts, and unused remaining funds at the end of the plan year may be forfeited. Your employer may offer some flexibility (e.g., more time via a grace period to incur expenses; or a limited amount of funds that can be carried over in to the next plan year). Because options vary by employer, it’s important to review your specific plan details or check with your employer for more information.

Planning the amount of your contributions carefully can help you make the most of your FSA and avoid losing unused funds. You cannot change your contribution election during the plan year unless you experience a QLE. Keep itemized receipts to verify debit card payments.

Get More Information or Submit Receipts



Visit www.nbsbenefits.com.



Call **855-399-3035**.



Fax **844-438-1496**.



Email service@nbsbenefits.com.



Download the **NBS Mobile Banking app**.



Participant Portal: www.mynbsbenefits.com.



Mail: **National Benefit Services, LLC**

P.O. Box 219393

Kansas City, MO 64121-9393



Flexible Spending Accounts



Dependent Care FSA

The Dependent Care FSA helps pay expenses associated with caring for children under age 13 and elder dependents so you or your spouse can work or attend school full-time.

Dependent Care FSA Guidelines

- To be eligible, you (and your spouse, if married) must be gainfully employed, looking for work, a full-time student, or incapable of self-care.
- You can use funds for daycare or babysitter expenses for your children under age 13, but only for the part of the year when the child is under 13.
- Only day camps – not overnight camps – can be considered for reimbursement.
- You can use funds for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.
- Dependent Care FSA claims may be submitted as incurred and will be paid as funds become available after monthly payroll contributions are deposited.



How to Access Funds/Pay or Get Reimbursed

Use your FSA debit card
(excludes the Dependent Care FSA).

OR

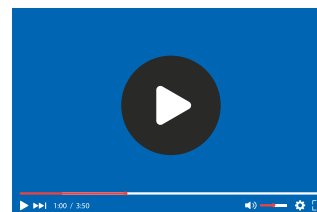
Pay out-of-pocket, and submit your receipts
for reimbursement.

Annual Maximum FSA Contributions

2026	HEALTH CARE FSA	DEPENDENT CARE FSA
Annual Maximum Contribution	\$3,400	\$7,500 (Single parent filing head of household; or married filing jointly); \$3,750 (married filing separately)
Run-out Period	90 days	No run-out period
Carryover	\$680	No carryover (use it or lose it)
Grace Period	No grace period	No grace period

for a
healthy
you

Visit fsastore.com for an array of
FSA-eligible products.



Watch and learn more!

HSA and FSA Comparison

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

	HEALTH SAVINGS ACCOUNT	FLEXIBLE SPENDING ACCOUNT*
Description	- Acts as a personal savings account. - Funds can be used to pay for current or future health care expenses with pretax dollars; or funds can be saved for retirement. - Funds can also be used for your dependents, even if they are not covered by the HDHP.	Health Care FSA – Use funds to pay qualified medical, dental, and vision expenses. Dependent Care FSA – Use funds to pay qualified dependent care expenses and services.
Contribution Source	Employee (You)	Employee (You)
Account Owner	Employee (You)	Employer
Underlying Insurance Requirement	HDHP	None
Maximum Annual Contribution	2026 Individual – \$4,400 Family – \$8,750 Age 55+ Additional Catch-up – \$1,000	2026 Health Care FSA – \$3,400 Dependent Care FSA \$7,500 (Single parent filing head of household; or married filing jointly) \$3,750 (Married filing separately)
Permissible Use of Funds	- Pay for qualified out-of-pocket medical, dental, and vision expenses. - If used on nonqualified expenses prior to age 65, subject to income tax plus a 20% penalty.	See details in the Description section above.
Year-to-year rollover of account balance?	Yes. Funds roll over and can be used anytime or saved for future use.	2026 Health Care FSA – Allows for carryover of \$680 in to the next plan year OR an extended grace period after the end of the plan year (typically 2½ months) to spend remaining funds. Dependent Care FSA – N/A
Does the account earn interest?	Yes	No
Portable?	Yes. It is always yours to keep, even if you change jobs or medical plans.	No

* FSAs are generally considered “use it or lose it” accounts, and unused remaining funds at the end of the plan year may be forfeited. Your employer may offer some flexibility (e.g., more time via a grace period to incur expenses; or a limited amount of funds that can be carried over in to the next plan year). Check with your employer for more details.

FLIP TO...

15

HSA

16

FSA

Qualified HSA and FSA Expenses



The products and services listed below are examples of medical expenses eligible for payment from your Health Care FSA or HSA*.

This list is not all-inclusive; additional expenses may qualify, and the items listed are subject to change in accordance with IRS regulations. Please refer to IRS *Publication 502 Medical and Dental Expenses* at www.irs.gov for complete details.

Abdominal supports

Acupuncture

Ambulance

Anesthetist

Arch supports

Artificial limbs

Blood tests

Braces

Cardiographs

Chiropractor

Crutches

Dental treatment

Dentures

Dermatologist

Diagnostic fees

Eyeglasses

Gynecologist

Healing services

Hearing aids and batteries

Hospital bills

Insulin treatment

Lab tests

Metabolism tests

Neurologist

Nursing

Obstetrician

Operating room costs

Ophthalmologist/Optician/Optomestrist

Orthopedic shoes

Orthopedist

Osteopath

Physician

Postnatal treatments

Prenatal care

Prescription medicines

Psychiatrist

Therapy equipment

Wheelchair

X-rays

* Excludes Dependent Care FSA.

Dental Coverage



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

DPPO Plan

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

MAC (Maximum Allowable Charge) Plans

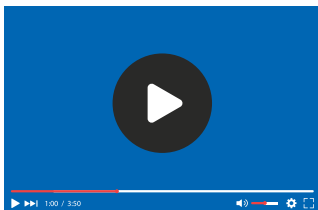
The plan sets a fixed maximum amount it will pay for each dental procedure, based on what's typical in the local area. If your dentist charges more than this amount, you may have to pay the difference. This helps keep costs predictable but may limit provider choices.

90th Percentile Plans

These plans pay up to the 90th percentile of usual charges in your area. This means they cover higher amounts compared to MAC plans — up to what 90% of dentists charge for that procedure. This often means less out-of-pocket cost for you if you visit a dentist who charges above the MAC limit, and potentially a wider network of providers.

Dental Benefits Summary

DENTAL – BCBSTX		
BLUECARE NETWORK	LOW (MAC) PPO	HIGH PPO
	In-Network	In-Network
Calendar Year Deductible Individual	\$75	\$50
Calendar Year Benefit Maximum Individual Family	\$1,000 MAC	\$2,000 90th Percentile



Watch and learn more!

Find an In-Network Provider



Visit www.bcbstx.com/find-care/find-a-dentist.



Call **800-521-2227**.

Dental Coverage

DENTAL – BCBSTX		
BLUECARE NETWORK	LOW (MAC) PPO	HIGH PPO
	In-Network	In-Network
PREVENTIVE SERVICES	YOU PAY	YOU PAY
Exams, cleanings, complete series X-rays	0%	0%
BASIC SERVICES	YOU PAY	YOU PAY
Fillings, extractions, periodontics, root canals, endodontics, oral surgery	50%	20%
MAJOR SERVICES	YOU PAY	YOU PAY
Crowns, bridges, dentures	70%	50%
ORTHODONTIA	PLAN PAYS	PLAN PAYS
Children to age 19 and Adults	Not covered	\$1,000 lifetime maximum
EMPLOYEE MONTHLY RATES		
BLUECARE NETWORK	LOW (MAC) PPO	HIGH PPO
Employee Only	\$25.20	\$54.07
Employee and Spouse	\$49.41	\$105.34
Employee and Child(ren)	\$68.74	\$119.25
Employee and Family	\$86.97	\$162.89

How Can I Get My ID Card?

