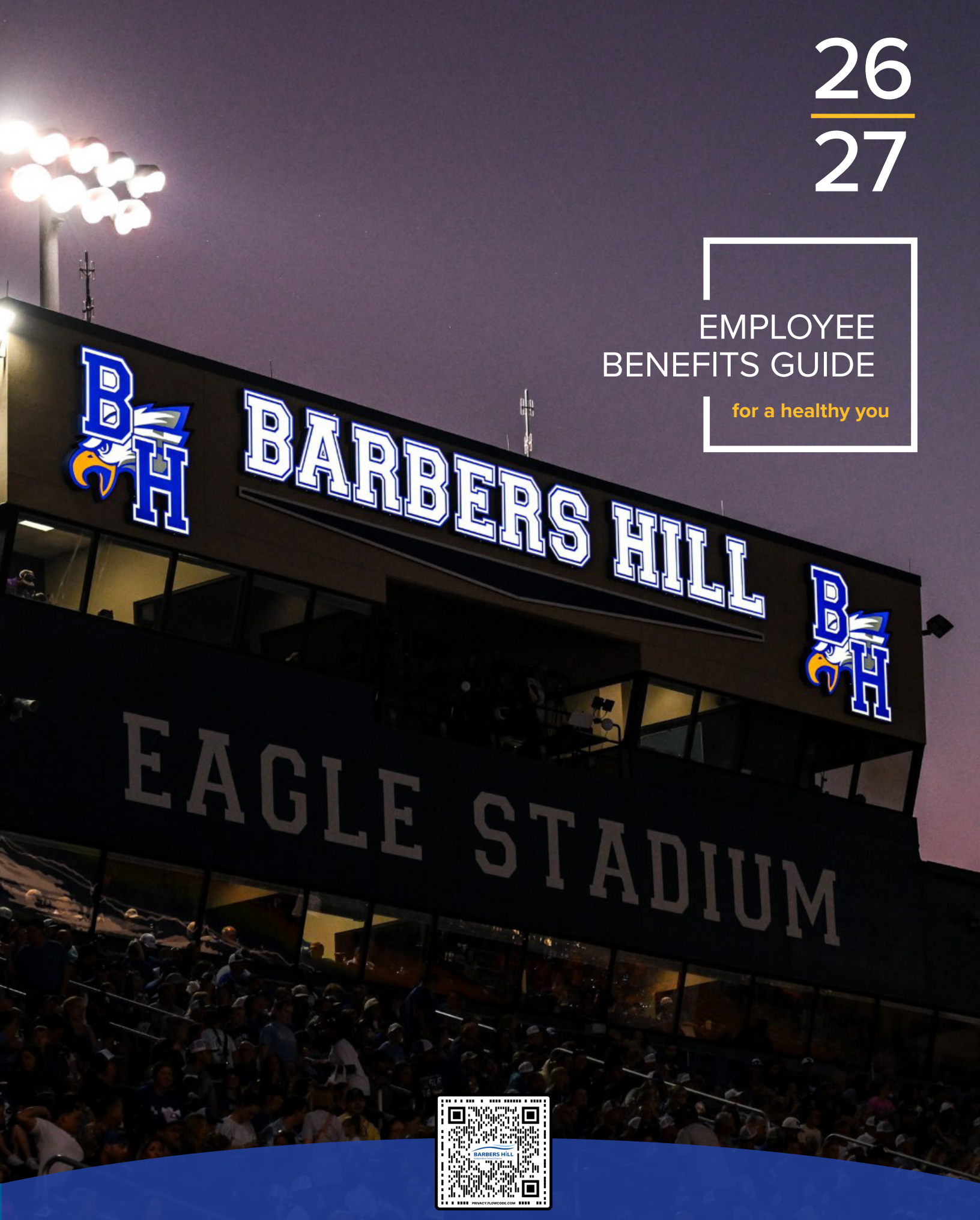


26 27

EMPLOYEE BENEFITS GUIDE

for a healthy you

Welcome

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

Availability of Medical Plan Benefits Information

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

Your Benefits Are in Effect

September 1, 2026 through August 31, 2027

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MEDICAL COVERAGE

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Important Contacts

Higginbotham Public Sector
833-510-4350
www.mybenefitshub.com/barbershillisd

Medical
TRS ActiveCare
866-355-5999
www.bcbstx.com/trsactivecare

Health Savings Account
Gulf Coast Educators Federal Credit Union
281-487-9333
www.gcefcu.org

Flexible Spending Account(s)
National Benefit Services
855-399-3035
www.mynbsbenefits.com

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

Vision
Superior Vision
Group #325660
800-507-3800
www.superiorvision.com

Life and AD&D
Lincoln Financial
Policy #: 10270871
800-423-2765
www.lfg.com

Permanent Life
5Star Life Insurance
866-863-9753
www.5starlifeinsurance.com

Educator Disability
New York Life
Policy #: SLH-100034
800-225-5695
www.newyorklife.com

Hospital Cash/Indemnity
Cigna
Policy #: HC111843
800-244-6224
www.cigna.com

Cancer
Chubb
888-499-0425
www.chubb.com

Critical Illness
Unum
Policy #: 474121 011
866-679-3054
www.unum.com

Accident
Cigna
Policy #: AI112309
800-244-6224
www.cigna.com

Telehealth
Recuro Health
855-673-2876
www.recurohealth.com

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

Employee Assistance Program
Lincoln Financial Group
888-628-4824
www.guidanceresources.com

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

Eligibility

OE: Open Enrollment
QLE: Qualifying Life Event

Who is Eligible for Benefits

NEW HIRE

Who is Eligible

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

When to Enroll

- By the deadline given by the Benefits Office

When Coverage Starts

- First of the month following or coincident with the date of hire.

