BENEFIT GUIDE

2026-2027 PLAN YEAR



NEW CANEY ISD

A SHINING STAR *in* TEXAS EDUCATION

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Important Contacts

New Caney ISD Benefits
Higginbotham Public Sector
833-870-2531
www.mybenefitshub.com/newcaneyisd

Medical
Cigna
800-997-1654
www.mycigna.com

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

Hospital Indemnity
Cigna
Group #: HC111860
800-754-3207
https://my.cigna.com/web/public/guest

Telehealth
Recuro
855-6RECURO (673-2876)
www.recurohealth.com

Dental
Cigna
800-244-6224
www.mycigna.com

Vision
Superior Vision
Group #: 39341
800-507-3800
www.superiorvision.com

Educator Disability
New York Life
Group #: SLH-100022
888-842-4462
www.newyorklife.com

Cancer
Chubb
Group #: 100000200
888-499-0425
www.chubb.com

Accident
The Hartford
Group #: VAC-681799
www.thehartford.com

Voluntary Term Life
New York Life
Group #: FLX-969524
888-842-4462
www.newyorklife.com

Urgent Care
Next Level Prime
833-957-6200
www.nextlevelurgentcare.com
navigator@nextlevelurgentcare.com

Accidental Death and Dismemberment
New York Life
Group #: OK-970954
888-842-4462
www.newyorklife.com

Legal Services
LegalEASE
888-416-4313
www.legaleaseplan.com

Identity Theft
Experian
855-797-0052
www.experian.com

Emergency Medical Transport
MASA
800-423-3226
www.masamts.com

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

Employee Assistance Program
New York Life/GuidanceResources
800-238-2125
www.newyorklife.com

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 (OE) or when you have a Qualifying Life Event (QLE).

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 available by accessing **www.mybenefitshub.com/newcaneyisd**.



Your New Benefits Begin and End
September 1, 2026 - August 31, 2027

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.

How to Enroll



Benefit questions?

Ask your Benefits Department.

Call Higginbotham Public Sector at **833-870-2531**.

Benefits Questions?

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

- Enrollment
- Eligibility
- Benefits
- Claims and Billing

Call or text **833-870-2531** 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 **newcaneyisd@hps.higginbotham.net**.

Bilingual representatives are available.

Login Process

1. Go to **www.mybenefitshub.com/newcaneyisd**. Scan the QR code to the right.
2. Click *Login*.
3. Enter your information:
   - Last name
   - Date of birth
   - Last four digits of your Social Security number

   Note: THE*benefits*HUB uses this information to check behind the scenes to confirm your employment status.
4. Once confirmed, the Additional Security Verification page will list the contact options from your profile. Select either the *Text*, *Email*, *Call*, or *Ask Admin* options to receive a code to complete the final verification step.
5. Enter the code you receive and click *Verify* to begin your benefits enrollment.
6. Review your personal information and verify covered dependents. Contact your employer with any discrepancies.
7. Select and confirm the dependent(s) who are to be covered on each benefit screen (medical, dental, etc.). If a dependent is not selected for a benefit, it will not be provided. NOTE: Dependents cannot be double-covered by married spouses within the district as both employees and dependents.

How to Enroll

Enrollment FAQs

What if I miss the enrollment deadline?

You may only enroll for or change your benefits during OE or if you have a QLE.

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/newcaneyisd** 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/newcaneyisd** 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?

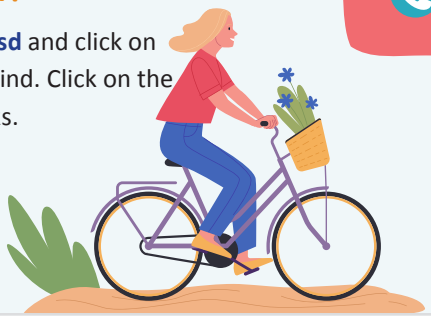
If the medical carrier provides ID cards and there is a plan change, new cards usually arrive within four weeks of your effective date. If there are no plan changes, a new card may not be issued.

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 Higginbotham Public Sector at **833-870-2531**.



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.

Are there FSA/HSA limitations for married couples?

Yes, generally. Married couples may not enroll in both a Flexible Spending Account (FSA) and a Health Savings Account (HSA). If your spouse is covered under an FSA that reimburses for medical expenses then you and your spouse are not HSA-eligible – even if you would not use your spouse's FSA to reimburse your expenses. However, there are some exceptions to the general limitation for specific types of FSAs. Contact the FSA and/or HSA provider before you enroll or reach out to your tax advisor for further guidance.

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

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 OE
- You have a QLE

See Important Limitations and Exclusions for details.

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

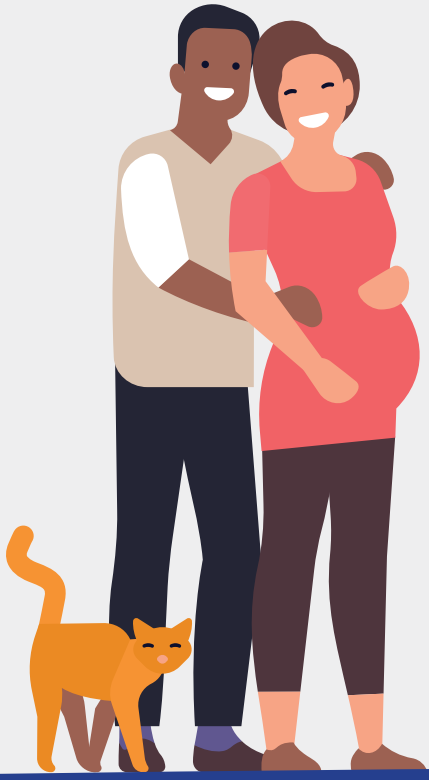
- A regular, full-time employee working an average of 20 hours per week

When to Enroll

- Enroll by the deadline given by Human Resources

When Coverage Starts

- First of the month following 30 days from date of hire



Employee

Who is Eligible

- A regular, full-time employee working an average of 20 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, Dental, Vision, Life, AD&D, Cancer, Accident, Hospital Indemnity, Emergency Medical Transport, Legal Services, Identity Theft Protection

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
- Death

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

- FMLA leave, 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
- Significant change in cost of spouse's coverage

You have 30 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:

- **Cigna HD HSA** – This plan is an HDHP.
- **Cigna Standard Copay PPO** – This plan is a PPO.
- **Cigna Value EPO (In-Network Only)** – This plan is an EPO.

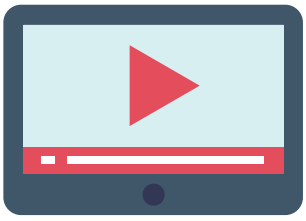
Find an In-Network Provider

Visit **www.mycigna.com**.

Call **800-244-6224**.

