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EMPLOYEE BENEFITS GUIDE

for a healthy you

YOUR NEW BENEFITS BEGIN AND END

September 1, 2026 – August 31, 2027

Welcome

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

Availability Of Summary Health Information

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

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

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Important Contacts

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

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

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

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

Flexible Spending Accounts
National Benefit Services
855-399-3035
www.nbsbenefits.com

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

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

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

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

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

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

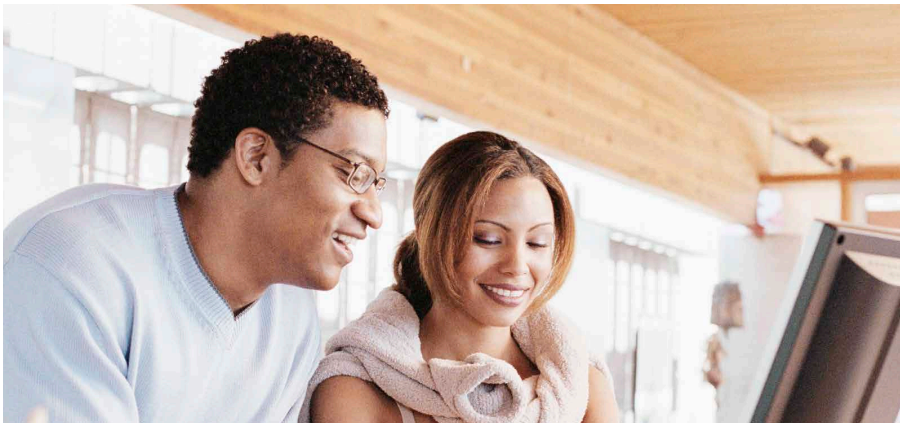
Hospital Indemnity
Chubb
Group # 100000046
https://my.combinedinsurance.com

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

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

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

How to Enroll



Enrolling in benefits is simple through THE*benefits*HUB.

1	Go to **www.mybenefitshub.com/redoakisd** or scan the QR code.
2	Click *Login*.
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 *Text*, *Email*, *Call*, or *Ask Admin* option to receive a code for completing final verification.
5	Enter the code, and click *Verify* 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 *Save & Continue*. 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 *Sign & Continue*. » Review and confirm your information. » Click *Finished*.

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 or text **833-870-3436** 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 **redoakisd@hps.higginbotham.net**.

Bilingual representatives are available.

SCAN THE QR CODE TO ENROLL

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 Office within 30 days of the event. Meeting with the Benefits Office to complete and sign the necessary paperwork is also required to make benefit election changes effective. Changes must be consistent with the QLE.

Frequently Asked Questions

Enrollment FAQs

What if I miss the enrollment deadline?

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

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

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

Where do I find benefit summaries and forms?

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

How do I find an in-network provider?

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

When will I get my ID cards?

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

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

Benefit questions?

Ask your Benefits Department.

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

Important Limitations and Exclusions Information

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

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

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

Eligibility

Who is Eligible for Benefits

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

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

See page 5 for Important Exclusions and Limitations.

About Your Coverage Effective Date

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

New Hire

Who is Eligible

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

When to Enroll

- Enroll by the deadline given by Human Resources

When Coverage Starts

- First day of work concurrent with the plan effective date

Employee

Who is Eligible

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

When to Enroll

- Enroll during OE or when you have a QLE

When Coverage Starts

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

Dependent(s)

Who is Eligible

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

When to Enroll

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

When Coverage Starts

- Based on OE or QLE effective dates

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

Qualifying Life Events

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

Marriage

Divorce

Legal separation

Annulment

Birth

Adoption

Placement for adoption

Change in benefits eligibility

Death

Undergoing COBRA event, court judgment, or decree

Becoming eligible for Medicare, Medicaid, or TRICARE

Receiving a Qualified Medical Child Support Order

Gain or loss of benefits coverage

Change in employment status affecting benefits

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

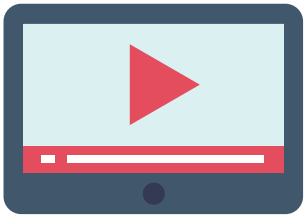
Medical Coverage

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

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

The TRS-ActiveCare 2 plan is closed to new enrollments, but you may continue in the plan if you are a currently enrolled participant.

TRS ACTIVECARE MEDICAL RATES			
ActiveCare Primary	Total Monthly Premium	Employer Contribution	Employee Cost
Employee Only	$614.00	$375.00	**$239.00**
Employee and Spouse	$1,658.00	$375.00	**$1,283.00**
Employee and Child(ren)	$1,044.00	$375.00	**$669.00**
Employee and Family	$2,088.00	$375.00	**$1,713.00**
ActiveCare Primary+	Total Monthly Premium	Employer Contribution	Employee Cost
Employee Only	$722.00	$375.00	**$347.00**
Employee and Spouse	$1,878.00	$375.00	**$1,503.00**
Employee and Child(ren)	$1,228.00	$375.00	**$853.00**
Employee and Family	$2,383.00	$375.00	**$2,008.00**
ActiveCare HD	Total Monthly Premium	Employer Contribution	Employee Cost
Employee Only	$628.00	$375.00	**$253.00**
Employee and Spouse	$1,696.00	$375.00	**$1,321.00**
Employee and Child(ren)	$1,068.00	$375.00	**$693.00**
Employee and Family	$2,136.00	$375.00	**$1,761.00**
ActiveCare 2	Total Monthly Premium	Employer Contribution	Employee Cost
Employee Only	$1,013.00	$375.00	**$638.00**
Employee and Spouse	$2,402.00	$375.00	**$2,027.00**
Employee and Child(ren)	$1,507.00	$375.00	**$1,132.00**
Employee and Family	$2,841.00	$375.00	**$2,466.00**



Watch and learn more!