EMPLOYEE

Who is Eligible

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

When to Enroll

- During OE or for a QLE

When Coverage Starts

- OE: Start of the plan year
- QLE: Ask the Benefits Office

DEPENDENT(S)

Who is Eligible

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

When to Enroll

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

When Coverage Starts

- Ask the Benefits Office

MAXIMUM DEPENDENT ELIGIBILITY AGE BY PLAN
To Age 26
Medical/Dental/Vision/Life/AD&D/Individual Life/HSA/ Critical Illness/Disability/Hospital Indemnity/Telehealth /Emergency Transport/Accident/Cancer

Qualifying Life Events

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



Marriage
Divorce
Annulment
Death of spouse



Birth
Adoption/placement for adoption
Change in benefits eligibility
Death of child



FMLA, COBRA event, judgment, or decree
Becoming eligible for Medicare, Medicaid, or TRICARE
Receiving a Qualified Medical Child Support Order



Gain or loss of benefits coverage
Change in employment status affecting benefits



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

How to Enroll



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

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

Benefits Questions?

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

- Enrollment
- Benefits
- Eligibility
- Claims and Billing

Call or text **833-510-4350** 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 **barbershillisd@hps.higginbotham.net**.

Bilingual representatives are available.

SCAN THE QR CODE TO ENROLL

SECTION 125 CAFETERIA PLAN GUIDELINES

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

Changes in benefit elections can occur only if you experience a QLE. You must present proof of the QLE to your Benefits Office within 31 days of the event. Meeting with the Benefits Office to complete and sign the necessary paperwork is also required to make benefit election changes effective. Changes must be consistent with the QLE.

Enrollment Frequently Asked Questions

What if I miss the enrollment deadline?

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

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

Yes. See the **Eligibility** page for details.

Where can I find benefits summaries and forms?

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

How can I find in-network providers?

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

When will I get my ID cards?

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

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

Benefits Questions?

Call the Higginbotham Public Sector benefits team at **833-510-4350**.

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

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

Are there FSA and HSA limitations for married couples?

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

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

Medical

BlueCross BlueShield of Texas

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



All TRS-Active participants may enroll in one of the following plans:

- **TRS-ActiveCare Primary**
- **TRS-ActiveCare Primary+**
- **TRS-ActiveCare HD**

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

TRS Region 4 Monthly Medical Rates

TRS MEDICAL	REGION 4		
	Total Monthly Premium	Employer Contribution	Employee Monthly Cost
ACTIVECARE PRIMARY			
Employee Only	$569.00	$250	$319.00
Employee & Spouse	$1,537.00	$250	$1,287.00
Employee & Child(ren)	$968.00	$250	$718.00
Employee & Family	$1,935.00	$250	$1,685.00
ACTIVECARE PRIMARY+			
Employee Only	$669.00	$250	$419.00
Employee & Spouse	$1,740.00	$250	$1,490.00
Employee & Child(ren)	$1,138.00	$250	$888.00
Employee & Family	$2,208.00	$250	$1,958.00
ACTIVECARE HD			
Employee Only	$583.00	$250	$333.00
Employee & Spouse	$1,575.00	$250	$1,325.00
Employee & Child(ren)	$992.00	$250	$742.00
Employee & Family	$1,983.00	$250	$1,733.00
ACTIVECARE 2			
Employee Only	$1,013.00	$250	$763.00
Employee & Spouse	$2,402.00	$250	$2,152.00
Employee & Child(ren)	$1,507.00	$250	$1,257.00
Employee & Family	$2,841.00	$250	$2,591.00

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

How to Calculate Your Monthly Premium

Total Monthly Premium

− Your Employer Contribution

= **Your Premium**

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

Being Healthy is Easy

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

** Eligibility rules may apply.*

See the Annual Enrollment Guide for more details.

Mental Health

You have in-office and virtual benefits:

- TRS-ActiveCare Primary x Region 4 Plan: $30 copay for office visits or $0 with Teladoc
- TRS-ActiveCare Primary+ Plan: $15 copay for office visits or $0 with Teladoc
- TRS-ActiveCare HD Plan: 30% coinsurance after deductible or $42 with Teladoc
- TRS-ActiveCare 2 Plan: $20 copay for office visits or $12 with Teladoc

You have **three plan options** — one regional plan and two stand

	TRS-ActiveCare Primary x Region 4	TRS-
Plan Summary	• Lowest premium of the three available plans • Copays for doctor visits before you meet your deductible • Statewide network • Primary Care Provider referrals required to see specialists • Not compatible with a Health Savings Account • No out-of-network coverage • **New!** Tiering options that lower your out-of-pocket costs when you choose certain facilities.	• Highest premium • Copays for many s • Lower deductible • Statewide network • Primary Care Prov • Not compatible wi • No out-of-network

Monthly Premiums	Total Premium	Employer Contribution	Your Premium	Total Premium
Employee Only	$569			$669
Employee and Spouse	$1,537			$1,740
Employee and Children	$968			$1,138
Employee and Family	$1,935			$2,208

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

Doctor Visits		
Primary Care	$30 copay	
Specialist	$70 copay	

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

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

Aug. 31, 2027

TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

lard plans — with a wide range of wellness benefits.