Preferred Provider Organization

A Preferred Provider Organization (PPO) plan allows you the freedom to see any provider when you need care. When you use in-network providers, you receive benefits at a discounted network cost. You may pay more for services if you use out-of-network providers. In-network office visits, urgent care, and prescription drugs are covered with a copay. Most other in-network services are covered at the coinsurance level.



Watch and learn more!

High Deductible Health Plan

A High Deductible Health Plan (HDHP) allows you the freedom to see any provider when you need care, but you will pay less if you use in-network providers. In exchange for a lower per-paycheck cost, you must satisfy a higher deductible that applies to almost all health care expenses, including those for prescription drugs. The plan pays 100% for health care and prescription drug expenses once you meet your deductible. If you enroll in the HDHP, you may be eligible to open an HSA (see page 14).

Exclusive Provider Organization

With an Exclusive Provider Organization (EPO) plan, you must only see in-network providers. With the exception of a true emergency, benefits are only payable if you go to in-network providers or facilities for care. If you go to an out-of-network provider or facility, you will be responsible for all costs. You do not have to select a primary care physician or get a referral to see a specialist. Always confirm that your doctors and specialists are in-network before seeking care.

Employee Monthly Contributions			
	Cigna HD HSA	Cigna Standard Copay PPO	Cigna Value EPO (In-Network)
Employee Only	$235.00	$326.00	$159.00
Employee and Spouse	$1,297.50	$1,540.50	$1,089.50
Employee and Child(ren)	$768.50	$935.00	$626.50
Employee and Family	$1,809.50	$2,128.50	$1,537.50

Medical Plans Summary

Medical – Cigna	Cigna HD HSA		Cigna Standard Copay PPO		Cigna Value EPO (In-Network Only)
Provider Network					
Network Type:	PPO		PPO		EPO
Network Name	Open Access Plus		Local Plus		Local Plus (In-Network Only)
Provider Search Link	Cigna.com		Cigna.com		Cigna.com
Type of Network	Nationwide		Narrow		Narrow
Coverage					
Deductible Type	Plan Year		Plan Year		Plan Year
Annual Deductible • Individual • Family	$8,500 In-Network / $10,000 Out-of-Network $17,000 In-Network / $20,000 Out-of-Network		$5,000 In-Network / $10,000 Out-of-Network $10,000 In-Network / $20,000 Out-of-Network		$10,000 $20,000
Annual Out-of-Pocket Maximum • Individual • Family	$8,500 In-Network / $28,000 Out-of-Network $17,000 In-Network / $56,000 Out-of-Network		$9,000 In-Network / $20,000 Out-of-Network $18,000 In-Network / $40,000 Out-of-Network		$10,000 $20,000
Coinsurance % (Plan Pays)	100% In-Network 50% Out-of-Network		80% In-Network 50% Out-of-Network		100% In-Network No Out-of-Network coverage
Primary Care Physician Required	No		No		No
Primary Care Physician Referral to Specialist Required	No		No		No
Eligible for Health Savings Account (HSA)	Yes		No		No
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Services					
Preventive Care	100%	Deductible, then 50%	100%	Deductible, then 50%	100%
Telehealth	Deductible, then 100%	Deductible, then 50%	$50 PCP / $75 Spec	Deductible, then 50%	Deductible, then 100%
Primary Care	Deductible, then 100%	Deductible, then 50%	$50 copay	Deductible, then 50%	Deductible, then 100%
Specialist	Deductible, then 100%	Deductible, then 50%	$75 copay	Deductible, then 50%	Deductible, then 100%
Diagnostic Lab & X-ray	Deductible, then 100%	Deductible, then 50%	Deductible, then 80%	Deductible, then 50%	Deductible, then 100%
Complex Lab & X-ray	Deductible, then 100%	Deductible, then 50%	Deductible, then 80%	Deductible, then 50%	Deductible, then 100%
Medical Event					
Urgent Care	Deductible, then 100%	Deductible, then 50%	$75 copay	Deductible, then 50%	Deductible, then 100%
Emergency Room (Freestanding & Hospital)	Deductible, then 100%	Deductible, then 100%	$500 copay, then 80%	$500 copay, then 80%	Deductible, then 100%
Inpatient Hospital Services	Deductible, then 100%	Deductible, then 50%	Deductible, then 80%	Deductible, then 50%	Deductible, then 100%
Outpatient Hospital Services	Deductible, then 100%	Deductible, then 50%	Deductible, then 80%	Deductible, then 50%	Deductible, then 100%
Emergency Medical Transport (Ground & Air)	Deductible, then 100%	Deductible, then 50%	Deductible, then 80%	Deductible, then 50%	Deductible, then 100%
Prescription Drugs					
Prescription Drug Deductible	Combined with medical	Combined with medical	None	None	Combined with medical
Generic	Deductible, then 100%	Deductible, then 50%	$20 copay	Deductible, then 50%	Deductible, then 100%
Preferred Brand Name	Deductible, then 100%	Deductible, then 50%	$50 copay	Deductible, then 50%	Deductible, then 100%
Non-preferred Brand Name	Deductible, then 100%	Deductible, then 50%	$80 copay	Deductible, then 50%	Deductible, then 100%
Specialty	Deductible, then 100%	Deductible, then 50%	$300 copay	Deductible, then 50%	Deductible, then 100%
Mail Order Supply	90-day - deductible, then 100%	90-day - deductible, then 50%	90-day	Deductible, then 50%	Deductible, then 100%

Next Level PRIME: Health Care at any Hour

Next Level Prime is a health care membership that is separate from our Cigna medical plans. As a health plan member, you get:

- Access to 45+ Next Level clinic locations
- Direct primary, preventive, and chronic care 7 days a week from 9 a.m. to 9 p.m.
- Urgent care 7 days a week from 9 a.m. to 9 p.m.
- 24/7 telemedicine/virtual visits and care navigation
- Health and wellness coaching and emotional wellness counseling
- Weight loss solutions, including access to GLP-1 drugs

Preventive, Primary, and Chronic Care

- Annual physicals and wellness exams
- Preventive screenings and vaccinations
- Diabetes and hypertension management
- Depression and anxiety support
- Blood draws and specialist referrals
- Weight management and GLP-1 programs
- And more

Urgent Care

- Respiratory infections and flu symptoms
- Urinary tract infections
- Rashes
- Sprains, strains, and minor injuries
- X-rays, splints, and stitches
- Ear infections, headaches, and back pain
- And more