Find an In-Network Provider

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

Call **866-355-5999**.

TRS-ActiveCare

REGION 10

Except Arlington ISD

TRS is committed to accessibility. If you have trouble accessing this content, contact TRS at **WebAccessibility@trs.texas.gov** to request an alternative format.

LEARN THE TERMS

- **PREMIUM:** The monthly amount you pay for health care coverage.
- **DEDUCTIBLE:** The annual amount for medical expenses you're responsible to pay before your plan begins to pay.
- **COPAY:** The set amount you pay for a covered service at the time you receive it. The amount can vary based on the service.
- **COINSURANCE:** The portion you're required to pay for services after you meet your deductible. It's often a specified percentage of the costs; e.g., you pay 20% while the health care plan pays 80%.
- **TIERING:** Grouping doctors and facilities into tiers based on quality, cost and best practice clinical guidelines. This helps you compare choices. Tier 1 providers and facilities offer top performance and best value. You pay less when you choose Tier 1 and may pay more when you choose Tier 2.
- **OUT-OF-POCKET MAXIMUM:** The maximum amount you pay each year for medical costs. After reaching the out-of-pocket maximum, the plan pays 100% of allowable charges for covered services.

2026-27 TRS-ActiveCare Plan Highlights Sept. 1, 2026 – A

How to Calculate Your Monthly Premium

Total Monthly Premium
− Your Employer Contribution

= Your Premium

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

Being Healthy is Easy

- $0 preventive services
- One-on-one health coaches
- Weight loss programs and nutrition
- TRS Virtual Health
- Member Rewards is even better. Now you'll get a check when you use Member Rewards and choose low-cost, high-quality doctors and facilities – up to $599* per tax year.
- Airrosti Remote Recovery gives you in-home virtual physical therapy to relieve common aches and pains at no cost.*

** Eligibility rules may apply.*

See the Annual Enrollment Guide for more details.

Mental Health

You have in-office and virtual benefits:

- TRS-ActiveCare Primary Plan: $30 copay for office visits or $0 with Teladoc
- TRS-ActiveCare Primary+ Plan: $15 copay for office visits or $0 with Teladoc
- TRS-ActiveCare HD Plan: 30% coinsurance after deductible or $42 with Teladoc
- TRS-ActiveCare 2 Plan: $20 copay for office visits or $12 with Teladoc

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

	TRS-ActiveCare Primary	TRS
Plan Summary	• Lowest premium of the three available plans • Copays for doctor visits before you meet your deductible • Statewide network • Primary Care Provider referrals required to see specialists • Not compatible with a Health Savings Account • No out-of-network coverage	• Highest premiun • Copays for many • Lower deductibl • Statewide netwo • Primary Care Pr • Not compatible • No out-of-netwo

Monthly Premiums	Total Premium	Employer Contribution	Your Premium	Total Premium
Employee Only	$614			$722
Employee and Spouse	$1,658			$1,878
Employee and Children	$1,044			$1,228
Employee and Family	$2,088			$2,383

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

Doctor Visits		
Primary Care	$30 copay	
Specialist	$70 copay	

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

Prescription Drugs		
Drug Deductible	Integrated with medical	$200 deduct
Generics (31-Day Supply/90-Day Supply)	$15/$45 copay; $0 copay for certain generics	
Preferred (Max does not apply if brand is selected and generic is available)	You pay 30% after deductible	You pay You pay
Non-preferred	You pay 50% after deductible	Yo
Specialty (31-Day Max) Call **1-844-367-6108** to see if your specialty medication is covered by SaveOnSP.	You pay 30% after deductible; $0 if SaveOnSP eligible	You pay
Insulin Out-of-Pocket Costs	$25 copay for 31-day supply; $75 for 61- to 90-day supply	$2 $

Aug. 31, 2027

TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

Each includes a wide range of wellness benefits.

This plan is closed to new enrollees. Current TRS-ActiveCare 2 participants can stay enrolled.

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

Employer Contribution	Your Premium	Total Premium	Employer Contribution	Your Premium	Total Premium	Employer Contribution	Your Premium
		$628			$1,013		
		$1,696			$2,402		
		$1,068			$1,507		
		$2,136			$2,841		

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

In-Network	Out-of-Network	
$1,000/$3,000	$2,000/$6,000	
You pay 20% after deductible	You pay 40% after deductible	
$7,900/$15,800	$23,700/$47,400	
No		

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

Tier 1: $20 copay Tier 2: $40 copay	You pay 40% after deductible
Tier 1: $55 copay Tier 2: $85 copay	You pay 40% after deductible

$50 copay	You pay 30% after deductible	You pay 50% after deductible
u pay 20% after deductible	You pay 30% after deductible	
0 per medical consultation	$30 per medical consultation	
2 per medical consultation	$42 per medical consultation	

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

tible per participant (brand drugs only)	Integrated with medical
$15/$45 copay	You pay 20% after deductible; $0 coinsurance for certain generics
25% after deductible ($100 max)/ 25% after deductible ($265 max)	You pay 25% after deductible
u pay 50% after deductible	You pay 50% after deductible
20% after deductible ($500 max); $0 if SaveOnSP eligible	You pay 20% after deductible
25 copay for 31-day supply; 75 for 61- to 90-day supply	You pay 25% after deductible

$200 brand deductible
$20/$45 copay
You pay 25% after deductible ($40 min/$80 max)/ You pay 25% after deductible ($105 min/$210 max)
You pay 50% after deductible ($100 min/$200 max)/ You pay 50% after deductible ($215 min/$430 max)
You pay 30% after deductible ($200 min/$900 max); $0 if SaveOnSP eligible
$25 copay for 31-day supply; $75 for 61- to 90-day supply

Questions?