ActiveCare Primary+	TRS-ActiveCare HD
of the three available plans services and drugs than the HD and Primary plans k ider referrals required to see specialists th a Health Savings Account k coverage	• Higher premium of the three available plans • Must meet your deductible before plan pays for non-preventive care • Nationwide network with out-of-network coverage • No requirement for Primary Care Providers or referrals • Compatible with a Health Savings Account

Employer Contribution	Your Premium	Total Premium	Employer Contribution	Your Premium
		$583		
		$1,575		
		$992		
		$1,983		

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

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

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

ole per participant (brand drugs only)	Integrated with medical
$15/$45 copay	You pay 20% after deductible; $0 coinsurance for certain generics
25% after deductible ($100 max)/ 25% after deductible ($265 max)	You pay 25% after deductible
u pay 50% after deductible	You pay 50% after deductible
0% after deductible ($500 max); $0 if SaveOnSP eligible	You pay 20% after deductible
5 copay for 31-day supply; 5 for 61- to 90-day supply	You pay 25% after deductible

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

TRS-ActiveCare 2
• Closed to new enrollees • Current enrollees can choose to stay in the plan • Lower deductible • Copays for many services and drugs • Nationwide network with out-of-network coverage • No requirement for Primary Care Providers or referrals

Total Premium	Employer Contribution	Your Premium
$1,013		
$2,402		
$1,507		
$2,841		

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

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

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

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

Questions?

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

Compare Prices for Common Medical Services

Closed to new enrollees.

Benefit	TRS-ActiveCare Primary x Region 4	TRS-ActiveCare Primary+	TRS-ActiveCare HD		TRS-ActiveCare 2	
	In-Network Only	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Labs	Office/Independent Lab: You pay $0 Outpatient: You pay 30% after deductible	Office/Independent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	Office/Independent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 40% after deductible
High-Tech Imaging (like CT Scan, Mammogram and MRI)	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible + $100 copay per procedure	You pay 40% after deductible + $100 copay per procedure
Outpatient (like colonoscopy, cataract surgery and steroid injections)	Tier 1: 30% coinsurance after deductible Tier 2: 40% coinsurance after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible ($150 facility copay per incident)	You pay 40% after deductible ($150 facility copay per incident)
Inpatient (like childbirth, complex joint replacement and cardiac surgery)	Tier 1: 30% coinsurance after deductible Tier 2: 40% coinsurance after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible ($500 facility per day maximum)	You pay 20% after deductible ($150 facility copay per day)	You pay 40% after deductible ($500 facility copay per incident)
Freestanding Emergency Room	You pay $500 copay + 30% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 30% after deductible	You pay $500 copay + 50% after deductible	You pay $500 copay + 20% after deductible	You pay $500 copay + 40% after deductible
Bariatric Surgery	Facility: You pay 30% after deductible Professional Services: You pay $5,000 copay + 30% after deductible Only covered if rendered at a BDC+ facility	Facility: You pay 20% after deductible Professional Services: You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility	Not Covered	Not Covered	Facility: You pay 20% after deductible ($150 facility copay per day) Professional Services: You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility	Not Covered
Annual Vision Exam (one per plan year)	Specialist: You pay $70 copay	Specialist: You pay $70 copay	You pay 30% after deductible	You pay 50% after deductible	Tier 1 Specialist: $55 copay Tier 2 Specialist: $85 copay	You pay 40% after deductible
Annual Hearing Exam (one per plan year)	PCP: $30 copay Specialist: $70 copay	PCP: $15 copay Specialist: $70 copay	You pay 30% after deductible	You pay 50% after deductible	Tier 1 PCP: $20 copay Tier 2 PCP: $40 copay Tier 1 Specialist: $55 copay Tier 2 Specialist: $85 copay	You pay 40% after deductible

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				
 Telehealth	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 cannot see your doctor; located in stores and pharmacies Hours vary based on store hours	Common infections Minor injuries Pregnancy tests Vaccinations	$	15 minutes
 Urgent Care	When you need immediate attention; walk-in basis is usually accepted Generally includes evening, weekend and holiday hours	Sprains and strains Minor broken bones Small cuts that may require stitches Minor burns and infections	$$	15-30 minutes
Emergency Care				
 Hospital ER	Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility 24 hours a day, 7 days a week	Chest pain Difficulty breathing Severe bleeding Blurred or sudden loss of vision Major broken bones	$$$$	4+ hours
 Freestanding ER	Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher 24 hours a day, 7 days a week	Most major injuries except trauma Severe pain	$$$$$$	Minimal

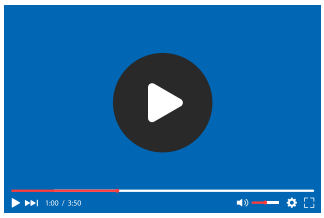
Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

Health Savings Account

Gulf Coast Educators
FEDERAL CREDIT UNION

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

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



Watch and learn more!