Cost

- $0 for employees
- $30 a month for family

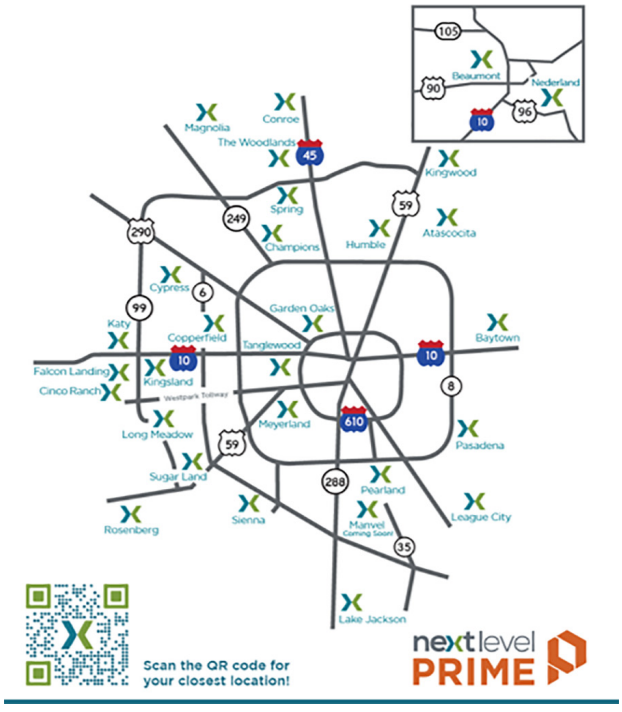
Hours and Locations

- 9:00 a.m. to 9:00 p.m. CT.
- 7 days a week
- Houston, Dallas, Austin, and San Antonio

How to Get Started

Download the **Next Level Urgent Care app** – it's the best and fastest way to access care!

Email **navigator@nextlevelurgentcare.com** or call **833-957-6200** if you need help or have questions.



Frequently Asked Questions

Access to Care

Do I need to make an appointment?

Preventive Care/Chronic Care	Urgent Care	Telemedicine
Yes! Appointments help ensure providers will have what you need on hand.	Not necessarily – schedule an appointment or walk in. **Note: Prime membership does not allow you to skip the line.**	Yes! Appointments are required, but available any time, day or night.

Schedule appointments through our mobile app!

How do I schedule an annual exam?

Use the Next Level mobile app to schedule appointments. A Prime provider will perform your intake virtually before scheduling your physical at a Prime location. Physicals are available 7 days a week between 9 a.m. to 9 p.m.

Who do I call after hours for support?

Care Navigators are available 24/7 via the Next Level mobile app. Prime providers are also available, day or night, for a telemedicine appointment.

Does Prime replace my primary care provider (PCP)?

No, but if you have a health concern when your PCP is unavailable, use Prime! You will get a summary of your office visit to take to your PCP for any follow-up needed.

Contacts

Call **832-957-6200**.

Email **navigator@nextlevelurgentcare.com**.

Download the **Next Level app**.

Health Care Services

Does Prime offer lab work, durable medical equipment (DME), and vaccines?

Yes, many labs, vaccines, and DME are included with your Next Level Prime membership. If your condition requires a specialist, Prime will refer you to an in-network specialist. If your condition is an emergency, Prime will send you to the nearest emergency room.

Is mental health covered under the Prime membership?

Yes, it includes up to 12 emotional wellness counseling sessions. All Prime providers can assist with many mental health concerns, such as depression, anxiety, and attention deficit disorders.

Is weight loss covered?

Yes, health coaches will work with you to personalize a weight loss plan, assist you in building healthy habits, and meet with you for up to 12 health coaching sessions. If needed, a heavily discounted weight loss subscription plan, including GLP-1 medications for qualifying members, is available.

Are prescriptions covered under Prime?

No, prescriptions aren't included with your membership, but the Next Level mobile app offers a pharmacy benefits card for significant drug discounts.

Advanced Lab Tests and Health Screenings

Function

New! Function Membership

Get a deeper understanding of your body and spot potential issues early.

Your benefit plan includes the opportunity for you and your family to enroll for a **Function** membership. Function empowers you to own your health through affordable access to advanced lab testing. A Function membership evaluates five times more biomarkers than the average physical, helping you gain a deeper understanding of what's going on in your body, monitor for early indicators of disease, and track your health as it evolves.

The membership includes:

- Access to 100+ lab tests at the start of your membership.
- Access to an additional 60+ midyear follow-up tests to track your progress.
- Detailed clinician notes highlighting areas of focus.
- A targeted action plan to help improve your health.
- Results stored on one secure platform for easy access anytime.

How the Process Works

After signing up for Function, you will get an email and text message to schedule a convenient time and location for your lab visit. Tests take less than 30 minutes and are done at one of more than 2,000 partner lab locations nationwide. You will then get a detailed summary of your results and a targeted action plan to help you reach your health goals. All results are stored in one secure location for you to access anytime. You can retest in six months to see how you are progressing. Nonroutine tests (e.g., advanced MRI, early detection of multiple cancers, allergies, heavy metals, and more) may be added for an additional cost.



Advanced Lab Tests and Health Screenings

Function

Test More. Know More.

Advanced testing across:

- Heart
- Immunity
- Metabolics
- Hormones
- Nutrients
- Heavy Metals
- Liver
- Kidneys
- Pancreas
- Prostate
- Sexual Health
- Electrolytes
- Thyroid
- Autoimmunity
- Urine
- Blood

The cost for an individual annual membership* is $335!

FSA/HSA Eligible

Funds from your FSA or HSA may be used to pay for your membership. Reimbursement is not guaranteed, so please contact your FSA/HSA provider in advance to confirm the terms of reimbursement. If you do not have an FSA or HSA, use a personal credit card.

*Function membership includes prepaid access to 160+ lab tests each year at a Quest Diagnostics site. Due to state regulations, members testing in New York and New Jersey will be charged an additional fee directly by Quest for each lab visit. We cannot accommodate lab testing in Hawaii or Rhode Island at this time. You can schedule lab testing in a neighboring state.



How to Enroll

Enroll anytime during the year. You will pay the membership fee(s) directly to Function.

Visit **www.functionhealth.com/aep/higginbotham**.

Health Savings Account

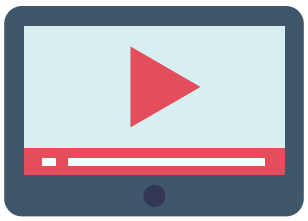
We offer an HSA to offset your HDHP medical costs, reduce your taxes, and offer a long-term tax-advantaged savings account.