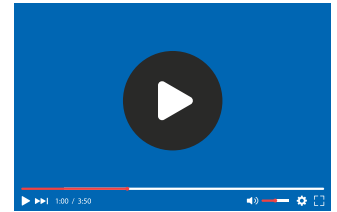
- Visit www.bcbstx.com.
- Call **800-521-2227**.

Vision Coverage



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

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



Watch and learn more!

Vision Benefits Summary

INSIGHT NETWORK	LOW PLAN	HIGH PLAN
	IN-NETWORK YOU PAY	IN-NETWORK YOU PAY
Exam Copay	\$10	\$10
Materials Copay	\$0	\$0
Frame Allowance	\$180	\$250
Retinal Imaging	Up to \$39	Up to \$39
MATERIALS	COVERED IN FULL IN-NETWORK	COVERED IN FULL IN-NETWORK
Covered In Full		
• Single Vision Lenses (Per Pair)	Yes	Yes
• Bifocal Lenses (Per Pair)	Yes	Yes
• Trifocal Lenses Covered (Per Pair)	Yes	Yes
• Standard Progressive Lenses (Per Pair)	No	No
• Polycarbonate Lenses	Child under age 19 (\$40 for adults)	Child under age 19 (\$40 for adults)
LENS ENHANCEMENTS	IN-NETWORK YOU PAY	IN-NETWORK YOU PAY
Standard Polycarbonate Lenses	\$40	\$40
Progressive Lenses by Tier		
• Tier I	\$85	\$85
• Tier II	\$95	\$95
• Tier III	\$110	\$110
• Tier IV	\$90 copay, 80% of charge less \$120 allowance	\$90 copay, 80% of charge less \$120 allowance
UV Coating	\$15	\$15
Scratch-Resistant Coating	\$15	\$15
Tints Solid and gradient	\$15	\$15
Polarized	20% off retail price	20% off retail price
CONTACTS AND LASIK	IN-NETWORK PLAN PAYS	IN-NETWORK PLAN PAYS
Contacts in Lieu of Glasses	Yes	Yes
Standard Contact Lens Allowance	\$180	\$250
Medically Necessary Contact Lens Allowance	Covered in full	Covered in full
Standard Contact Lens Fitting Allowance	Up to \$40 for standard 10% off retail price for premium	Up to \$40 for standard 10% off retail price for premium
LASIK Benefit	15% off retail price or 5% off promotional price	15% off retail price or 5% off promotional price

Vision Coverage

	LOW PLAN	HIGH PLAN
BENEFIT FREQUENCY		
Lenses	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 12 months
Contacts	Once every 12 months	Once every 12 months
EMPLOYEE MONTHLY RATES		
Employee Only	\$10.97	\$13.80
Employee and Spouse	\$18.73	\$23.56
Employee and Child(ren)	\$19.82	\$24.97
Employee and Family	\$29.97	\$37.68

Find an In-Network Provider



Visit www.eyemedvisioncare.com/bcbstxvis.



Call **800-521-2227**.

How Can I Get My ID Card?

- Visit www.bcbstx.com.
- Call **800-521-2227**.



for a healthy you

Life and AD&D Insurance

CHUBB®

FOR EMPLOYEES / BASIC

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

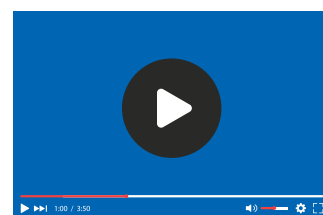
With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts such as credit cards, loans, and bills. AD&D coverage provides specific benefits if an accident causes bodily harm or loss (e.g., the loss of a hand, foot, or eye). If death occurs from an accident, 100% of the AD&D benefit would be paid to you or your beneficiary(ies). Life and AD&D coverage amounts reduce by 65% at age 65, and by 50% at age 70.

Employee Basic Life and AD&D

Eligible employees receive Basic Life and AD&D at no cost. **You are automatically covered at \$10,000 for each benefit.**

Designating a Beneficiary

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



Watch and learn more!

Employees covered by Basic Life and AD&D receive six face-to-face counseling sessions, plus unlimited telephonic sessions.

for a
healthy
you

Life and AD&D Insurance

CHUBB®

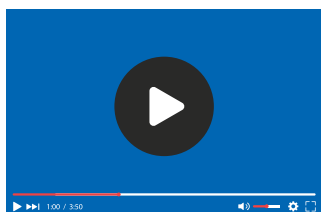
VOLUNTARY

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

With voluntary Life and AD&D insurance, you or your beneficiary(ies) can use the coverage to pay off debts such as credit cards, loans, and bills. AD&D coverage amounts reduce by 50% at age 70.

Designating a Beneficiary

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



Watch and learn more!

Voluntary Life and AD&D

If you need more coverage than Basic Life and AD&D, you may buy Voluntary Life and AD&D coverage for yourself and your dependent(s). If you do not elect Voluntary Life and AD&D coverage when first eligible, or if you want to increase your benefit amount at a later date, you may need to show proof of good health. You must elect Voluntary Life and AD&D coverage for yourself before covering your spouse and/or child(ren).

VOLUNTARY LIFE AND AD&D INSURANCE

Employee	• Increments of \$10,000, up to \$500,000, not to exceed seven times your annual salary • New hire Guaranteed Issue \$250,000
Spouse	• Increments of \$5,000, up to \$500,000, not to exceed 100% of your election • New hire Guaranteed Issue \$100,000
Child(ren)	• \$10,000 • New hire Guaranteed Issue \$10,000

VOLUNTARY LIFE RATES PER \$1,000 EMPLOYEE/SPOUSE¹

AGE	RATE	AGE	RATE
<25	\$0.05	45-49	\$0.23
25-29	\$0.06	50-54	\$0.38
30-34	\$0.07	55-59	\$0.62
35-39	\$0.09	60-64	\$0.78
40-44	\$0.14	65+	\$1.36

VOLUNTARY AD&D RATES PER \$1,000

EMPLOYEE	SPOUSE	CHILD(REN)
\$0.03	\$0.03	\$0.03

¹ Spouse rate is based on employee's age.

Permanent Life Insurance



Help protect your family with the TrueFlex Plan from **Texas Republic Life Insurance Company**. This universal life insurance plan offers level premiums and a level death benefit to age 121, as long as there is no lapse in premium payments.

Plan Highlights

- **Family Coverage:** Coverage is available for your spouse and dependent children ages 15 days to 26 years old.
- **Portability:** If you change jobs or retire, and continue to pay your premium, your coverage continues with no loss of benefits or premium increases.
- **Convenient Payment:** Your premium can be payroll-deducted.
- **Easy to Qualify for Coverage:** For coverage up to the \$50,000 Guaranteed Issue amount, just answer three questions with no medical exam required. During the last six months, has the proposed insured:
 1. Been actively at work on a full-time basis and performing usual duties?
 2. Been absent from work due to illness or medical treatment for more than five consecutive working days?
 3. Been disabled or received tests, treatment, or care of any kind in a hospital or nursing home; or received chemotherapy, hormonal therapy for cancer, radiation, dialysis treatment; or received treatment for alcohol or drug abuse?