HSA Eligibility

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

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

Note: You may have an HSA at the financial institution of your choice, but only accounts opened through Gulf Coast Educators Federal Credit Union are eligible for automatic payroll deductions.

How to Pay or Get Reimbursed

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

Contributions

You may contribute up to the IRS annual maximum.

2026 Maximum HSA Contributions

	EMPLOYEE
Individual	$4,400
Family	$8,750

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

Two Ways To Use Your HSA

Use it Now

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

Invest Over Time

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



Triple Tax Savings

Tax-free contributions

Tax-free growth

Tax-free withdrawals

Get More Information or Submit Receipts

Visit **www.gcefcu.org**.

Call **281-487-9333**.

Download the **Gulf Coast Educators FCU**.

Flexible Spending Accounts

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

Health Care FSA

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

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

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

Important Reminders!

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

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

Get More Information or Submit Receipts

Visit **www.nbsbenefits.com**.

Call **855-399-3035**.

Fax **844-438-1496**.

Email **service@nbsbenefits.com**.

Download the **NBS app**.

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



Flexible Spending Accounts

Dependent Care FSA

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

Dependent Care FSA Guidelines

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



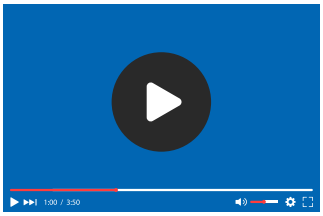
How to Access Funds/Pay or Get Reimbursed

Use your FSA debit card
(excludes the Dependent Care FSA).
OR
Pay out-of-pocket, and submit your receipts for reimbursement.

Annual Maximum FSA Contributions

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

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



Watch and learn more!

HSA and FSA Comparison

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

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

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

FLIP TO... 12 HSA 13 FSA

Qualified HSA and FSA Expenses





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

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

Abdominal supports
Acupuncture
Ambulance
Anesthetist
Arch supports
Artificial limbs
Blood tests
Braces
Cardiographs
Chiropractor
Crutches
Dental treatment
Dentures
Dermatologist
Diagnostic fees
Eyeglasses
Gynecologist
Healing services
Hearing aids and batteries
Hospital bills
Insulin treatment
Lab tests
Metabolism tests
Neurologist
Nursing
Obstetrician
Operating room costs
Ophthalmologist/Optician/Optometrist
Orthopedic shoes
Orthopedist
Osteopath
Physician
Postnatal treatments
Prenatal care
Prescription medicines
Psychiatrist
Therapy equipment
Wheelchair
X-rays

* Excludes Dependent Care FSA.

Dental Coverage

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

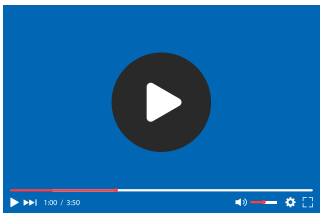
DHMO Plan

If you enroll in the DHMO plan, you and all eligible dependents must select a primary care dentist (PCD) from the DHMO network directory to manage your care. Your initial PCD will be automatically assigned to you based on your ZIP code. You may change your PCD by contacting **Cigna** directly.

Dental services are unlimited and have fixed copays. There are no deductibles or claim forms to file. Out-of-network care is not covered.

DPPO Plans

Two levels of benefits are available with the DPPO plans: in-network and out-of-network. You may see 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.



Watch and learn more!

Find an In-Network Provider

Visit **www.cigna.com**.

Call **800-244-6224**.

Dental Benefits Summary

DENTAL – CIGNA			
	DPPO LOW	DPPO HIGH	DHMO
Network Type	DPPO	DPPO	DHMO
OON Reimbursement Type	Based on Contracted Fees	Based on Contracted Fees	Based on Fee per Service
PROVIDER NETWORK			
Dental Network Name	Cigna Dental Choice	Cigna Dental Choice	Cigna Dental Care Plan
PLAN FEATURES			
Annual Maximum Benefit per Member	$750	$1,250 (Year 1)	N/A
Annual Deductible Amount • Individual • Family	 $50 $150	 $50 $150	 N/A
Plan Annual Maximum Rollover or Increasing Maximum Threshold and Amount	N/A	$1,250 Year 1, $1,550 Year 2, $1,850 Year 3, $2,150 Year 4 and beyond	N/A

How Can I Get My ID Card?

- Visit **www.cigna.com.**
- Call **800-244-6224**.