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

HSA Eligibility

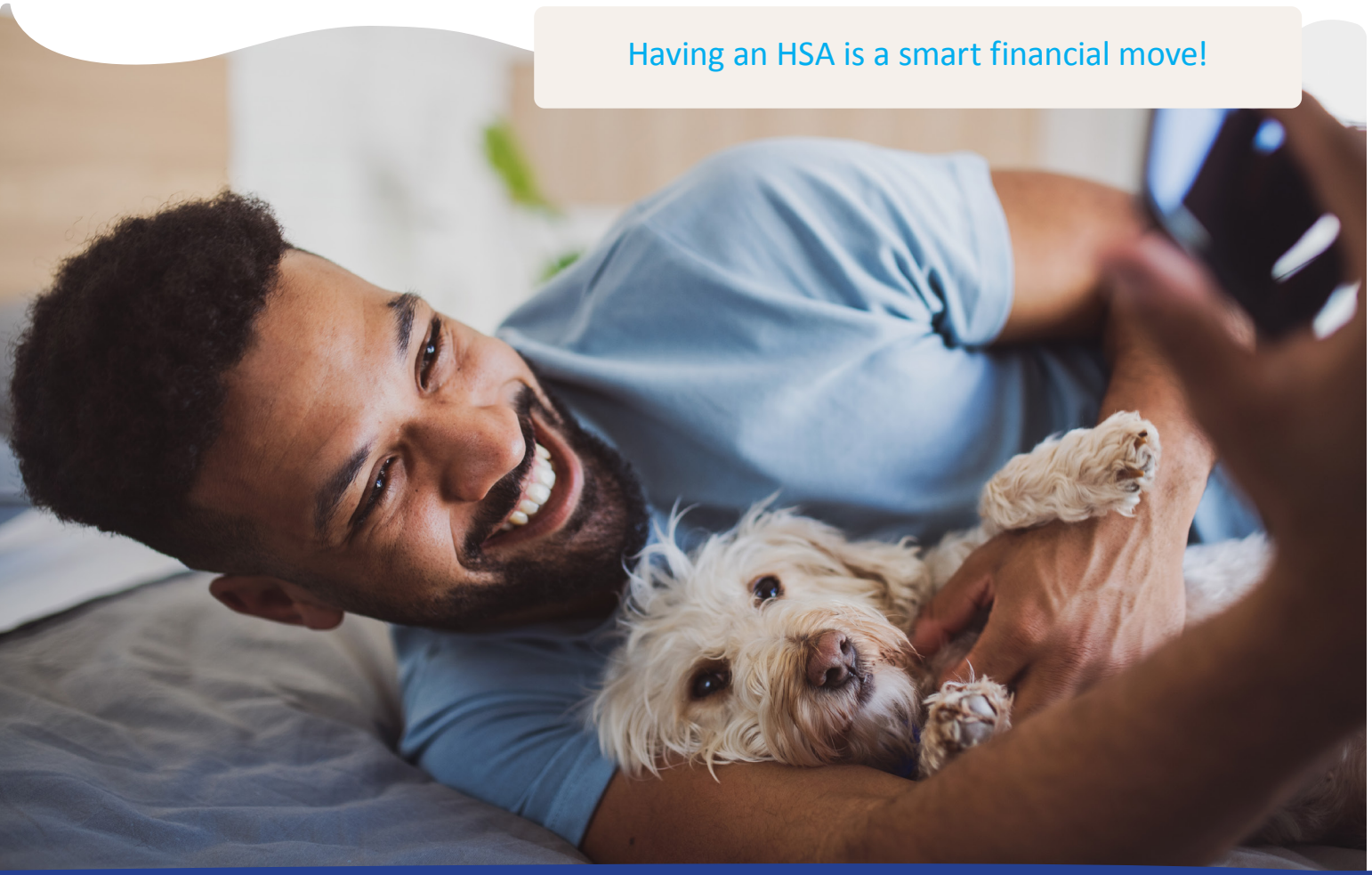
You are eligible to open and contribute to an HSA if you are:

- Enrolled in an HSA-eligible HDHP
- Not covered by another plan that is not a qualified HDHP, such as your spouse's health plan
- Not enrolled in a Health Care FSA
- Not eligible to be claimed as a dependent on someone else's tax return
- Not enrolled in Medicare, Medicaid, or TRICARE
- Not receiving Veterans Administration benefits



Watch and learn more!

Having an HSA is a smart financial move!



Health Savings Account

EECU

Maximum HSA Contributions
2026
$4,400 Individual
$8,750 Family
If you are age 55 or older, you can contribute an extra $1,000.

Two Ways to Use Your HSA Funds

Use it Now

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

Let it Grow

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

Important HSA Information

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



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

Withdrawals for qualifying medical expenses are tax-free.

HSA Contacts

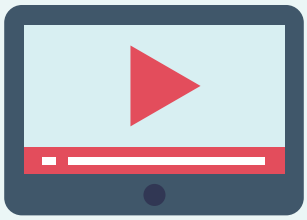
Visit **www.eecu.org** or download the **EECU Mobile Banking app** to find a local financial center, check your balance, pay bills, and more.

Call/Text **817-882-0800** for EECU member service.

Call **800-333-9934** for lost or stolen cards.

Hospital Indemnity Insurance

The Hospital Indemnity plan helps you with the high cost of medical care by paying you a cash benefit when you have an inpatient hospital stay. Unlike traditional insurance that 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	
Service	Benefit
Hospital / ICU Admission	$2,000
Hospital Confinement	$200 per day, up to 365 days
ICU Confinement	$600 per day, up to 365 days
Newborn Nursery Care Admission	$500
Employee Monthly Contributions	
Employee Only	$17.56
Employee + Spouse	$40.68
Employee + Child(ren)	$37.90
Employee + Family	$60.86



Telemedicine

RECURO HEALTH

You have the opportunity to elect quality telemedicine services instead of – or in addition to – enrolling for medical coverage. Connect anytime day or night with U.S. board-certified, state-licensed doctors via your mobile phone, online portal, or mobile app.

Telemedicine is a convenient and cost-effective option for on-demand care. There are no copays or deductibles to meet. Just **$14 a month** covers you, your spouse, and children to age 26. If needed, prescriptions will be sent to the pharmacy of your choice.