INDIVIDUAL LIFE			
EMPLOYEE MONTHLY RATE (LIFE WITH ADB • NON-TOBACCO)			
AGE	FACE AMOUNT		
	\$25,000	\$50,000	\$75,000
25	\$10.75	\$19.25	\$27.75
35	\$13.79	\$25.33	\$36.88
45	\$25.17	\$48.08	\$71.00
55	\$52.60	\$102.96	\$153.31



2026 Plan Year Enrollment

The following Guaranteed Issue benefit amounts are available to eligible applicants, regardless of their health status, with no doctor exam or physical required.

- **Employee:** \$50,000

To Enroll and For More Information



Visit www.texasrepubliclife.com.



Call **512-330-0099**.

Educator Disability Insurance



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

EDUCATOR DISABILITY	
Benefits Begin The first number indicates the number of days you must be disabled due to Injury and the second number indicates the number of days you must be disabled due to Sickness .	0/7 ¹ 14/14 ¹ 30/30 ¹ 60/60 90/90 180/180
Percentage of Earnings You Receive	Up to 66 2/3%
Monthly Benefit	Between \$200 and \$10,000
Maximum Benefit Period	Varies based on schedule selected and age at disability
Pre-existing Condition Exclusion	3/12 ²

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

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

Are there pre-existing condition limitations?

Yes. All plans include pre-existing condition limitations that could impact you if you are a first-time enrollee in your employer's disability plan (including your initial new hire enrollment). Review the plan documents for full details.

File a Disability Claim



Visit www.thehartford.com.



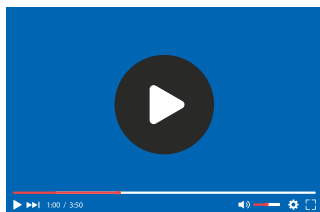
Call **866-547-4205**.



Educator Disability Rates



Visit www.mybenefitshub.com/georgetownisd for rates.



Watch and learn more!

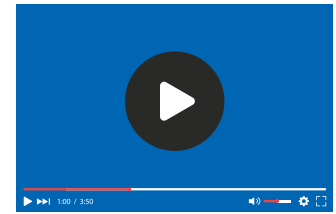
for a
healthy
you

Hospital Indemnity Insurance



The Hospital Indemnity plans help you with the high cost of medical care by paying you a cash benefit when you have an inpatient hospital stay.

Unlike traditional insurance which pays a benefit to the hospital or doctor, these plans pay you directly. It is up to you how you want to use the cash benefit. These costs may include meals, travel, childcare or eldercare, deductibles, coinsurance, medication, or time away from work. **See the plan document for full details.**



Watch and learn more!

Hospital Indemnity Benefits Summary

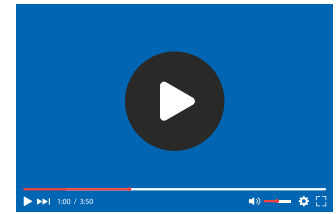
HOSPITAL INDEMNITY – LINCOLN FINANCIAL GROUP		
	LOW PLAN	HIGH PLAN
PLAN FEATURES		
Hospital Admission Benefit Amount	\$1,500	\$2,000
Hospital Admission Benefit	2 hospital admissions and 1 ICU admission per year	2 hospital admissions and 1 ICU admission per year
Daily Hospital Stay Benefit Amount and Maximum Days per Calendar Year	\$150 up to 30 days	\$200 up to 30 days
Hospital ICU Admission Benefit Amount	\$3,000	\$4,000
Daily Hospital ICU Benefit Amount and Maximum Days per Calendar Year	\$300 up to 30 days	\$400 up to 30 days
Observation Benefit Amount and Maximum Days per Calendar Year	\$100 up to 1 day per calendar year	\$200 up to 1 day per calendar year
Newborn Care Stay Benefit and Maximum Days	\$500 up to 2 days	\$500 up to 2 days
NICU Benefits and Maximum Days	125% of ICU admission and Daily ICU confinement benefits	125% of ICU admission and Daily ICU confinement benefits
Pregnancy Coverage Included	Yes	Yes
WELLNESS BENEFIT		
Wellness Benefit	\$50 per person	\$50 per person
PLAN PROVISIONS		
HSA Compatible	Yes	Yes
Pre-existing Condition Limitation Period	None	None
RATES (MONTHLY)		
Employee Only	\$19.90	\$29.94
Employee and Spouse	\$41.84	\$62.82
Employee and Child(ren)	\$33.60	\$50.50
Employee and Family	\$48.20	\$73.74

Cancer Insurance

CHUBB®

Treatment for cancer is often lengthy and expensive. While your health insurance helps pay the medical expenses for cancer treatment, it does not cover the cost of non-medical expenses, such as out-of-town treatments, special diets, daily living, and household upkeep.

In addition to these non-medical expenses you are responsible for paying your health plan deductibles and/or coinsurance. Cancer insurance helps pay for these direct and indirect treatment costs so you can focus on your health. **See the plan document for full details.**



Watch and learn more!

Cancer Insurance Benefits Summary

CANCER – CHUBB		
	LOW PLAN	HIGH PLAN
PLAN FEATURES		
CORE BENEFITS		
First Occurrence Benefit	Diagnosis of Cancer Benefit Employee or Spouse: \$5,000 Child(ren): \$7,500 First Cancer Benefit \$100 paid upon receipt of first covered claim Only 1 payment per certificate	Diagnosis of Cancer Benefit Employee or Spouse: \$10,000 Child(ren): \$15,000 First Cancer Benefit \$100 paid upon receipt of first covered claim Only 1 payment per certificate
Radiation, Chemotherapy, and Immunotherapy	Maximum per covered person per 12-month period: \$10,000	Maximum per covered person per 12-month period: \$15,000
Surgical Benefit	Up to \$4,125	Up to \$4,125
Transportation Benefit (Employee and Family)	\$100 per trip Maximum 12 trips per calendar year	\$100 per trip Maximum 12 trips per calendar year
Lodging Benefit (Employee and Family)	\$100 per day Maximum 100 days per calendar year	\$100 per day Maximum 100 days per calendar year
Hospital Confinement	\$100 per day – days 1 through 30 Additional days: \$200 Maximum days per confinement: 31	\$300 per day – days 1 through 30 Additional days: \$600 Maximum days per confinement: 31
Hospital Intensive Care Confinement	\$600 per day – days 1 through 30 Additional days: \$600 Maximum days per confinement: 31	\$600 per day – days 1 through 30 Additional days: \$600 Maximum days per confinement: 31
TREATMENT BENEFITS		
Ambulatory Surgical Facility	\$200 per day Maximum 4 days per calendar year	\$200 per day Maximum 4 days per calendar year
Outpatient Surgery Facility	\$200 per day Maximum 4 days per calendar year	\$200 per day Maximum 4 days per calendar year
Donor Benefit	\$200 per day of confinement Lifetime maximum donations: 2	\$200 per day of confinement Lifetime maximum donations: 2
Drugs and Medicines – Inpatient	\$150 per day of confinement Maximum confinements per calendar year: 6	\$150 per day of confinement Maximum confinements per calendar year: 6
Drugs and Medicines – Outpatient	Hormone therapy benefit: \$50 per calendar month Maximum months per calendar year: 12	Hormone therapy benefit: \$50 per calendar month Maximum months per calendar year: 12
Bone Marrow Transplant	First bone marrow transplant: \$6,000 Additional transplant: 50% Lifetime maximum transplant(s): 2	First bone marrow transplant: \$9,000 Additional transplant: 50% Lifetime maximum transplant(s): 2
Stem Cell Transplant	First stem cell transplant: \$600 Additional transplant: 50% Lifetime maximum transplant(s): 2	First stem cell transplant: \$900 Additional transplant: 50% Lifetime maximum transplant(s): 2