DENTAL – CIGNA			
	DPPO LOW	DPPO HIGH	DHMO
	In-Network Reimbursement*		
REIMBURSEMENT PERCENTAGES			
Class 1: Preventive/Diagnostic Care	100%	100%	Fee per service
Class 2: Basic Restorative Care	70% after deductible	80% after deductible	Fee per service
Class 3: Major Restorative Care	50% after deductible	50% after deductible	Fee per service
Class 3: Implants	50% after deductible	50% after deductible	Fee per service
ORTHODONTIA			
Class 4: Orthodontia Reimbursement Percentage	N/A	50% No deductible	You pay a fixed dollar amount to the dentist for the covered service
Class 4: Orthodontia: Lifetime Maximum Amount	N/A	$1,000	
Class 4: Orthodontia: Children Only or Adults & Child Coverage (or enter N/A)	N/A	Dependent Children	
Class 4: Orthodontia: To What Age are Children Covered?	N/A	To age 19	
SERVICES CLASS			
Palliative Treatment	Class 2	Class 2	N/A
Oral Surgery: Simple Extractions	Class 2	Class 2	N/A
Oral Surgery: Surgical Extractions	Class 2	Class 2	N/A
Periodontics Nonsurgical	Class 3	Class 2	N/A
Periodontics Surgical	Class 3	Class 2	N/A
Endodontics Nonsurgical	Class 3	Class 2	N/A
Endodontics Surgical	Class 3	Class 2	N/A
PLAN PROVISIONS			
Number of Dental Cleanings Available per Year	3 per policy year	3 per policy year	
Do Waiting Periods Apply for Any Preventive, Basic, Major, or Orthodontia Services?	No waiting period	No waiting period	No waiting period
Are Benefits Determined by Policy Year or Calendar Year?	Policy Year	Policy Year	
Are Limitations for Late Entrants Included in the Policy?	No	No	No
Is a Missing Tooth Clause Included in the Policy?	No	No	No
Can Benefits Be Utilized Outside of the U.S.?	Yes, coverage applies towards out-of-network benefits.	Yes, coverage applies towards out-of-network benefits.	No
RATES (MONTHLY)			
Employee Only	$29.53	$52.74	$10.74
Employee & Spouse	$57.40	$88.01	$18.95
Employee & Child(ren)	$60.15	$90.94	$25.58
Employee & Family	$86.82	$132.25	$37.04

*You will be reimbursed up to the Maximum Allowable Charge (MAC) for services received from an out-of-network dentist. You are responsible for charges in excess of the MAC, so stay in-network to avoid balance billing.

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 plans will pay the highest level of benefits when you see in-network providers.

Find an In-Network Provider

Visit **www.superiorvision.com**.

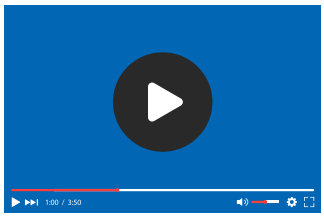
Call **800-507-3800**.

Vision Benefits Summary

VISION –SUPERIOR VISION				
	BASE PLAN		BUY UP PLAN	
PROVIDER NETWORK				
Vision Network Name	Superior Select Southwest network		Superior Select Southwest network	
BENEFIT FREQUENCY (PER PLAN YEAR)				
Exam	12 months		12 months	
Frames	24 months		12 months	
Lenses (standard) per pair	12 months		12 months	
Contact Lenses	12 months		12 months	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
SERVICES (COPAYS)				
Exam	$10 copay	Not covered	$10 copay	Not covered
Materials Copay	$25 copay	Not covered	$10 copay	Not covered
MATERIALS COPAY (PER PAIR)				
Frame Allowance	$150 retail allowance	Up to $70	$150 retail allowance	Up to $70
Are Single Vision Lenses Covered in Full?	Covered in full	Up to $25	Covered in full	Up to $25
Are Bifocal Lenses Covered in Full?	Covered in full	Up to $40	Covered in full	Up to $40
Are Trifocal Lenses Covered in Full?	Covered in full	Up to $45	Covered in full	Up to $45
Progressive Lenses	Member pays difference between progressive and standard retail lined trifocal.	Up to $45	Member pays difference between progressive and standard retail lined trifocal.	Up to $45

How Can I Get My ID Card?

- Visit **www.superiorvision.com**.
- Call **800-507-3800**.



Watch and learn more!

VISION –SUPERIOR VISION				
	BASE PLAN		BUY UP PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
LENS ENHANCEMENTS				
Are Standard Polycarbonate Lenses Covered in Full?	Covered in full	Up to $20	Covered in full	Up to $20
Scratch-resistant Coating	Covered in full	Up to $25	Covered in full	Up to $25
UV Treatment	Covered in full	Up to $20	Covered in full	Up to $20
CONTACTS & LASIK				
Are Contacts in Lieu of Glasses?	Yes		Yes	
Conventional Contact Lens Allowance	$175 retail allowance	Up to $80	$175 retail allowance	Up to $80
Medically Necessary Contact Lens Allowance	Covered in full	Up to $150	Covered in full	Up to $150
LASIK Benefit	$200 allowance		$200 allowance	
PLAN PROVISIONS				
Are Benefits Determined by Policy Year, Service Year, or Calendar Year?	Service Year		Service Year	
Can Benefits Be Utilized Outside of the U.S.?	Out-of-Network Basis Only		Out-of-Network Basis Only	
RATES (MONTHLY)				
Employee Only	$7.13		$10.82	
Employee & Spouse	$12.11		$18.48	
Employee & Child(ren)	$12.83		$19.51	
Employee & Family	$19.24		$28.70	