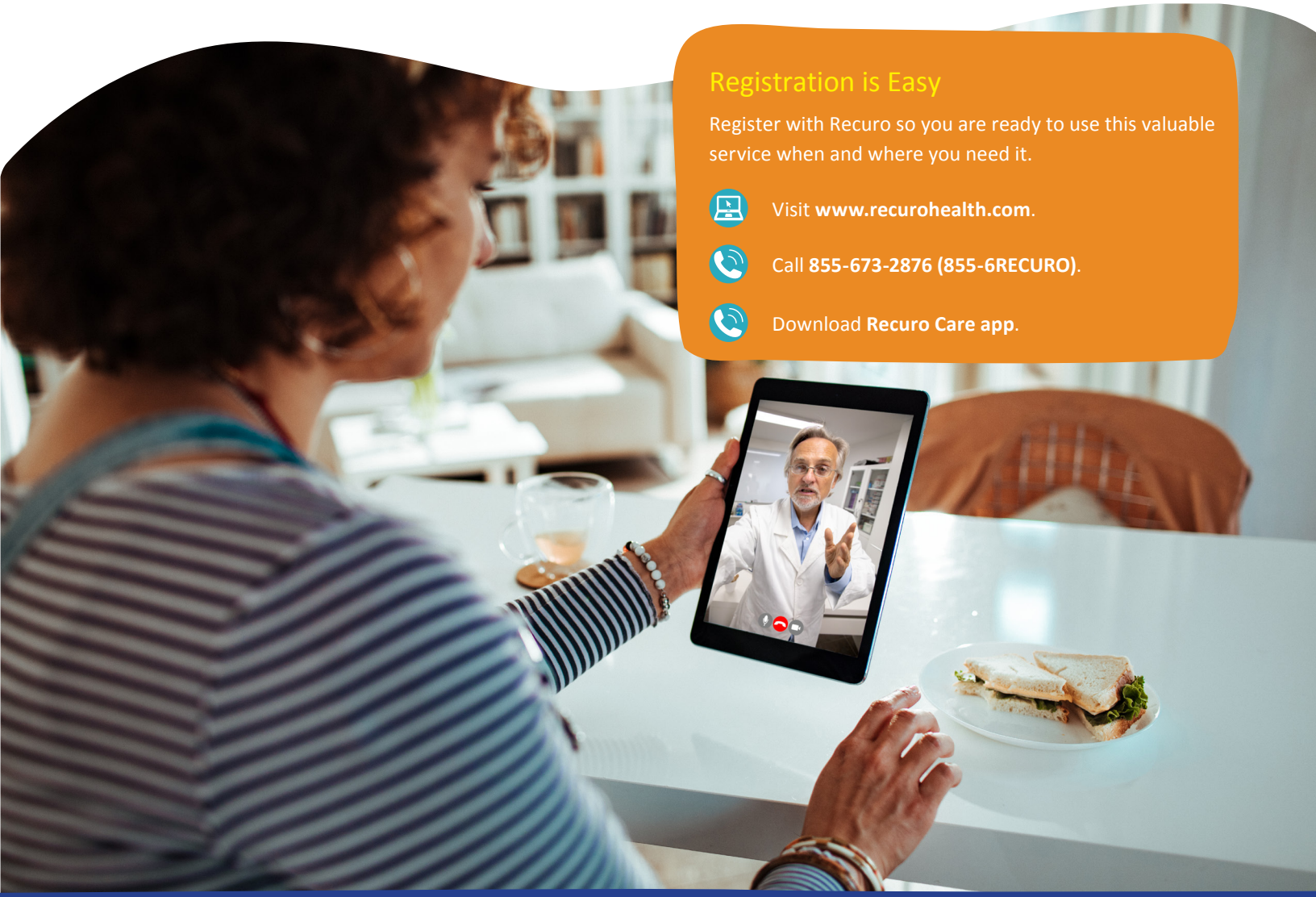
The telemedicine plan includes psychiatry and behavioral health medication management from a licensed professional as well as therapy and counseling services from social workers and psychologists. Behavioral health-focused risk assessments are available.

Common Conditions Treated

Use telemedicine for minor conditions such as:

- Allergies
- Stomach flu
- Sinus infections
- Urinary tract infections
- Gout
- Strep
- Rashes
- Pink eye
- Flu
- And more

Do not use telemedicine for serious or life-threatening emergencies.



Registration is Easy

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

- Visit **www.recurohealth.com**.
- Call **855-673-2876 (855-6RECURO)**.
- Download **Recuro Care app**.

Dental Coverage

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

DHMO Plan

If you enroll in the DHMO plan, you must select a primary care dentist (PCD) from the DHMO network directory to manage your care. Each eligible dependent may choose their own PCD. Dental services are unlimited; you pay fixed copays, there are no deductibles, and there are no claim forms to file. There is no coverage for services provided without a referral from your PCD or if you seek care from out-of-network providers.

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.

Wellness Plus Progressive Maximum Benefit

When you or your covered dependents receive preventive care services during a plan year, your annual maximum benefit increases the following year, up to the plan's maximum allowed amount.

Find an In-Network Provider

Visit **www.mycigna.com.**

Call **800-244-6224**.

Watch and learn more!

Dental Benefits Summary

Dental Plan		
	DPPO	DHMO
Calendar Year Deductible • Individual • Family	 $50 $150	 N/A N/A
Calendar Year Benefit Maximum Per Individual • Year 1 • Year 2 • Year 3 • Year 4 and Beyond	 $1,500 $1,700 $1,900 $2,100	N/A
	You Pay	
Preventive Services Oral evaluations, routine cleanings, X-rays, fluoride application, sealants, non-orthodontic space maintainers	$0	Fee based
Basic Services Fillings, minor and major endodontics, periodontics, oral surgery, general and IV sedation, prefabricated crowns	20% after deductible	Fee based
Major Services Inlays, onlays, prosthesis over implant, repairs to crowns, bridges, and dentures	50% after deductible	Fee based
Orthodontia Children to age 19	50% No deductible $1,000 lifetime maximum	Fee based
Employee Monthly Contributions		
Employee Only	$40.19	$11.33
Employee + Spouse	$76.11	$20.12
Employee + Child(ren)	$99.60	$24.58
Employee + Family	$135.58	$36.22



Vision Coverage

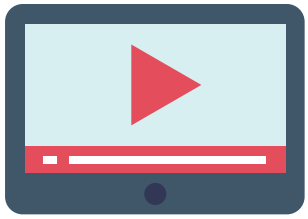
SuperiorVision

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

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

Vision Benefits Summary

Superior Vision Plan		
	High Plan	Low Plan
	In-Network You Pay	In-Network Reimbursement
Exam/Materials	$10 copay/$10 copay	$10 copay/$10 copay
Lenses • Single vision • Lined bifocals • Lined trifocals	 $0 $0 $0	 $0 $0 $0
Frames	$150 Allowance	$100 Allowance
Contacts In lieu of frames and lenses • Fitting and evaluation • Medically necessary	 $25 Copay $150 Allowance	 $25 Copay $120 Allowance
Benefit Frequency (Based on date of service)		
Exam	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 24 months
Contacts	Once every 12 months	Once every 12 months
Employee Monthly Contributions		
Employee	$9.10	$5.56
Employee + Spouse	$17.40	$10.64
Employee + Child(ren)	$17.40	$10.64
Employee + Family	$24.36	$14.88



Watch and learn more!

- 20% off amount of frames over allowance
- 20% off amount on conventional contacts over allowance
- 10% off amount on disposable contacts over allowance



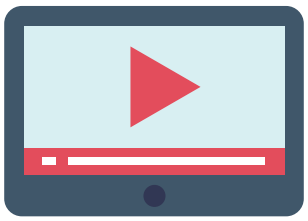
Find an In-Network Provider

Visit **www.superiorvision.com**.

Call **800-507-3800**.