Call a Personal Health Guide at **1-866-355-5999** for help with medical services.
Call Express Scripts® by Evernorth Pharmacy Benefit Services at **1-844-367-6108** for help with your pharmacy benefits.

Compare Prices for Common Medical Services

Closed to new enrollees.

Benefit	TRS-ActiveCare Primary	TRS-ActiveCare Primary+	TRS-ActiveCare HD		TRS-ActiveCare 2	
	In-Network Only	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Labs	Office/Independent Lab: You pay $0 Outpatient: You pay 30% after deductible	Office/Independent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	Office/Independent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 40% after deductible
High-Tech Imaging (like CT Scan, Mammogram and MRI)	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible + $100 copay per procedure	You pay 40% after deductible + $100 copay per procedure
Outpatient (like colonoscopy, cataract surgery and steroid injections)	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible ($150 facility copay per incident)	You pay 40% after deductible ($150 facility copay per incident)
Inpatient (like childbirth, complex joint replacement and cardiac surgery)	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible ($500 facility per day maximum)	You pay 20% after deductible ($150 facility copay per day)	You pay 40% after deductible ($500 facility copay per incident)
Freestanding Emergency Room	You pay $500 copay + 30% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 30% after deductible	You pay $500 copay + 50% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 40% after deductible
Bariatric Surgery	Facility: You pay 30% after deductible Professional Services: You pay $5,000 copay + 30% after deductible Only covered if rendered at a BDC+ facility	Facility: You pay 20% after deductible Professional Services: You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility	Not Covered	Not Covered	Facility: You pay 20% after deductible ($150 facility copay per day) Professional Services: You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility	Not Covered
Annual Vision Exam (one per plan year)	Specialist: You pay $70 copay	Specialist: You pay $70 copay	You pay 30% after deductible	You pay 50% after deductible	Tier 1 Specialist: $55 copay Tier 2 Specialist: $85 copay	You pay 40% after deductible
Annual Hearing Exam (one per plan year)	PCP: $30 copay Specialist: $70 copay	PCP: $15 copay Specialist: $70 copay	You pay 30% after deductible	You pay 50% after deductible	Tier 1 PCP: $20 copay Tier 2 PCP: $40 copay Tier 1 Specialist: $55 copay Tier 2 Specialist: $85 copay	You pay 40% after deductible

Prescription Savings Program

Clever RX Benefits

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

Questions?

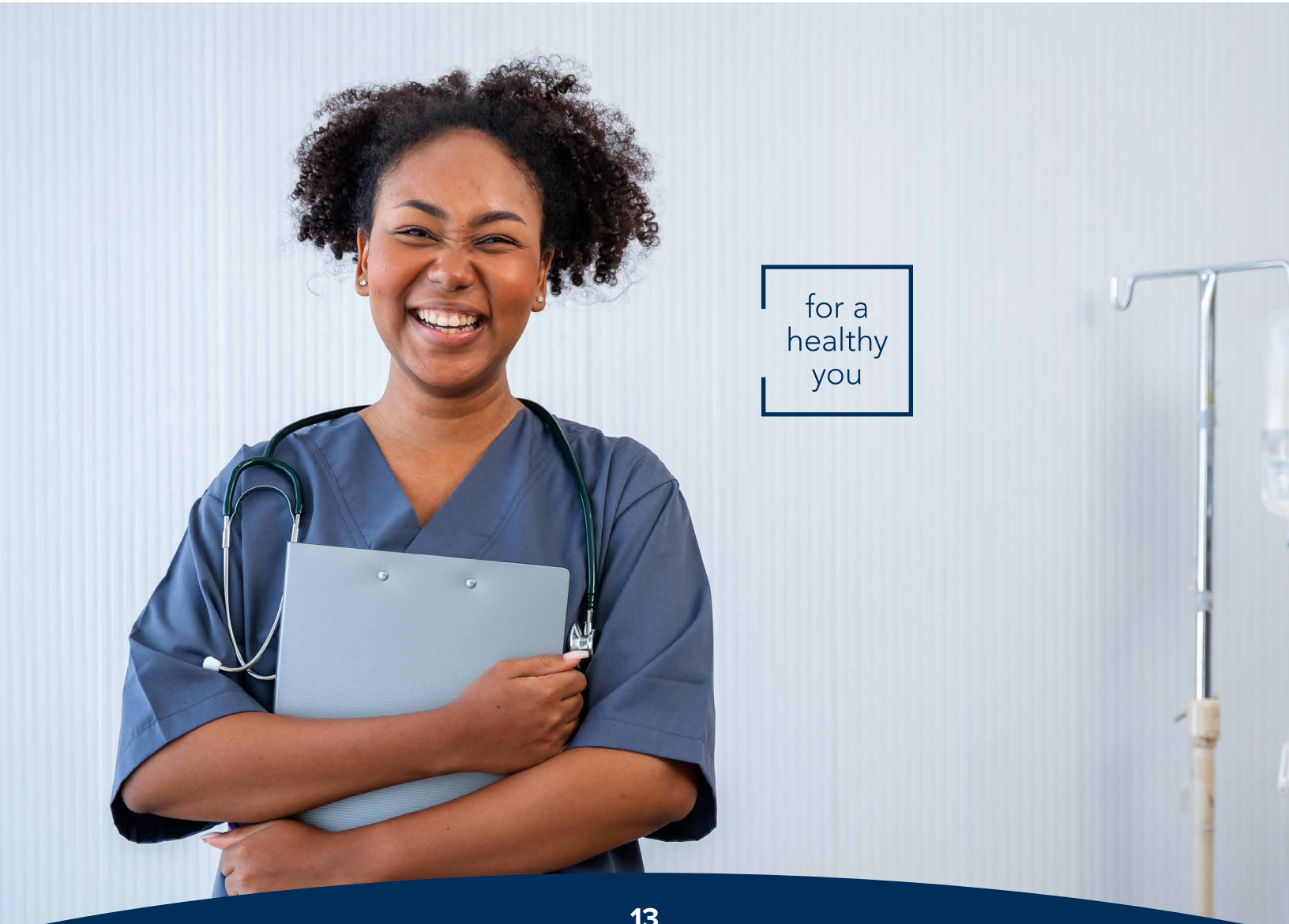
Call Clever RX Customer Service at **800-873-1195**.