Cancer Insurance

CHUBB®

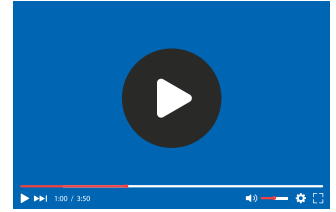
CANCER – CHUBB		
	LOW PLAN	HIGH PLAN
ADDITIONAL BENEFITS		
Ambulance	Ground \$200 per trip Maximum trips per confinement: 2 per calendar year Air \$2,000 per trip Maximum trips per confinement: 2 per calendar year	Ground \$200 per trip Maximum trips per confinement: 2 per calendar year Air \$2,000 per trip Maximum trips per confinement: 2 per calendar year
Blood and Plasma	\$300 per transfusion Maximum transfusions per calendar year: 2	\$300 per transfusion Maximum transfusions per calendar year: 2
Home Health Care	\$100 per day not to exceed the number of days confined Maximum days per calendar year: 30	\$300 per day not to exceed the number of days confined Maximum days per calendar year: 30
Hospice	\$100 per day	\$300 per day
Hair Prosthesis	\$150 per hair piece Lifetime maximum: 1	\$150 per hair piece Lifetime maximum: 1
Medical Equipment	\$150 per piece of equipment Maximum pieces per calendar year: 2	\$150 per piece of equipment, Maximum pieces per calendar year: 2
Reconstructive Surgery – Breast	TRAM flap \$2,000 Reconstruction \$500 Symmetry \$500	TRAM flap \$2,000 Reconstruction \$500 Symmetry \$500
Reconstructive Surgery – Facial	\$500	\$500
RIDERS		
Heart Attack & Stroke	Employee or spouse: \$5,000 Child(ren): \$7,500 Recurrence Benefit Employee or spouse: \$2,500 Child(ren): \$3,750	Employee or spouse: \$10,000 Child(ren): \$15,000; Recurrence Benefit Employee or spouse: \$5,000 Child(ren): \$7,500
WELLNESS BENEFIT		
Health Screening/Wellness Benefit Amount	\$50 per covered person, per calendar year Follow-up test benefit amount: \$100	\$50 per covered person, per calendar year Follow-up test benefit amount: \$100
ADDITIONAL INFORMATION		
Prosthesis	Surgical: \$1,000 per device Lifetime maximum benefit \$1,000 Non-surgical prosthesis benefit: \$100 Lifetime maximum number of devices: 1	Surgical: \$2,000 per device Lifetime maximum benefit \$2,000 Non-surgical prosthesis benefit: \$200 Lifetime maximum number of devices: 1
Experimental Treatment	Alternative care benefit: \$75 per visit Maximum visits per calendar year: 4	Alternative care benefit: \$75 per visit Maximum visits per calendar year: 4
RATES (MONTHLY)		
Employee Only	\$15.64	\$31.30
Employee and Family	\$26.58	\$53.26

Critical Illness Insurance



Critical Illness insurance helps pay the cost of non-medical expenses related to a covered critical illness or cancer.

The plan provides a lump-sum benefit payment to you upon first and second diagnosis of any covered critical illness or cancer. The benefit can help cover expenses such as lost income, out-of-town treatments, special diets, daily living, and household upkeep costs. This coverage is portable. **See the plan document for full details.**



Watch and learn more!

Critical Illness Insurance Benefits Summary

CRITICAL ILLNESS INSURANCE			
Employee Benefit Amounts – \$5,000 - \$50,000 in \$5,000 increments			
Spouse Benefit Amount Maximum – \$5,000 - \$50,000 in \$5,000 increments up to 100% of employee amount			
Child(ren) Benefit Amount Maximum – 50% of employee election			
FIRST OCCURRENCE BENEFIT			
Vascular - Heart Attack - Stroke - Coronary Artery Disease - Coronary Artery Bypass - Angioplasty - Sudden Cardiac Arrest	100% 100% 10% 50% 50% 100%	Neurological - Mild Stage Alzheimer's Disease - Advanced Stage Alzheimer's Disease - Amyotrophic Lateral Sclerosis (ALS) - Parkinson's Disease - Huntington's Disease	100% 100% 100% 100% 100%
Other Specified - Major Organ Failure - End-Stage Renal Disease - Paralysis - Coma - Blindness - Loss or Hearing or Speech	100% 100% 100% 100% 100% 100%	Childhood Diseases - Type 1 Diabetes - Down Syndrome - Congenital Defects - Cerebral Palsy - Cystic Fibrosis - Muscular Dystrophy	100% ¹ 100% ¹ 100% ¹ 100% ¹ 100% ¹ 100% ¹
CANCER			
Covered Conditions - Invasive Cancer - Carcinoma in Situ - Skin Cancer	100% 25% \$500		
Recurrence Benefit - Invasive Cancer - Carcinoma in Situ - Skin Cancer	100% 25% \$500		
WELLNESS			
Health Screening / Wellness Benefit	\$100		

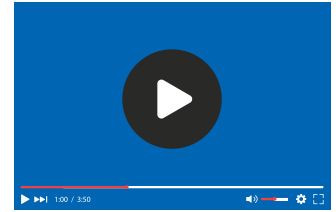
¹ 50% of elected coverage amount

Accident Insurance

CHUBB®

Accident insurance provides affordable protection against a sudden, unforeseen accident.

Accident insurance helps offset the direct and indirect expenses such as copayments, deductibles, ambulance, physical therapy, childcare, rent, and other costs not covered by traditional health plans. You will be paid a specific sum of money directly based on the care and services provided for your covered accident. Use the money any way you see fit. **See the plan document for full details.**



Watch and learn more!

Accident Insurance Benefits Summary

ACCIDENT – CHUBB		
	LOW PLAN	HIGH PLAN
Ambulance		
• Ground	\$500	\$750
• Air	\$1,500	\$2,000
Emergency Room	\$150	\$200
Hospital Admission	\$1,000	\$1,500
Daily Hospital Confinement	\$200 per day – up to 365 days	\$200 per day – up to 365 days
Hospital ICU Admission	\$1,000	\$1,500
Intensive Care Unit	\$400 per day – up to 30 days	\$500 per day – up to 30 days
Specific Sum Injuries Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, etc.	\$150-\$8,000	\$200-\$10,000
ACCIDENTAL DEATH & DISMEMBERMENT ¹		
Employee	\$50,000	\$100,000
Spouse	\$50,000	\$100,000
Child	\$10,000	\$20,000
Wellness Benefit Amount	\$50 per member per year	\$50 per member per year
RATES (MONTHLY)		
Employee Only	\$6.00	\$12.96
Employee and Spouse	\$11.20	\$21.58
Employee and Child(ren)	\$16.00	\$28.74
Employee and Family	\$18.88	\$37.34

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



Financial Planning



403(b) Retirement Savings Plan

A 403(b) plan is a special type of employer-sponsored retirement plan designed for eligible public education, religious, and other tax-exempt organizations.