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!

Voluntary Educator Disability	
Elimination Period 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 illness before benefits begin.	7/7 14/14 30/30 60/60 90/90
Gross Monthly Benefit	Units of $100/Minimum of $200
Maximum Gross Monthly Benefit	Lesser of 66.67% of your monthly covered earnings or $8,000 max
Maximum Benefit Period	Social Security Normal Retirement Age
Pre-existing Condition Exclusion	3/12



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)

File a Disability Claim

Visit **www.newyorklife.com**.

Call **888-842-4462**.

Group #: SLH-100022.

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.

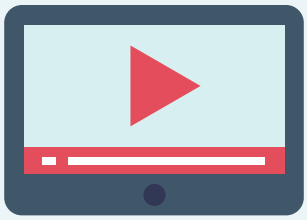
Visit **www.mybenefitshub.com/newcaneyisd** for rates.



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
Diagnosis of Cancer	$5,000	$10,000
Radiation and Chemotherapy	$15,000 maximum per year	$20,000 maximum per year
Internal Cancer – First Occurrence*	$100	$100
Employee Monthly Contributions		
Employee	$16.84	$28.18
Employee + Spouse	$32.00	$53.94
Employee + Child(ren)	$21.38	$35.08
Employee + Family	$37.60	$62.54

* **Carcinoma in situ is not considered internal cancer.**



Accident Insurance

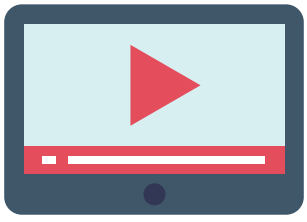
THE HARTFORD

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 document for full details.

Accident Insurance	
Service	**Benefit**
Ambulance • Ground • Air	 $300 $900
Emergency Room	$150
Admission • Hospital	 $1,000
Confinement • Hospital – up to 30 days per lifetime • ICU – up to 30 days per accident	 $200 per day $400 per day
Specific Sum Injuries Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, etc.	$150-$10,000
Accidental Death & Dismemberment[1] • Employee • Spouse • Child(ren)	 $30,000 50% of employee amount 25% of employee amount
Employee Monthly Contributions	
Employee	$7.00
Employee + Spouse	$11.04
Employee + Child(ren)	$11.92
Employee + Family	$18.68

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



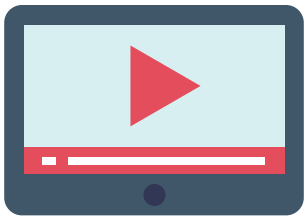


Watch and learn more!

Life and AD&D Insurance

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

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



Watch and learn more!

Basic Term Life and AD&D

Basic Term Life and AD&D insurance are provided at no cost to you. You are automatically covered at $30,000 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

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

You can also cover your dependent spouse and child(ren).

Supplemental Term Life and AD&D Insurance	
Employee	• Increments of $10,000, up to $500,000 • New Hire Guaranteed Issue $200,000 • OE Guaranteed Issue $20,000
Spouse	• Increments of $5,000, up to $500,000, not to exceed 100% of employee's election • New Hire Guaranteed Issue $50,000 • OE Guaranteed Issue $10,000
Child(ren)	• Increments of $5,000, up to $10,000 • Birth to six months – $1,000 • Seven months to age 26 – $10,000

Supplemental Term Life Rates		
Age	Employee Coverage Monthly Rate per $10,000	Spouse Coverage Monthly Rate per $1,000
<25	$0.36	$0.45
25-29	$0.43	$0.45
30-34	$0.58	$0.64
35-39	$0.65	$0.73
40-44	$0.72	$1.00
45-49	$1.08	$1.46
50-54	$1.66	$2.48
55-59	$3.10	$3.86
60-64	$4.76	$5.97
65-69	$9.15	$11.58
70-99	$14.84	$14.84

Child(ren)	
To age 26	$2.00

Supplemental AD&D Rates per $1,000		
Employee	Spouse	Child(ren)
$0.02	$0.04	$0.04

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.

Legal Services

LegalEASE

A legal benefits plan provides benefits that cover the most common legal needs you may encounter.

Life events can lead to unexpected legal concerns that are difficult to handle alone. Enrolling in a legal benefits plan reduces the stress of finding and paying for an attorney when it matters most.

LegalEASE offers a plan that provides support and protection for unexpected personal legal issues.

For More Information

Visit **www.legaleaseplan.com/newcaney**.

Call **800-248-9000**.

Plan Highlights

- Advice from an attorney with expertise specific to your personal legal matter
- Access to a national network of attorneys with exceptional experience that are matched to meet your needs
- In- and out-of-network coverage
- Concierge services to help navigate common individual or family legal issues



Plan Value

As a member, you have access to a national network of over 20,300 attorneys who are matched to your specific legal needs. Being a LegalEASE benefits member also saves you time and costly legal fees. But most importantly, it gives you confidence and provides coverage for:

- Home and consumer (refinancing, tenant dispute, foreclosure)
- Financial (debt collection, contracts)
- Auto and traffic (license suspensions, administrative proceedings)
- Family (divorce, adoption, name change)
- Estate planning and wills (will, living will, health care power of attorney)

Employee Monthly Contributions	
Employee + Family	$15.16

Identity Theft Protection and Financial Wellness

You have two identity theft protection and support plans – plus a financial wellness platform – to choose from that give you and your family the protection it needs.

Identity Theft helps monitor any potential threats to your identity and alerts you if there are areas of concern. It includes identity theft insurance, restoration, credit lock, dark web monitoring, safe browser, and more.

The financial wellness platform and digital privacy tools help you keep passwords and other personal information private and secure while surfing the web. It provides a credit education so you can improve how lenders see you and gives you access to reports and scores lenders use to make credit approval decisions.

For More Information

Visit **www.mybenefitshub.com/newcaneyisd**.

Call **855-797-0052**.

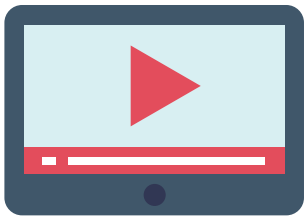
Employee Monthly Contributions		
	Elite Plan	Premium Plan
Employee	$7.50	$4.50
Employee + Family	$14.00	$10.50



Emergency Transport Services

Did you know that a ground ambulance ride can cost more than $1,200 and an air ambulance ride can cost up to $70,000? If you or a family member is in need of an emergency medical transport, your insurance coverage and Medicare may not cover all of the costs.

After your medical crisis, contact the medical transport carrier to negotiate with your medical plan provider and cover the balance on your medical transportation bills.



Watch and learn more!