BIN: 020529

PCN: CLEVR

Group Number: 1085

Member ID: 1720



Health Care Options

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

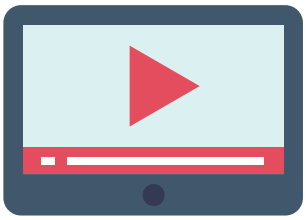
HEALTH CARE PROVIDER		SYMPTOMS	AVERAGE COST	AVERAGE WAIT
Non-Emergency Care				
 **Telemedicine**	Access to care via phone, online video, or mobile app whether you are at home, work, or traveling; medications can be prescribed 24 hours a day, 7 days a week	Allergies Cough/cold/flu Rash Stomachache	$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

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

Health Savings Account

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

	EMPLOYEE
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 **https://www.eecu.org**.

Call **817-882-0800**.

Download the **EECU Mobile Banking**.

Flexible Spending Accounts

Set aside pretax dollars from each paycheck to pay for certain IRS-approved health 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.

Annual Maximum FSA Contributions

2026	HEALTH CARE FSA
Annual Maximum Contribution	$3,400
Run-out Period	90 days
Carryover	No carryover
Grace Period	75 days

How to Access Funds/Pay or Get Reimbursed

Use your FSA debit card
OR
Pay out-of-pocket, and submit your receipts for reimbursement.

Flexible Spending Accounts

Get More Information or Submit Receipts

Visit **www.nbsbenefits.com**.

Call **855-399-3035**.

Fax **844-438-1496**.

Email **service@nbsbenefits.com**.

Download the **Carrier app**.

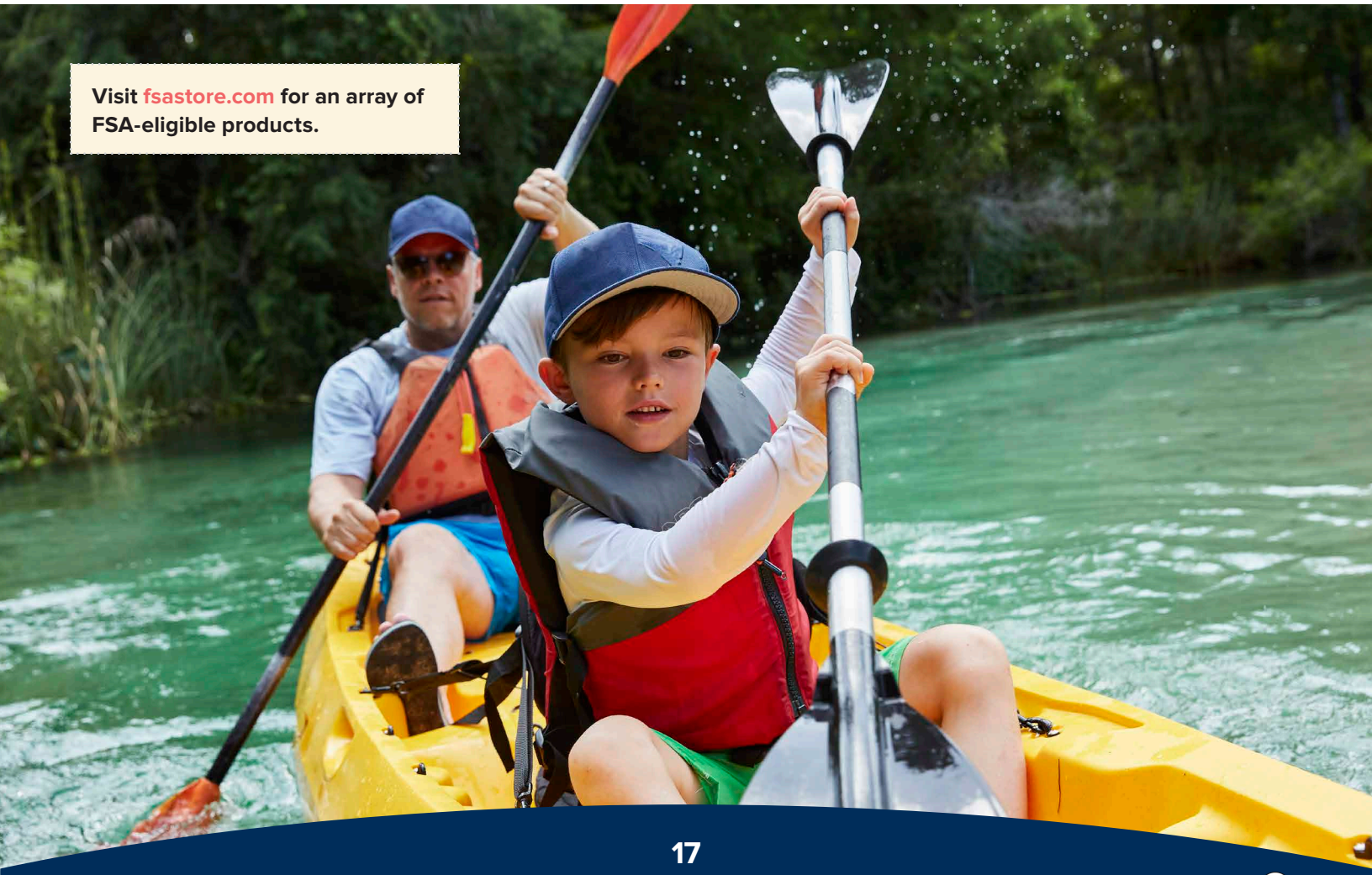
Participant Portal: **www.mynbsbenefits.com**.