Life and AD&D Insurance

FOR EMPLOYEES / BASIC

Lincoln Financial Group®

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

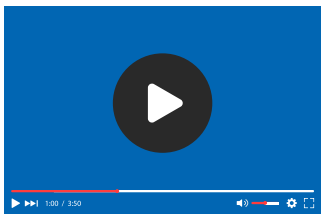
With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts such as credit cards, loans, and bills. AD&D coverage provides specific benefits if an accident causes bodily harm or loss (e.g., the loss of a hand, foot, or eye). If death occurs from an accident, 100% of the AD&D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

Employee Basic Life and AD&D

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

Designating a Beneficiary

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



Watch and learn more!



Life and AD&D Insurance

VOLUNTARY

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

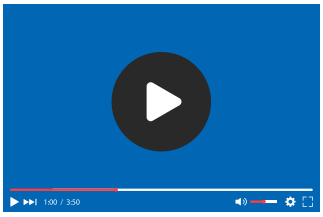
With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts such as credit cards, loans, and bills. AD&D coverage provides specific benefits if an accident causes bodily harm or loss (e.g., the loss of a hand, foot, or eye). If death occurs from an accident, 100% of the AD&D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

Designating a Beneficiary

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

Voluntary Life and AD&D

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



Watch and learn more!

VOLUNTARY LIFE AND AD&D – LINCOLN FINANCIAL	
INITIAL GUARANTEED ISSUE (GI) AMOUNTS	
Employee GI Amount	$250,000
Spouse GI Amount	$50,000
Child(ren) GI Amount	$10,000
OPEN ENROLLMENT	
Can Coverage Amount Increase to GI Limit at Each Open Enrollment Without EOI?	Yes
How Many Increments Can be Increased Annually Without EOI?	4 Increments of $10,000 for employee and 2 increments of $10,000 for spouse
Employee Minimum/Maximum Coverage Amount	$10,000/ 7 times employee's annual salary
Spouse Minimum/Maximum Coverage Amount	$5,000/Not to exceed 100% of employee's salary
Child(ren) Minimum/Maximum Coverage Amount	$10,000/Not to exceed 100% of employee's salary
Child(ren) Maximum Coverage Amount For Children Age 14 Days to Six Months	N/A
PLAN PROVISIONS	
Employee & Spouse Reduction Schedule	Benefits reduce by 50% at age 70.
Waiver of Premium	Included
Conversion	Available when insurance terminates
Portability	Included

Life and AD&D Insurance

VOLUNTARY

Rates By Tier (Monthly)

VOLUNTARY LIFE AND AD&D – LINCOLN FINANCIAL	
RATES (MONTHLY)	
EMPLOYEE & SPOUSE RATES PER $1,000 [1]	
Age	**Rate**
<20	$0.050
20-24	$0.050
25-29	$0.050
30-34	$0.060
35-39	$0.080
40-44	$0.130
45-49	$0.210
50-54	$0.320
55-59	$0.470
60-64	$0.650
65-69	$0.870
70-74	$1.950
CHILD RATES PER $1,000	
Child Rate per $1,000	$0.125
VOLUNTARY AD&D RATES (MONTHLY)	
Employee Rate per $1,000	$0.021
Family Rate per $1,000	$0.046

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

Permanent Life Insurance

Help protect your family with The Family Protection Plan from **5Star Life Insurance Company**. This level term life insurance plan offers level premiums and a level death benefit to age 121, as long as there is no lapse in premium payments. The death benefit is paid in a lump-sum cash payment.



Plan Highlights

- **Spouse Coverage:** Cover your spouse, even if you do not elect coverage for yourself.
- **Dependent Coverage:** Financially dependent children and grandchildren ages 14 days to 26 years old can get coverage too.
- **Portability:** If you change jobs or retire, and continue to pay your premium, your coverage continues with no loss of benefits or premium increases. 5Star will bill you directly.
- **Terminal Illness Benefit:** Receive 30% of your coverage in a lump-sum payment if a terminal condition limits your life expectancy to less than 12 months.
- **Quality of Life Benefit:** This optional rider accelerates a portion of your death benefit on a monthly basis – up to 75% – should the following occur:
  - » You have a permanent inability to perform at least two of the six ADLs (Activities of Daily Living) without substantial assistance; or
  - » You suffer from a severe cognitive impairment such as dementia, Alzheimer's disease, or other forms of senility that require substantial supervision.
- **Convenient Payment:** Your premium can be payroll-deducted.

To Enroll and For More Information

Visit **www.5starlifeinsurance.com**.

Call **866-914-5202**.

2026 Plan Year Enrollment

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

- **Employee:** $150,000
- **Spouse:** $50,000
- **Child:** $10,000

Educator Disability Insurance

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Educator Disability insurance is available for you to purchase. It combines features of Short Term Disability and Long Term Disability, and you may choose the benefit amount and waiting period that best suit your needs.