Saving with a 403(b) plan gives you the ability to defer a portion of your paycheck and invest funds in a portfolio of your choosing. By participating, you can take advantage of tax savings, reduce your retirement income gap, and get one step closer to achieving financial independence.

To establish a 403(b) account, you must first select an investment provider from a list of approved vendors, and then elect contributions on a pre-tax or Roth basis.

Please note that early withdrawals from a 403(b) account are subject to a 10% early withdrawal penalty unless a qualifying event takes place.



Why Contribute?

- Avoid a gap in your income during retirement
- Take advantage of tax benefits
- Improve your financial wellbeing
- Automatic payroll deductions take stress out of planning
- Decrease your dependency on government-funded pension plans

2026 Contribution Limits

You can contribute 100% of your compensation up to \$24,500, whichever is less. If you are age 50 or older, you can contribute up to an additional \$8,000 for a total of \$32,500. If you are ages 60-63, you can contribute up to an additional \$11,250 for a total of \$35,750.

You can contribute to both 403(b) and 457(b) plans simultaneously.

Get started at www.ramsretirement.com/403b

Enrollment assistance is available at www.ramsretirement.com/telewealth or by calling the Enrollment Hotline at 800-943-9179.



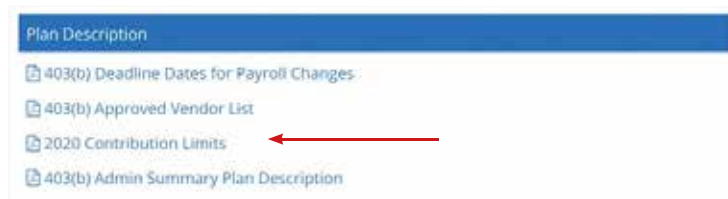
Financial Planning



How to Register

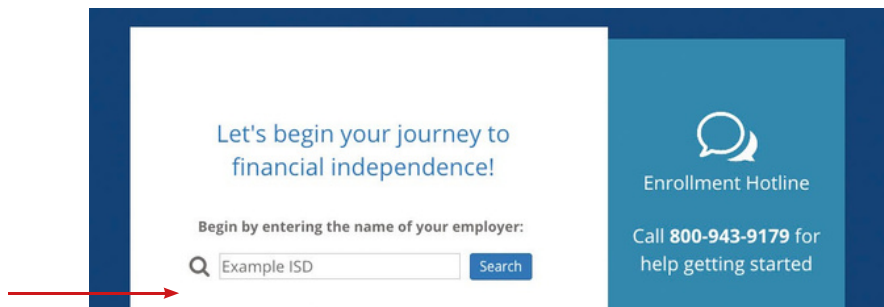
Step One: Create an account with an approved vendor

1. Visit www.ramsretirement.com/documents.
2. Search for your employer and open the 403(b) Approved Vendor list.
3. Do your research and contact a vendor on the list directly to establish your retirement account.



Step Two: Create an administration account

1. Visit www.ramsretirement.com/403b and click Enroll.
2. Enter the name of your employer and select the 403(b) Admin Plan.
3. Follow each step until you get a completion notice.
4. You're done! Login your account any time you wish to make contribution adjustments.



Get started at www.ramsretirement.com/403b

Enrollment assistance is available at www.ramsretirement.com/telewealth or by calling the Enrollment Hotline at 800-943-9179.



Region 10 RAMS | 900 S. Capital of Texas Hwy, Suite 350, Austin, TX 78746 | Customer Service: 800.943.9179 | www.ramsretirement.com

Investment advisory services offered through HUB Investment Partners LLC, an SEC registered investment advisor. Insurance Services offered through HUB International. HUB International, owns and operates several other entities which provide various services to employers and individuals across the U.S.

Financial Planning



457(b) Retirement Savings Plan

A Section 457(b) plan is a special type of employer-sponsored retirement plan that certain governmental employers, and other tax-exempt organizations can establish for their employees.

Your employer offers the **RAMS 457(b)** plan as a way to help you build savings for your post-retirement expenses. Contributing regularly to a 457(b) plan can empower you and give you the confidence to retire with more in your pocket to cover housing, healthcare, vacations, bills, and other expenses at the time of retirement.



2026 Contribution Limits

In 2026, you may contribute 100 percent of your compensation, up to \$24,500. If you are age 50 or older, you may contribute up to an additional \$8,000, for a total of \$32,500. If you are age 60–63, you may contribute up to an additional \$11,250, for a total of \$35,750.

You may contribute simultaneously to 403(b) and 457(b) plans.



Plan Benefits

- Oversight by superintendents and HR directors, providing assurance that the interests of public employees are represented.
- Low, transparent fees
- A wide range of investment options to choose from, including managed portfolios, target-date funds, and self-directed options.
- No 10% tax or penalty is charged for early distribution.
- No redemption charges or hidden fees are charged.
- No product commissions are charged.
- Total control over starting and pausing contributions
- Access to financial education through FinPath
- Wellness, which includes financial counseling, financial health tools, and monthly opportunities to win prizes**
- Access to free W-2 tax preparation and free creation of a personal will*

Start at www.ramsretirement.com/457b

Assistance is available at www.ramsretirement.com or by calling 800-943-9179.



Financial Planning

Exclusive Benefits of RAMS 457(b)

As a benefit of having your retirement dollars managed by the RAMS program, you are automatically eligible for financial resources exclusive to you and your family. This is just another way that saving for retirement can benefit you—both now and in the long run.



FinPath - Financial Education

FinPath* is a financial wellness program designed to help you develop better financial habits and make your money go further.

The program includes:

- Unlimited financial coaching sessions
- Financial wellness tools to help you budget, reduce debt, plan for emergencies, and more
- Financial education workshops and courses from FinPath University
- Opportunities to win prizes, including a \$1,000 monthly drawing



Estate Planning

Dedicating a little time to creating a solid estate plan can help you prepare for both the expected and the unexpected.

Redeem a complimentary will† (valued at \$259) to help protect your legacy and your loved ones.



Tax Preparation

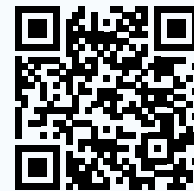
We can help you take the stress out of your tax bill. Our team can help you file your W-2 tax returns at no cost, or provide a \$250 credit toward complex preparation services.‡

Ready to start saving?

1. Visit www.ramsretirement.com/457b and click on **Enroll Now**.
2. Enter the name of your employer and select the **457(b) Savings Plan** option.
3. Follow the on-screen steps to select your payroll contribution and choose your investment. Don't forget to designate a beneficiary!

*Note: If you are unsure which investment option to select, schedule a virtual TeleWealth** meeting.*

4. Continue until you receive a confirmation notice—and you're all set!



**Scan the QR code
to start
registration.**



Need help?