Mail: **National Benefit Services, LLC**
P.O. Box 219393
Kansas City, MO 64121-9393

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.



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

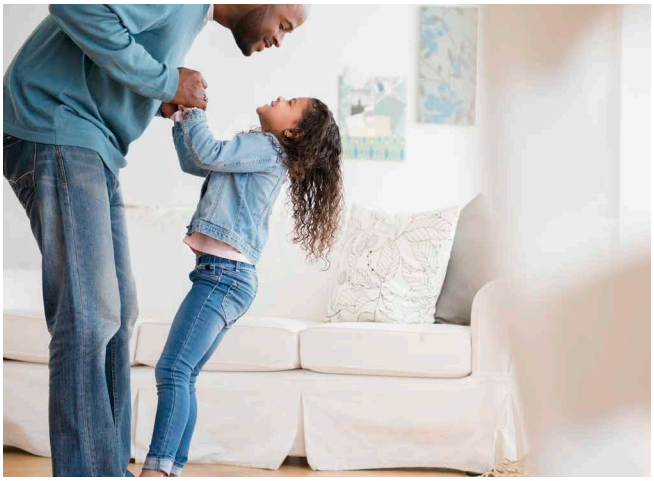
HSA and FSA Comparison

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

	HEALTH SAVINGS ACCOUNT (HSA)	FLEXIBLE SPENDING ACCOUNT (FSA)
Internal Revenue Code	Section 223	Section 125
Description	An HSA is an actual bank account in your name that allow you to save and pay for unreimbursed qualified medical expenses tax-free.	An FSA allows you to pay out-of-pocket expenses tax-free for: • copays, deductibles, and certain services not covered by medical plan
Employer Eligibility	A qualified High Deductible Health Plan	All employers
Contribution Source	You and/or your employer	You and/or your employer
Account Owner	Individual	Employer
Underlying Insurance Requirement	High Deductible Health Plan	None
Insurance Plan Minimum Deductible	**2026** • $1,700 single • $3,400 family	N/A
Maximum Contribution	**2026** • $4,400 single • $8,750 family • $1,000 age 55+ catch-up	$3,400
Permissible Use of Funds	Use any way you wish. If used for non-qualified medical expenses, funds are subject to the current tax rate plus a 20% penalty.	Reimbursement for qualified medical expenses as defined in Section 213(d) of the Internal Revenue Code.
Cash-Outs of Unused Amounts (if no medical expenses)	Permitted, but subject to current tax rate plus 20% penalty (waived after age 65).	Not permitted
Year-to-year rollover of account balance?	Yes, it will roll over to use for subsequent year's health coverage.	No. However, you have 75 days after the end of the plan year to incur new expenses and 90 days after the end of the plan year to submit receipts.
Does the account earn interest?	Yes	No
Portable?	Yes, it is portable year-to-year and between jobs.	No

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

Abdominal supports

Acupuncture

Ambulance

Anesthetist

Arch supports

Artificial limbs

Blood tests

Braces

Cardiographs

Chiropractor

Crutches

Dental treatment

Dentures

Dermatologist

Diagnostic fees

Eyeglasses

Gynecologist

Healing services

Hearing aids and batteries

Hospital bills

Insulin treatment

Lab tests

Metabolism tests

Neurologist

Nursing

Obstetrician

Operating room costs

Ophthalmologist/Optician/Optometrist

Orthopedic shoes

Orthopedist

Osteopath

Physician

Postnatal treatments

Prenatal care

Prescription medicines

Psychiatrist

Therapy equipment

Wheelchair

X-rays

Dental Coverage

Renaissance
DENTAL · VISION · LIFE · DISABILITY

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

Find an In-Network Provider

Visit **www.myrenproviders.com**.

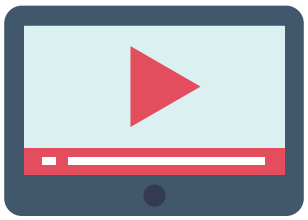
Call **800-894-4532**.

DPPO Plan

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

Dental Benefits Summary

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



Watch and learn more!

Vision Coverage

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

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

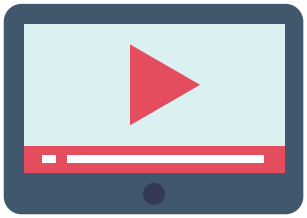
Vision Benefits Summary

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

Find an In-Network Provider

Visit **www.eyemed.com**.

Call **866-804-0982**.



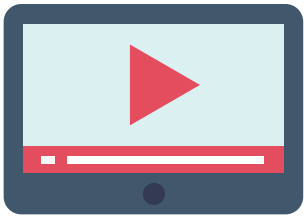
Watch and learn more!

Life and AD&D Insurance

THE HARTFORD

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

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



Watch and learn more!

Basic Term Life and AD&D

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

Supplemental Term Life

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

Designating a Beneficiary

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

Life and AD&D Insurance

THE HARTFORD

Supplemental AD&D

Supplemental AD&D coverage is separate and apart from your Basic and Supplemental Term Life insurance coverage. It provides benefits beyond your disability or life insurance for covered losses that are the result of an accidental injury or loss of life. The full amount of AD&D coverage you select is called the Full Amount and is equal to the benefit payable for the loss of life. Benefits for other losses — such as loss of sight, speech or hearing; coma; or paralysis — are payable as a predetermined percentage of the full amount.