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.

Are there pre-existing condition limitations?

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

Will I get all of my disability benefit?

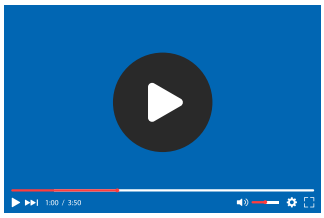
Your disability benefit may be reduced by other income you receive or are eligible to receive due to your disability, such as:

- 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.mybenefitshub.com/barbershillisd**.

Call **800-225-5695**.



Watch and learn more!



Educator Disability Insurance

EDUCATOR DISABILITY – NEW YORK LIFE	
PLAN FEATURES	
Benefit Waiting Periods	0/7[1], 14/14[1], 30/30, 60/60, 90/90, 180/180
Percentage of Earnings You Receive	Up to 66.67% of monthly earnings
Maximum Gross Monthly Benefit	$8,000
Maximum Benefit Period	The later of your social Security Normal Retirment Age or the maximum benefit period provided in your Summary of Benefits.
Pre-existing Condition Exclusion	3/12[2]*

DISABILITY (SEMI-MONTHLY RATES PER ELECTED AMOUNT)

Sample Annual Salary	Monthly Benefit Amount	0 days/7 days	14/14 days	30/30 days	60/60 days	90/90 days	180/180 days
$20,000	$1,200	$18.42	$15.72	$13.02	$9.24	$7.86	$5.76
$27,500	$1,600	$24.56	$20.96	$17.36	$12.32	$10.48	$7.68
$35,000	$2,000	$30.70	$26.20	$21.70	$15.40	$13.10	$9.60
$42,500	$2,400	$36.84	$31.44	$26.04	$18.48	$15.72	$11.52
$50,000	$2,800	$42.98	$36.68	$30.38	$21.56	$18.34	$13.44
$57,500	$3,200	$49.12	$41.92	$34.72	$24.64	$20.96	$15.36
$65,000	$3,800	$58.33	$49.78	$41.23	$29.26	$24.89	$18.24
$72,500	$4,200	$64.47	$55.02	$45.57	$32.34	$27.51	$20.16
$80,000	$4,600	$70.61	$60.26	$49.91	$35.42	$30.13	$22.08
$87,500	$5,000	$76.75	$65.50	$54.25	$38.50	$32.75	$24.00
$95,000	$5,400	$82.89	$70.74	$58.59	$41.58	$35.37	$25.92
$102,500	$5,800	$89.09	$75.98	$62.93	$44.66	$37.99	$27.84
$110,000	$6,200	$95.17	$81.22	$67.27	$47.74	$40.61	$29.76
$117,500	$6,600	$101.31	$86.46	$71.61	$50.82	$43.23	$31.68
$125,000	$7,000	$107.45	$91.70	$75.95	$53.90	$45.85	$33.60
$132,500	$7,400	$113.59	$96.94	$80.29	$56.98	$48.47	$35.52
$140,000	$7,800	$119.73	$102.18	$84.63	$60.06	$51.09	$37.44
$147,500	$8,000	$122.80	$104.80	$86.80	$61.60	$52.40	$38.40
$155,000	$8,000	$122.80	$104.80	$86.80	$61.60	$52.40	$38.40
$162,500	$8,000	$122.80	$104.80	$86.80	$61.60	$52.40	$38.40
$170,000	$8,000	$122.80	$104.80	$86.80	$61.60	$52.40	$38.40
$177,500	$8,000	$122.80	$104.80	$86.80	$61.60	$52.40	$38.40
$185,000	$8,000	$122.80	$104.80	$86.80	$61.60	$52.40	$38.40
$192,500	$8,000	$122.80	$104.80	$86.80	$61.60	$52.40	$38.40
$200,000	$8,000	$122.80	$104.80	$86.80	$61.60	$52.40	$38.40

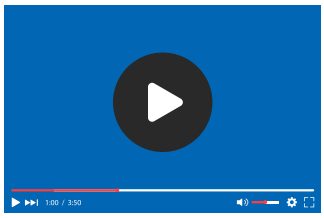
[1] If your elimination period is 30 days or less, and you are confined to a hospital for 24 hours or more, the elimination period will be waived, and benefits will be payable from the first day of hospitalization.

[2]Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.

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 or are admitted to an intensive care unit.

You decide how to use the cash, whether it is to pay for bills, gas, childcare or eldercare, medication, or other out-of-pocket expenses.



Watch and learn more!