Assistance is available at www.ramsretirement.com or by calling 800-943-9179.

Region 10 RAMS | 900 S. Capital of Texas Hwy, Suite 350, Austin, TX 78746 | Customer Service: 800.943.9179 | www.ramsretirement.com

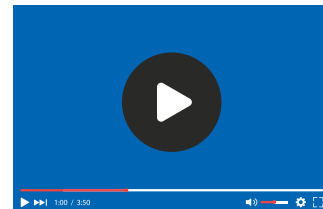
Investment advisory services are offered through HUB Investment Partners LLC, an SEC-registered investment advisor. Insurance services are offered through HUB International. Recordkeeping and third-party administration services are offered through TCG Administrators, a HUB International company. FinPath is offered through RPW Solutions. *Registration is required to use FinPath. †Services may be offered through third-party providers. **TeleWealth virtual meetings are provided by TCG Advisors, a HUB International company. ‡Tax and estate services may be provided through third-party providers.

Emergency Medical Transport



MASA Medical Transport Solutions (MASA MTS) helps you prepare for the unexpected with affordable medical emergency air and ground transportation.

If you or your family members need emergency medical transport, your insurance coverage and Medicare may not cover all of the costs. Following your medical crisis, MASA MTS will negotiate with your medical plan provider and cover your remaining balance on your medical transportation bills. Participation in this plan is voluntary.



Watch and learn more!

For More Information



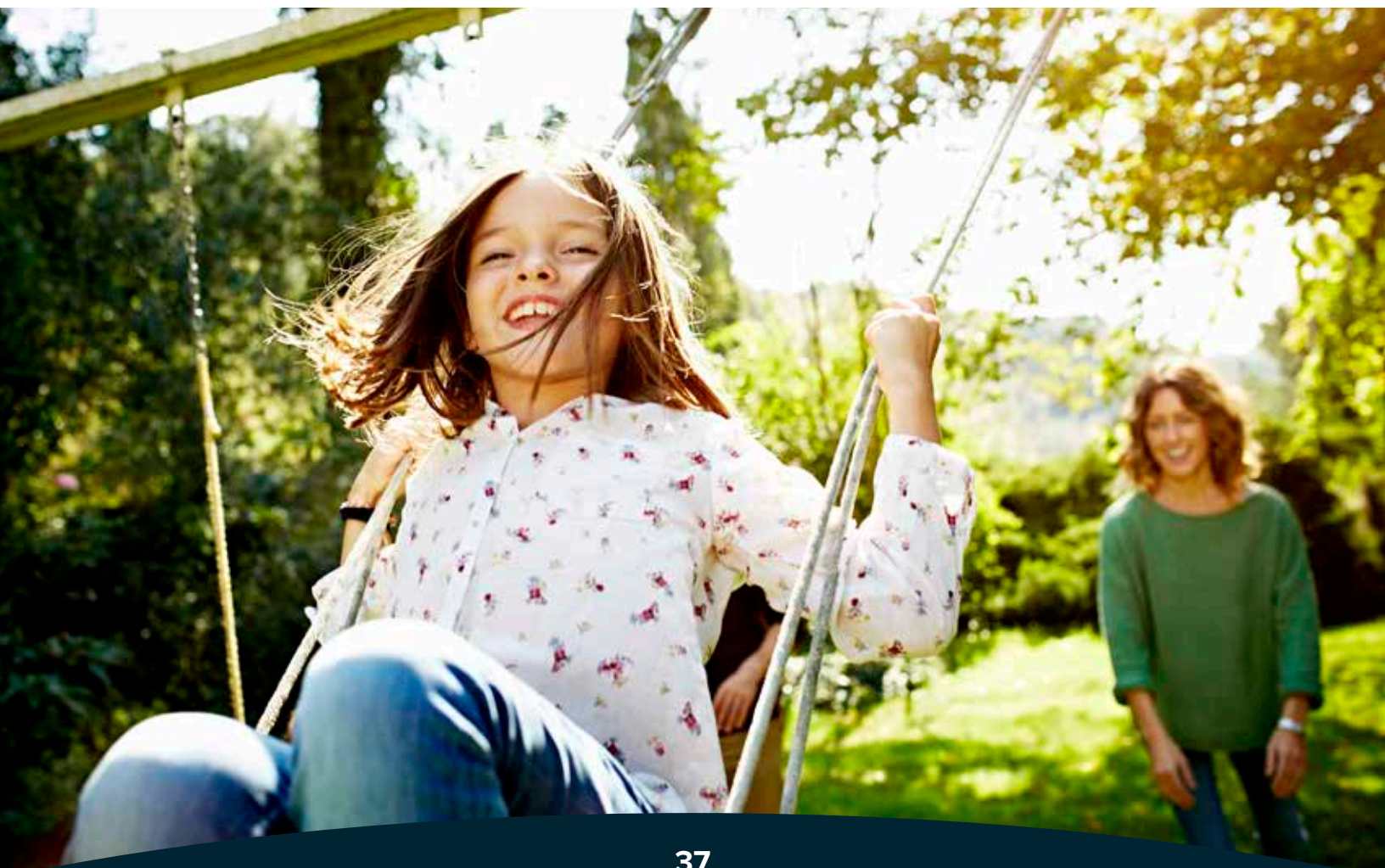
Visit www.masamts.com.



Call **800-643-9023**.



Download the **MASA Global app**.



Emergency Medical Transport

Emergency Medical Transport Benefits Summary

EMERGENCY MEDICAL TRANSPORT – MASA		
SERVICES	PLANS	
	Emergent Plus Plan	Platinum Plan
Emergency Ground Ambulance Coverage	X ²	X ²
Emergency Air Ambulance Coverage	X ²	X ²
Hospital to Hospital Ambulance Coverage	X ²	X ²
Repatriation Near Home Coverage	X ²	X ⁴
Minor Return Transportation Coverage		X ³
Pet Return Transportation Coverage		X ³
Patient Return Transportation Coverage		X ⁴
Companion Emergency Transportation Coverage		X ³
Hospital Visitor Transportation Coverage		X ³
Mortal Remains Transportation Coverage		X ⁴
Vehicle & RV Return Coverage		X ³
Organ Retrieval Transportation Coverage		X ¹
Organ Recipient Transportation Coverage		X ¹
RATES (MONTHLY)		
Family	\$13.50	\$35.00

Coverage territories:

¹ United States only

² United States and Canada

³ United States, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas, and Bermuda

⁴ Worldwide coverage to include any region with the exclusion of Antarctica and not prohibited by U.S. law or U.S. travel advisories

Disclaimer: This material is for informational purposes only and does not provide any coverage. The benefits listed, and the descriptions thereof, do not guarantee coverage and do not represent the full terms and conditions applicable for usage and may only be offered in some memberships or policies. Premiums, benefits, and coverage vary depending on the plan selected. For a complete list of benefits, premiums, terms, conditions, and restrictions, please refer to the applicable member services agreement or policy for your state. For additional information and disclosures about MASA plans, visit <https://info.masaglobal.com/disclaimers>.

Identity Theft Protection



This plan helps to prevent or minimize the harm caused by identity theft when someone uses your personal information without permission.