Supplemental AD&D Coverage Amounts

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

Supplemental Coverage Highlights

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

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

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

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

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

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

Telemedicine

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

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

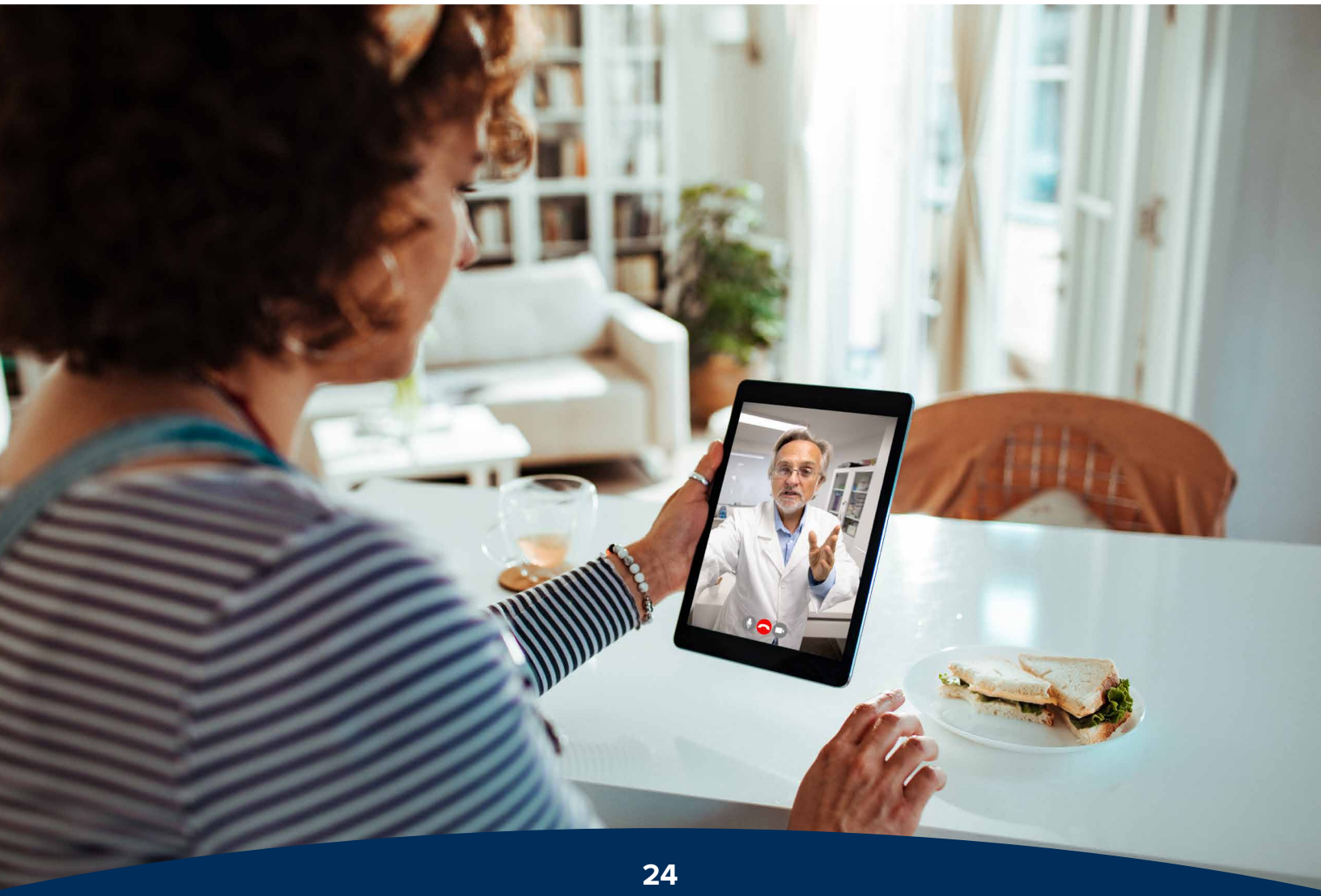
Registration is Easy

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

Visit **www.recurohealth.com**.

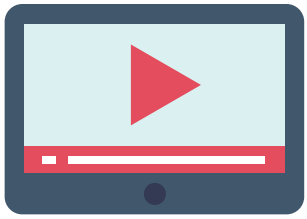
Call **855-673-2876**.

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



Educator Disability Insurance

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



Watch and learn more!

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

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

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

Educator Disability FAQ

What is disability insurance?

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

Does this plan have pre-existing condition limitations?

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

Will I get all of my disability benefit?

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

- Social Security disability insurance
- State teacher retirement disability plans
- Workers' compensation
- Other employer-based disability insurance coverage you may have
- Unemployment benefits
- Retirement benefits that your employer fully or partially pays for (such as a pension plan)

Educator Disability Insurance

THE HARTFORD

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

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

Step One

Choose your elimination period, or waiting period. This is how long you are disabled and unable to work before your benefit will begin. It will be displayed as two numbers, such as 0/7, 14/14, 60/60, etc.

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

When choosing your elimination period, determine how long you could go without a paycheck. Choose your elimination period based on your answer.