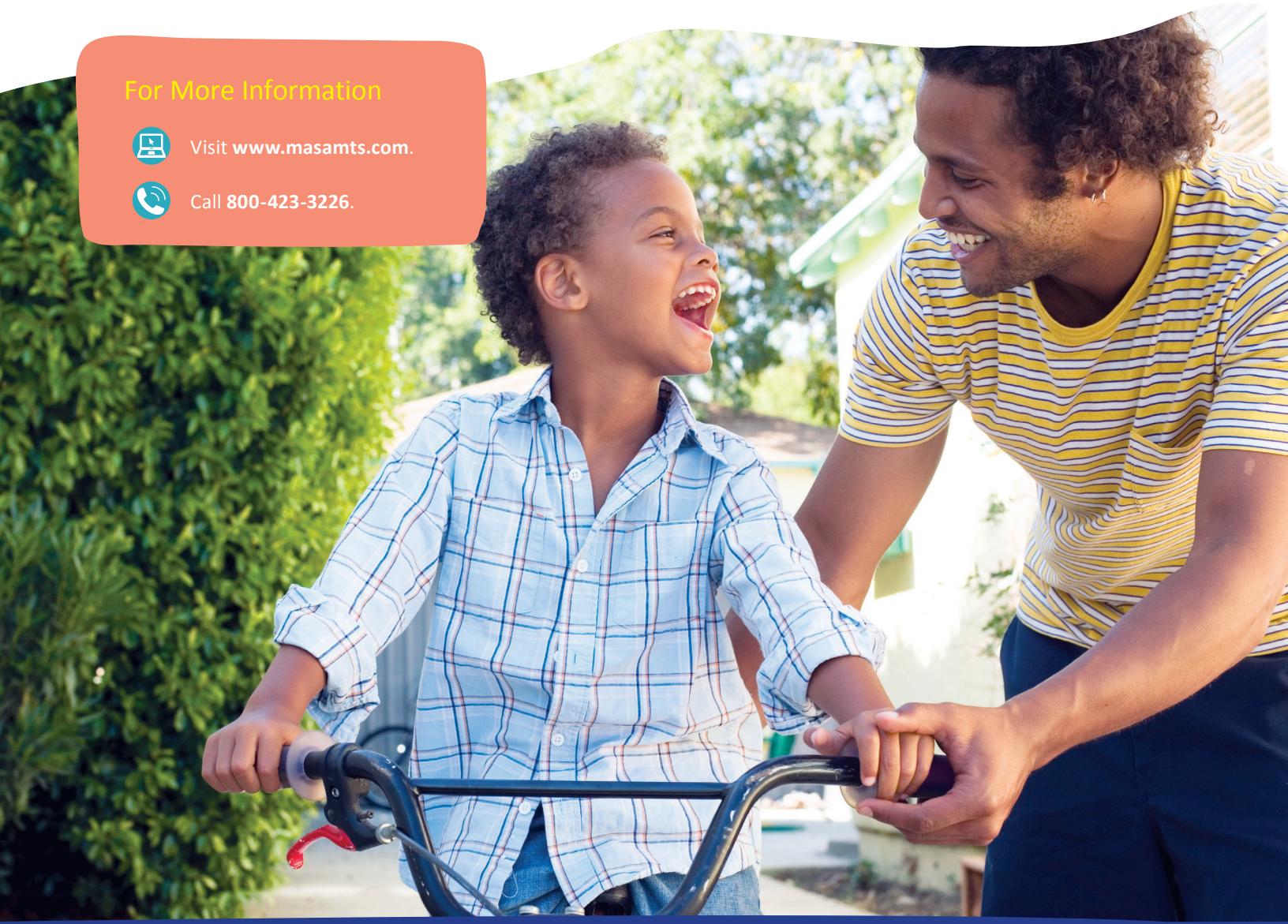
Employee Monthly Contributions	
Employee + Family	$14

Access the benefits website at **www.mybenefitshub.com/newcaneyisd** for rates.

For More Information

Visit **www.masamts.com**.

Call **800-423-3226**.



HSA and FSA Comparison

Knowing the difference between an HSA and FSA 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 HDHP	All employers
Contribution Source	You and/or your employer	You and/or your employer
Account Owner	Individual	Employer
Underlying Insurance Requirement	HDHP	None
Insurance Plan Minimum Deductible	**2026** • $1,700 single • $3,400 family	**2026** N/A
Maximum Contribution	**2026** • $4,400 single • $8,750 family • $1,000 age 55+ catch-up	**2026** $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, your employer's plan contains a $500 rollover provision.
Does the account earn interest?	Yes	No
Portable?	Yes, it is portable year-to-year and between jobs.	No

Flip to... 14 HSA 30 FSA

Flexible Spending Accounts

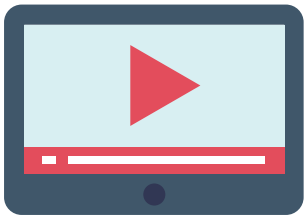
An FSA allows you to set aside pretax dollars from each paycheck to pay for certain IRS-approved health and dependent care expenses.

Health Care FSA

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

- Dental and vision expenses
- Medical deductibles and coinsurance
- Prescription copays
- Hearing aids and batteries

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



Watch and learn more!

Limited Purpose Health Care FSA

A Limited Purpose Health Care FSA is available if you enrolled in the HDHP medical plan and contribute to an HSA. You can use a Limited Purpose Health Care FSA to pay for eligible out-of-pocket dental and vision expenses only, such as:

- Dental and orthodontia care (e.g., fillings, X-rays, and braces)
- Vision care (e.g., eyeglasses, contact lenses, and LASIK surgery)

How the Health Care and Limited Purpose FSAs Work

You can access the funds in your FSA two different ways:

- Use your NBS Benefits Debit Card to pay for qualified expenses, doctor visits, and prescription copays.
- Pay out-of-pocket and submit your receipts for reimbursement:
  - Visit **www.nbsbenefits.com**.
  - Call **855-399-3035**.
  - Fax **844-438-1496**.
  - Email **service@nbsbenefits.com**.
  - Download the **NBS Mobile Banking app**.
  - Participant Portal: **www.mynbsbenefits.com**.
  - Mail:
    National Benefit Services, LLC
    P.O. Box 219393
    Kansas City, MO 64121-9393



Dependent Care FSA

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

Dependent Care FSA Guidelines

- Overnight camps are not eligible for reimbursement (only day camps can be considered).
- If your child turns 13 midyear, you may only request reimbursement for the part of the year when the child is under age 13.
- You may request reimbursement for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.