- Monitoring of credit files, financial accounts, and the dark web for fraudulent activity
- Alerts when suspicious activity is detected
- Identity restoration services
- Fraud resolution services

To Learn More



Visit www.experian.com.



Call **855-797-0052**.



Download the [Experian app](#).

IDENTITY THEFT – EXPERIAN		
	PREMIUM PLAN	ELITE PLAN
Employee Only	\$4.50	\$7.50
Employee and Family	\$9.00	\$14.00



Glossary of Terms

ACA (Affordable Care Act) – The ACA is comprehensive health care reform law enacted in March 2010. References to ACA at HPS typically involve reporting requirements, specifically, that obligate employers to report medical coverage for employees and to provide documents for employee tax preparation. HPS partners with ACA service providers to assist clients in meeting these requirements.

Actively-at-work – This term refers to being at work as opposed to being on vacation, leave, or away from work for any other reason. Companywide or position-wide reporting dates (like summer breaks or winter breaks for teachers) do not apply here.

ADL (Activities of Daily Living) – This is a concept related to eligibility for Long Term Care (LTC) benefits. There are six ADLs: bathing, dressing, toileting, transferring, eating, and continence. Most LTC plans require that the covered individual be unable to perform a certain number of these tasks to be eligible for benefits.

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

Benefit Duration – This is the maximum period of time in which a claimant can receive benefits.

Benefit Reduction – Some plans may include percentage reductions in benefit amounts when participants reach a certain age.

Cafeteria/Section 125 Plan – This plan provides participants an opportunity to pay for qualified benefits on a pretax basis. Premiums for most medical, dental, vision, FSA, HSA, accident, and cancer plans are deducted on a pretax basis, which reduces participants' taxable income.

Certificate of Benefits (Certificate of Coverage) – The certificate serves as the primary official plan document for participants of group benefits, as they are not enrolled in an individual policy.

COBRA – COBRA allows participants who lose their health benefits the right to continue group health benefits for limited periods of time under certain circumstances including voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals will have to pay the full premium (including any employer contribution applied when employed) up to 102% of the cost to the plan. Coverage is typically available for 18 months but can be extended in certain situations.

Copay – Also known as a copayment, this is the fixed amount you pay for health care services received at the time of service. A copay typically goes toward your deductible.

Coinsurance – After you have met your deductible, this is your share of the cost of a covered health care service, which is calculated as a percent of the allowed amount for the service. For example, your coinsurance is 20% (while the insurer pays the remaining 80%).

Contingent Beneficiary – This is who will receive a benefit in the event of the beneficiary's (aka the primary beneficiary) death. A policy may have more than one contingent beneficiary.

Contingent Plans – Contingent plans make benefits available to participants only when another specific benefit has been elected. Examples of contingent plans include voluntary life for dependents (contingent on the election of employee voluntary life) and a Health Saving Account (contingent on the election of a High Deductible Health Plan).

Continuation of Coverage – Many plans offered by HPS clients are continuable under COBRA or portability or conversion options. Standalone clients and cooperatives will have "continuation of coverage" documents that detail plan continuation availability.

Conversion – Conversion is a benefit continuation option that transforms group coverage into individual coverage, separate from the group policy. This typically comes with much higher premiums.

Covered Expenses – These are health care expenses covered under your health plan.

Glossary of Terms

Deductible – This is the amount a participant must cover for health care services before the insurer will share costs and provide coinsurance.

Dental Reimbursement Types – Various types of dental plans (except DHMO plans) will pay out-of-network benefits differently.

- **MAC/MRC/NAP (Maximum Allowable Charge/Maximum Reimbursable Charge/Network Access Plan):** Participants will receive the same payouts (contracted fees) for services whether they go in or out of network; and they may be balance billed when going out of network.
- **UCR/R&C(Usual, Customary, and Reasonable/Reasonable & Customary):** When going out of network, the plan will pay an amount determined by the usual cost charged for the service by dentists in a certain geographical area.

Eligibility Waiting Period – This period is the amount of time new hires must wait before they are eligible for benefits. Most HPS clients will allow for new hires to be eligible the first of the month following (or coincident with) their date of hire.

Elimination Period – Also known as a waiting period, this is the number of calendar days that participants in a Disability plan must be disabled before they are eligible to receive benefits.

Employer Contribution – The amount of premium or financial contribution an employer provides to participants for insurance, spending accounts, or retirement.

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

EOI (Evidence of Insurability)/Statement of Health (SOH) – Some plans require an application or a "proof of good health" type of statement to obtain coverage. This is commonly referred to as EOI (Evidence of Insurability). Such applications or statements must be submitted electronically or by mail to the carrier for approval.

Evergreen Clause – This clause, written into a client's Cafeteria/Section 125 Plan, allows a client to roll over Flexible Spending Account elections into the new plan year.

FMLA (Family and Medical Leave Act) – This act ensures employees have job-protected and unpaid leave for qualified medical and family reasons.

FSA (Flexible Spending Account) – An option that allows participants to set aside pretax dollars to pay for qualified expenses (i.e., certain medical care or dependent care expenses) during a specific period (usually a 12-month period). Participants determine how much to contribute to their FSA at the beginning of the plan year. Most funds must be used by the end of the year, depending upon the type of FSA, as there is a limited carryover amount.

Grace Period – As it pertains to FSAs, this is the period immediately following the end of the plan year during which participants can incur new claims to use their remaining FSA funds.

Guaranteed Issue – Some plans may include Guaranteed Issue coverage to new enrollees without EOI.

HDHP (High Deductible Health Plan) – A qualified health plan that combines lower monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

HMO/DHMO (Health Maintenance Organization/ Dental Health Maintenance Organization) – Medical plans labeled as HMO plans have a specified network of providers, and benefits are generally not available outside of that network except in an emergency. DHMO plans follow this same model for dental coverage.

HPS (Higginbotham Public Sector) – HPS is the insurance broker that represents your account.

HRA (Health Reimbursement Arrangement) – This is an employer-owned savings account to which the company deposits pretax dollars for each of its covered employees. Employees can then use the funds in their HRA to reimburse themselves for incurred qualified health care expenses.

HSA (Health Savings Account) – This is an employee-owned savings account used to pay for eligible health care expenses with pretax dollars. Funds in the account do not have to be used within a specified time period. An HSA must be coupled with qualified HDHP.

Glossary of Terms

In-network – Doctors (e.g., a primary care physician or specialist), hospitals, and other providers that contract with your insurance company provide health care services at discounted rates. These providers are on an outlined list of health care practitioners.

Inpatient – A person who is treated as a registered patient in a hospital or other health care facility.

Medically Necessary – Services or supplies provided by a hospital, health care facility, or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease, or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease, or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

Medicare – An insurance program administered by the federal government to provide health coverage to individuals age 65 or older, or who have certain disabilities or illnesses.

Member – You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries, and surviving spouses.

Open Enrollment – Open Enrollment refers to the annual period during which employees may enroll in available benefits or make coverage changes without a Qualifying Life Event.

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

Out-of-pocket Expense – Amount that you must pay toward the cost of health care services. This includes deductibles, copayments, and coinsurance.

Out-of-pocket Maximum – Also known as an out-of-pocket limit, this is the most you pay during a policy or benefit period (usually a 12-month period) before your health insurance or plan begins to pay 100% of the allowed amount for covered services.