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

Step Two

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

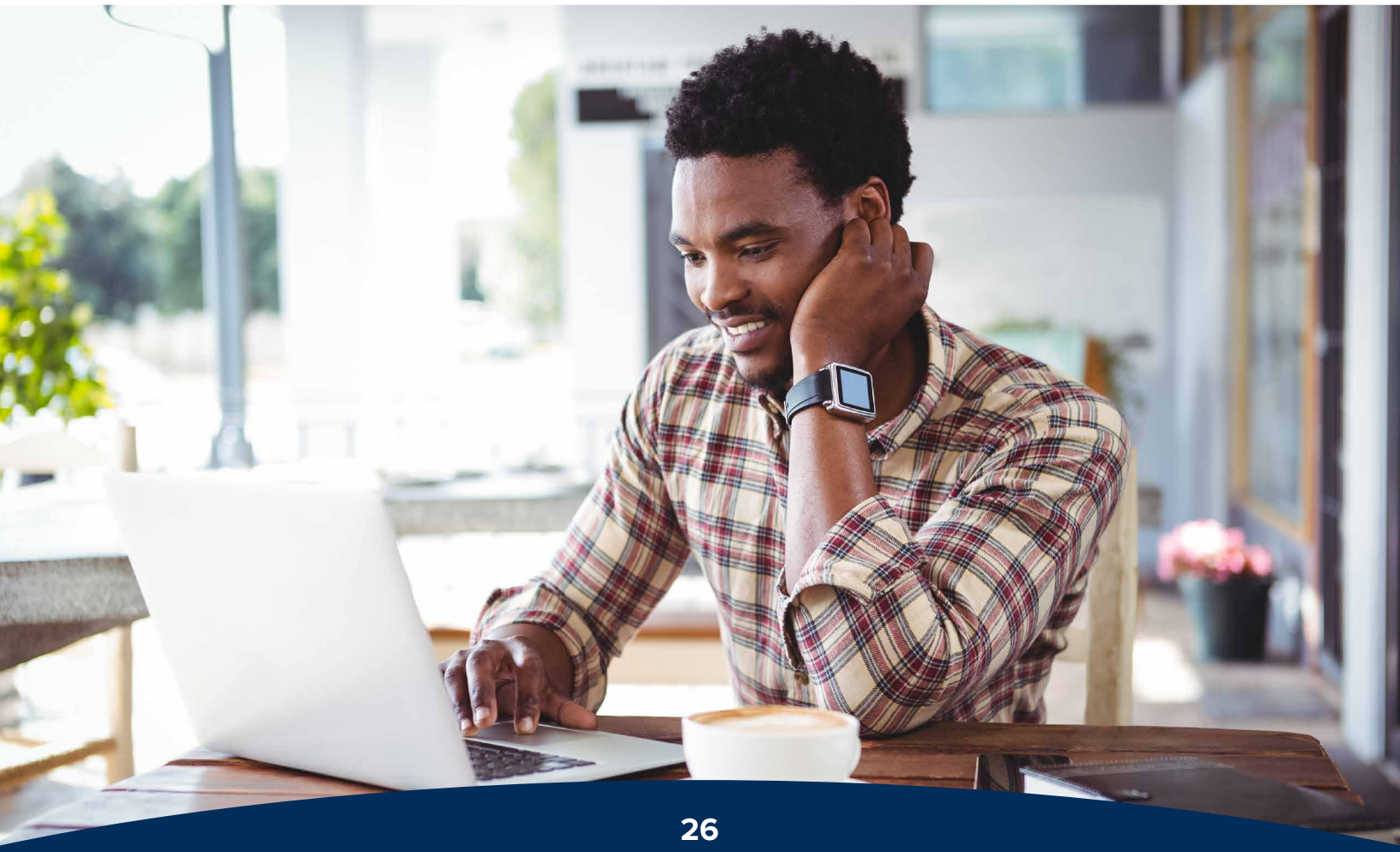
When choosing your monthly benefit, consider how much money you need to pay your monthly bills. Choose your monthly benefit amount based on your answer.

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

File a Disability Claim

Visit **www.thehartford.com**.

Call **866-574-9124**.



Accident Insurance

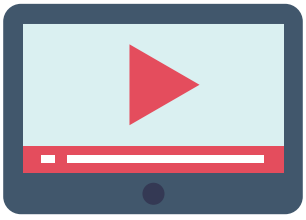
Lincoln Financial Group®

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

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

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

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

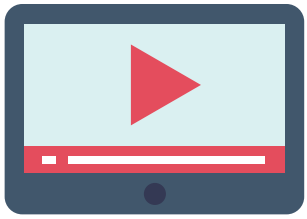


Watch and learn more!

Hospital Indemnity Insurance

CHUBB

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



Watch and learn more!

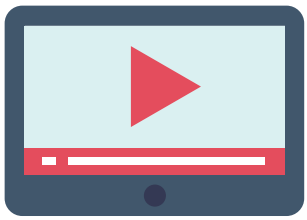
HOSPITAL INDEMNITY INSURANCE		
	Plan 1	Plan 2
Hospital Admission	$1,500	$2,500
Hospital Confinement	$100 per day up to 31 days	$250 per day up to 31 days
Intensive Care Unit Admission	$1,500	$2,500
Intensive Care Unit Confinement	$150 per day up to 31 days	$250 per day up to 31 days
Newborn Nursery	$150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

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

Cancer Insurance

CHUBB

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



Watch and learn more!

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

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

Emergency Transport Services

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

Emergent Air Transportation

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

Emergent Ground Transportation

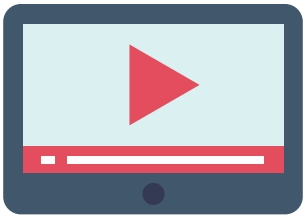
In the event of a serious medical emergency, you have access to emergency ground transportation into a medical facility or between medical facilities.

Non-Emergency Inter-Facility Transportation

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

Repatriation/Recuperation

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



Watch and learn more!

For More Information

Visit **www.masamts.com**.

Call **800-423-3226**.