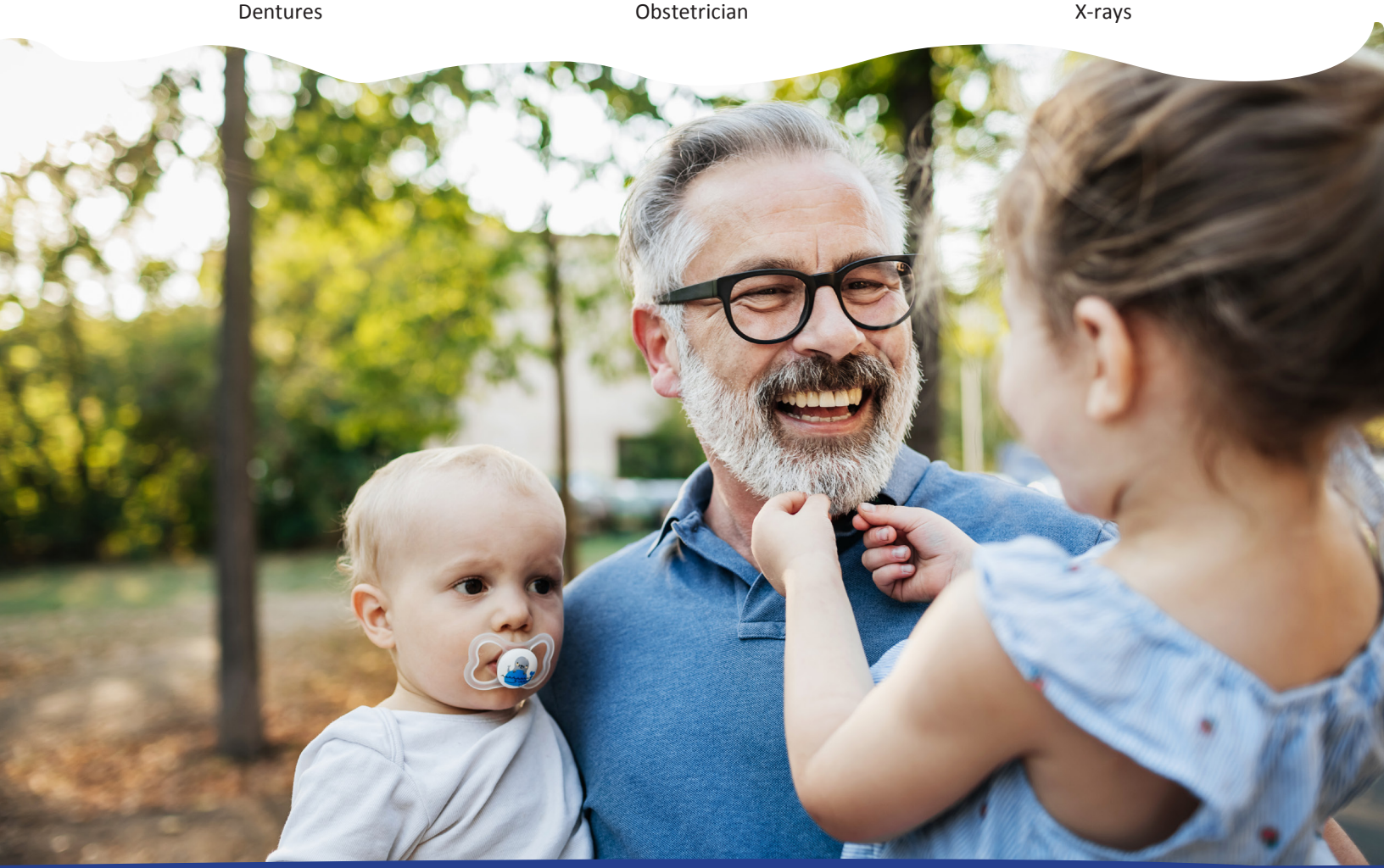
Annual Maximum FSA Contributions		
2026	Health Care FSA Limited Purpose FSA	Dependent Care FSA
Annual Maximum Contribution	$3,400	$7,500 (Single parent filing head of household; or married filing jointly); $3,750 (married filing separately)
Run-out Period	90 days	No run-out period
Carryover	$500	No carryover (use it or lose it)
Grace Period	No grace period	No grace period

You are entitled to the full election from day one of the plan year for the Health Care 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



Employee Assistance Program

An Employee Assistance Program (EAP) is a program that assists you in resolving problems such as finding child or elder care, relationship challenges, financial or legal problems, etc. This program is provided by your employer at no cost to you.

Call us anytime, any day

We're just a phone call away whenever you need us, at no extra cost to you. An advocate can help you assess your needs and develop a solution. He or she can also direct you to community resources and online tools.

Visit a specialist

You have face-to-face sessions with a behavior counselor available to your household members. Call us to request a referral.

Monthly Webinars

Educational seminars on a variety of relevant topics such as managing your life, work, money and health, are available in a quarterly calendar of monthly webcasts distributed to your employer.

Achieve work-life balance

For help handling life's challenges go online for articles and resources including on family, care giving, pet care, aging, grief, balancing, working smarter, and more.

Legal consultation and referrals

Receive a free 30-minute consultation with a network attorney and up to 25% discount on select fees.

Financial consultations

Receive a free 30-minute consultation and 25% discount on tax planning and preparation.

Get 24/7 Support

Visit **www.guidanceresources.com**.

Call **800-344-9752**.



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.

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.

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:

New Caney ISD
Human Resources
21580 Loop 494
New Caney, TX 77357
281-577-8600

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 New Caney 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. New Caney ISD has determined that the prescription drug coverage offered by the New Caney 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.

Important Legal Notices

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

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

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting New Caney 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 New Caney 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 **281-577-8600**.

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
New Caney ISD
Human Resources
21580 Loop 494
New Caney, TX 77357
281-577-8600

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

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

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

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

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:

New Caney ISD
Human Resources
21580 Loop 494
New Caney, TX 77357
281-577-8600

II. Effective Date

This Notice is effective February 15, 2026.

III. Our Responsibilities

We are required by law to:

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

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

IV. How We May Use and Disclose Your PHI

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

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

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

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

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

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

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

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

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

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

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

V. Special Situations

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

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

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

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

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

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

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

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

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

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

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

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

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

Research. We may disclose your PHI to researchers when:

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

VI. Required Disclosures

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

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

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

VII. Other Disclosures

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

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

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

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

VIII. Your Rights

You have the following rights with respect to your PHI:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IX. Complaints

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

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

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.

Important Legal Notices

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 New Caney ISD group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the New Caney ISD plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan Contact Information

National Benefit Services
430 W 7th Street Suite 219893RA
Kansas City, MO 64105
800-274-0503

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.

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**.

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: New Caney ISD		
5. Employer Address: 21580 Loop 494	**6. Employer Phone Number:** 281-577-8600	
7. City: New Caney	**8. State:** TX	**9. ZIP Code:** 77357
10. Who can we contact at this job?: Elizabeth Jackson		
11. Phone Number (if different from above): N/A	**12. E-Mail Address:** ejackson@newcaneyisd.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 New Caney 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. New Caney ISD reserves the right to change or discontinue its employee benefits plans anytime.