PCP (Primary Care Physician) – A doctor who is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, and pediatricians.

Plan Year – A 12-month period of benefits coverage under a group health plan, which may or may not coincide with a calendar year.

Plan Year Maximum – The maximum amount of benefit available to a participant for each plan year.

Portability – Portability is a continuation option available that allows participants to continue group coverage beyond their employment. Premiums typically remain in line with active participants, but coverage depends on the continuation of the group policy. If the group policy terminates, portability will no longer be available.

PPO (Preferred Provider Organization) – Health plans labeled as PPO refer to the network structure and plan availability. In-network PPO plan providers have agreed to offer services at a contracted rate, which means members generally pay less and get the highest level of benefits. Out-of-network services and providers are also available, but you may pay more for care and generally receive fewer benefits.

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

Pre-existing Condition – A pre-existing condition is a medical event, treatment, or diagnosis that occurs prior to the effective date of insurance coverage.

Pre-existing Condition Limitation – Some plans may limit benefits due to pre-existing conditions for a set period of time.

Premium – A reference to the cost (usually monthly) of insurance/benefits paid by the employer or employee.

QLE (Qualifying Life Event) – These are events that allow changes to pretax benefits outside of Open Enrollment. Changes must typically be made within 30 or 31 days of the event. Examples of QLEs include marriage, birth, divorce, gain or loss of benefits coverage, and change in employment status affecting benefits.

Glossary of Terms

Rate Guarantee – Plan pricing can be under a rate guarantee for a certain amount of time, typically two to four years. The premium rates cannot be changed during this time.

Renewal – When a plan's rate guarantee expires, a rate renewal will be received from the carrier's underwriter. This establishes new rates beyond the expiration of the rate guarantee. Clients can either accept the new rates, attempt to negotiate the renewal (usually assisted by HPS), or publish an RFP (Request for Proposal) to shop for a new carrier.

Rollover – As it pertains to a Health Care FSA or Limited Purpose Health Care FSA, a client can establish a limit of \$680 (for 2026) of unused funds that can be rolled over to the next plan year, provided the participant re-enrolls in the FSA plan.

Run-out Period – Related to FSAs, this is a period immediately following the end of the plan year in which participants can submit claims incurred within the plan year. For new onboarding clients, this period can be managed by the current or new administrator. The current administrator may charge a fee. If the new administrator manages the run-out period, it will need a report of the FSA participants and their remaining FSA balances.

SSNRA (Social Security Normal Retirement Age) – This is the normal retirement age for an employee under the federal Social Security Act.

SSDI (Social Security Disability Insurance) – Disability benefits are available through Social Security as long as a participant is "insured" (has worked long enough and paid into Social Security) and has been defined as disabled by the federal government.

THEbenefitsHUB – This is the benefits enrollment system used by HPS.

Underwriting – This is the process of evaluating the risks of insuring an individual or group and establishing premium rates and coverage for the individual or group. Clients are subject to underwriting during RFPs and renewals, and their employees are subject to underwriting when submitting EOI statements for coverage.

Usual, Customary and Reasonable (UCR) Allowance –

This is the fee paid for covered services that is: (1) a similar amount to the fee charged by a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in a similar geographic area; and (3) reasonable in light of any unusual clinical circumstances.

Waiver of Premium (WOP) – This is a feature in some insurance plans that allows premiums to be suspended for a participant for a period of disability.

Important Legal Notices

Women's Health and Cancer Rights Act of 1998

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

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

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

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

Special Enrollment Rights

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

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

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

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

Marriage, Birth or Adoption

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

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Georgetown ISD
Human Resources
507 E. University Ave.
Georgetown, TX 78626
512-943-5000

Your Prescription Drug Coverage and Medicare

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

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

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

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

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

Important Legal Notices

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

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

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

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

Contact the Human Resources Department at
512-943-5000.

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

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

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

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

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

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

September 1, 2026
Georgetown ISD
Human Resources
507 E. University Ave.
Georgetown, TX 78626
512-943-5000

Notice of HIPAA Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Georgetown ISD's Group Health Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information (PHI) is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

1. Your past, present, or future physical or mental health or condition;
2. The provision of health care to you; or
3. The past, present, or future payment for the provision of health care to you.

Important Legal Notices

I. Contact Information

If you have any questions about this Notice or about our privacy practices, and for any correspondence or requests related to the contents of this Notice, please contact:

Georgetown ISD
Human Resources
507 E. University Ave.
Georgetown, TX 78626
512-943-5000

II. Effective Date

This Notice is effective February 15, 2026.

III. Our Responsibilities

We are required by law to:

1. maintain the privacy of your PHI;
2. provide you with certain rights with respect to your PHI;
3. provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and
4. follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

IV. How We May Use and Disclose Your PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient.

For Treatment. When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by health care providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about you with physicians who are treating you.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Substance Use Disorder (SUD) Treatment Information. Some of your health information may be part of a SUD patient record and subject to additional protections under federal law (42 CFR Part 2) governing confidentiality of SUD patient records.

If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the SUD patient record for purposes of treatment, payment or health care operations, we may use and disclose your SUD patient record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your SUD patient record through specific consent you provide to us or another third party, we will use and disclose your SUD patient record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your SUD patient record, or testimony that describes the information contained in your SUD patient record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

Important Legal Notices

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

As Required by Law. We will disclose your PHI when required to do so by federal, state, or local law. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose PHI to certain employees of the Employer. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

V. Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your PHI for public health activities. These activities generally include the following:

1. to prevent or control disease, injury, or disability;
2. to report births and deaths;
3. to report child abuse or neglect;
4. to report reactions to medications or problems with products;
5. to notify people of recalls of products they may be using;
6. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
7. to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your PHI if asked to do so by a law-enforcement official.

1. in response to a court order, subpoena, warrant, summons, or similar process;
2. to identify or locate a suspect, fugitive, material witness, or missing person;
3. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
4. about a death that we believe may be the result of criminal conduct; and

Important Legal Notices

5. about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your PHI to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your PHI to researchers when:

1. The individual identifiers have been removed; or
2. When an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

VI. Required Disclosures

The following is a description of disclosures of your PHI we are required to make.

Government Audits. We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

VII. Other Disclosures

Personal Representatives. We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1. You have been, or may be, subject to domestic violence, abuse, or neglect by such person; or
2. Treating such person as your personal representative could endanger you; and
3. In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

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

VIII. Your Rights

You have the following rights with respect to your PHI:

Right to Inspect and Copy. You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your PHI, you must submit your request in writing. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

Important Legal Notices

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. is not part of the medical information kept by or for the Plan;
2. was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
3. is not part of the information that you would be permitted to inspect and copy; or
4. is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an “accounting” of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your PHI that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

IX. Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the person listed in the Contact Information section of this Notice. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Important Legal Notices

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, 2026. Contact your State for more information on eligibility.

Texas – Medicaid

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

To see if any other States have added a premium assistance program since **January 31, 2026**, or for more information on special enrollment rights, can contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Continuation of Coverage Rights Under COBRA

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

Plan Contact Information

Georgetown ISD
Human Resources/ NBS
507 E. University Ave.
Georgetown, TX 78626
512-943-5000

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

Important Legal Notices

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

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

You are protected from balance billing for:

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

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

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

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

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

for a
healthy
you



HigginbothamTM
Public Sector

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