EMPLOYEE MONTHLY CONTRIBUTIONS	
Employee and Family	$14.00

ID Theft Protection

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

Protect yourself and restore your identity with coverage that includes:

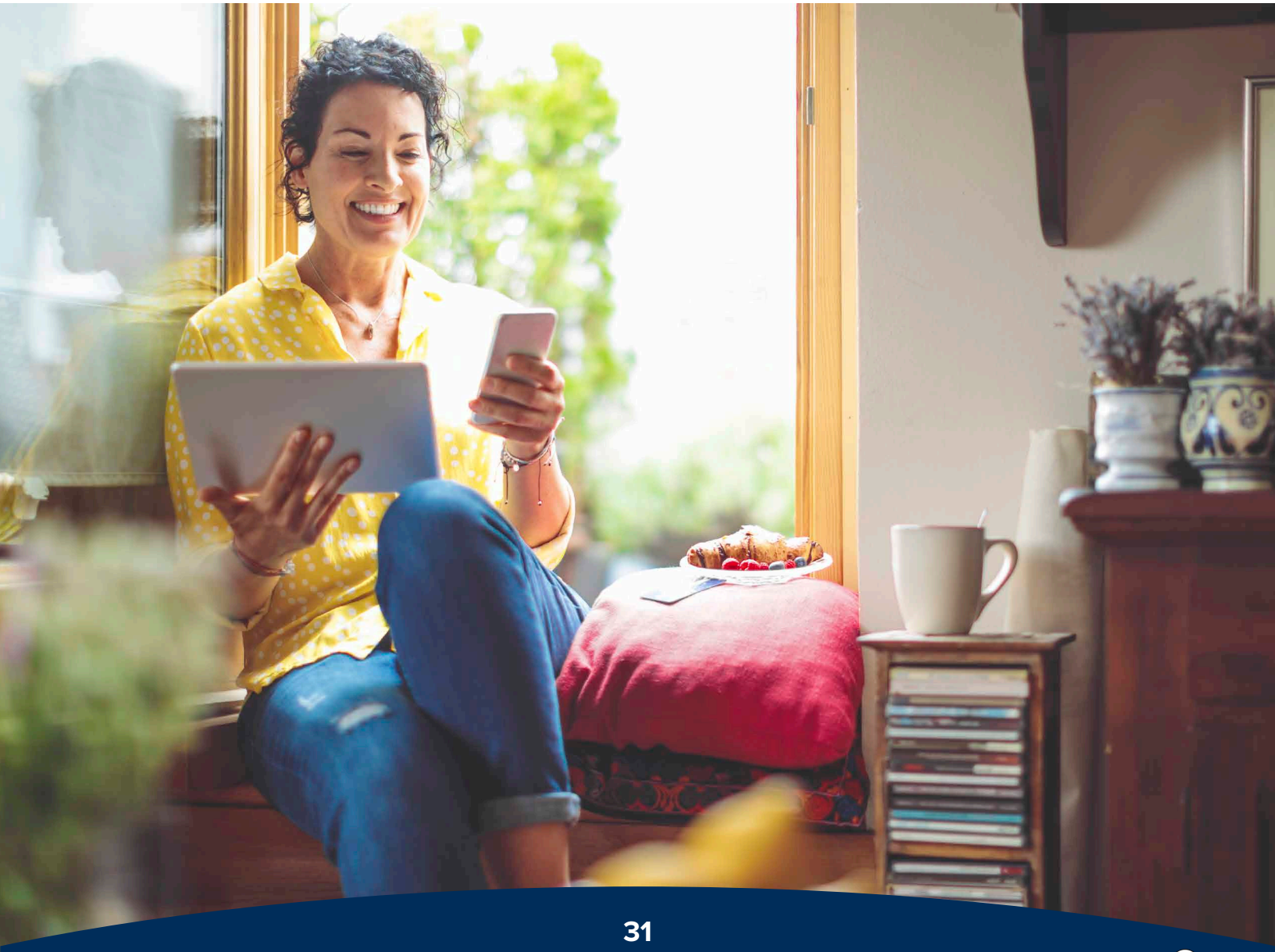
- Identity consultation and advice
- Licensed private investigators
- Identity and credit monitoring
- Social media monitoring
- Identity restoration
- Threat and credit alerts
- 24/7 emergency ID protection access
- Mobile app

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

For More Information

Visit **www.experian.com**.

Call **855-797-0052**.



Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SSNRA – Social Security Normal Retirement Age.

Important Legal Notices

Women's Health and Cancer Rights Act of 1998

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

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

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

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

Special Enrollment Rights

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

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

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

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

Marriage, Birth or Adoption

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

For More Information or Assistance

To request special enrollment or obtain more information, contact:

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

Your Prescription Drug Coverage and Medicare

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

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

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

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

Important Legal Notices

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

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

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

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

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

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

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

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

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 Red Oak 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:

Important Legal Notices

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.

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:

September 1, 2026
Red Oak ISD
109 W. Red Oak Road
Red Oak, TX 75154
972-617-2941

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.

Important Legal Notices

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.

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.

Important Legal Notices

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
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.

Important Legal Notices

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.

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.

Important Legal Notices

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.

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, you can contact either:

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

Continuation of Coverage Rights Under COBRA

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

Plan Contact Information

Bswift (TRS ActiveCare)
PO Box 860620
Minneapolis, MN 55486-0620
833-682-8972

Important Legal Notices

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

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

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

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

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

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

Important Legal Notices

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

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

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

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

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

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

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

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

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

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

Important Legal Notices

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name: Red Oak ISD	**4. Employer Identification Number (EIN):** 75-6002838	
5. Employer Address: 109 W. Red Oak Road	**6. Employer Phone Number:** 972-617-2941	
7. City: Red Oak	**8. State:** TX	**9. ZIP Code:** 75154
10. Who can we contact at this job?: Maricela Torres		
11. Phone Number (if different from above): 972-617-2941	**12. E-Mail Address:** benefits@redoakisd.org	

As your employer, we offer a health plan to all eligible employees (see the Eligibility section of this guide). This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

[1] Indexed annually; see **https://www.irs.gov/pub/irs-drop/rp-22-34.pdf** for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Notes

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