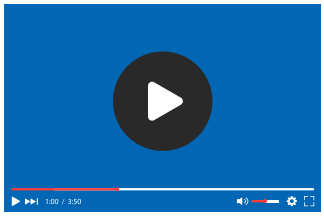
Hospital Indemnity Insurance Benefits Summary

HOSPITAL INDEMNITY – CIGNA		
	Plan 1	**Plan 2**
PLAN FEATURES		
Hospital Admission	$750	$1,500
Hospital Chronic Condition Admission	$50	$100
Hospital Stay	$100	$200
ICU Stay	$200	$400
Hospital Observation Stay	$500 per 24-hour period	$500 per 24-hour period
Newborn Nursery Care Admission	$500	$500
MONTHLY RATES		
Employee Only	$10.80	$18.80
Employee & Spouse	$19.69	$33.96
Employee & Child(ren)	$21.66	$37.00
Employee & Family	$33.31	$56.79

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 Benefits Summary

CANCER – CHUBB		
	Plan 1	**Plan 2**
PLAN FEATURES		
CORE BENEFITS		
First Occurrence Benefit	$100	$100
Diagnosis of Cancer	$5,000 Employee/Spouse $7,500 Child(ren)	$10,000 Employee/Spouse $15,000 Child(ren)
Hospital Confinement	$100 per day for 30 days	$300 per day for 30 days
Hospital ICU Confinement	$600 per day for 30 days	$600 per day for 30 days
Radiation and Chemotherapy	$10,000 max per person per 12-months	$20,000 max per person per 12-months
Medical Imaging	$500 per imaging, 2 per calendar year	$500 per imaging, 2 per calendar year
TREATMENT BENEFITS		
Donor Benefit	$100 per day of confinement, lifetime max of 2	$100 per day of confinement, lifetime max of 3
Drugs and Medicines – Inpatient	$150 per day, max of 6	$150 per day, max of 6
Bone Marrow Transplant	First $6,000, additional 50%, lifetime max 2	First $9,000, additional 50%, lifetime max 2
Stem Cell Transplant	First $600, additional 50%, lifetime max 2	First $900, additional 50%, lifetime max 2
ADDITIONAL BENEFITS		
Blood and Plasma	$300 per transfusion; Maximum transfusions per calendar year: 2	
Home Health Care	$100 per day not to exceed the number of days confined. Maximum days per calendar year: 30	
Hospice	$100 per day	
Hair Piece	$150 per hair piece. Lifetime maximum: 1	$150 per hair piece. Lifetime maximum: 1
Medical Equipment	$150 per piece of equipment. Maximum pieces per calendar year: 2	$150 per piece of equipment. Maximum pieces per calendar year: 2
Reconstructive Surgery	Breast TRAM flap: $2,000; Breast Reconstruction: $500; Breast Symmetry: $500; Facial Reconstruction: $500	Breast TRAM flap: $2,000; Breast Reconstruction: $500; Breast Symmetry: $500; Facial Reconstruction: $501

Cancer Insurance

CHUBB®

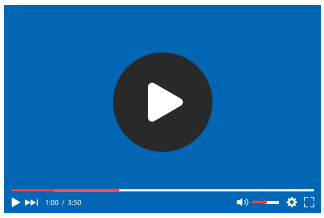
CANCER – CHUBB		
	Plan 1	**Plan 2**
RIDERS		
Heart Attack & Stroke	Employee/Spouse $5,000, Child(ren) $7,500; Recurrence benefit: Employee/Spouse $2,500, Child(ren) $3,750	Employee/Spouse $10,000, Child(ren) $15,000; Recurrence benefit: Employee/Spouse $5,000, Child(ren) $7,500
WELLNESS BENEFIT		
Health Screening/Wellness Benefit Amount	$100 per covered person per year; follow up test benefit $100	$100 per covered person per year; follow up test benefit $100
PLAN PROVISIONS		
Is There a Waiting Period for Claims in the First 30 Days?	No	No
Pre-existing Condition Limitation Period	12/12	12/12
ADDITIONAL INFORMATION		
Waiver of Premium	Included following a 60-day period of total disability due to cancer	Included following a 60-day period of total disability due to cancer
Conversion	Portability Included	Portability Included
Portability	Included	Included
RATES (MONTHLY)		
Employee Only	$20.16	$31.70
Employee & Spouse	$38.66	$60.96
Employee & Child(ren)	$27.38	$45.14
Employee & Family	$43.08	$69.22



Critical Illness Insurance

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

The plan provides a lump-sum benefit payment to you upon first and second diagnosis of any covered critical illness. The benefit can help cover expenses such as lost income, out-of-town treatments, special diets, daily living, and household upkeep costs.



Watch and learn more!

Critical Illness Insurance Benefits Summary

CRITICAL ILLNESS – UNUM	
COVERAGE AMOUNTS	
Employee Benefit Amount(s)	$10,000, $20,000, $30,000
Spouse Benefit Amount Maximum	100% of EE
Child(ren) Benefit Amount Maximum	100% of EE
COVERED CONDITIONS	
Full Coverage End Stage Renal (Kidney) Failure, Heart Attack (Myocardial Infarction), Major Organ Failure Requiring Transplant, Stroke, Benign Brain Tumor, Coma, Loss of Hearing, Loss of Sight, Loss of Speech, Occupational HIV or Hepatitis, Permanent Paralysis, ALS, Dementia and Alzheimer's Disease, Functional Loss, Multiple Sclerosis, Parkinson's Disease.	100% of benefit amount
Partial Coverage Coronary Artery Disease (Major) Coronary Artery Disease (Minor) Infectious Disease	 50% 10% 25%
Childhood Conditions Cerebral Palsy, Cleft Lip or Palate, Cystic Fibrosis, Down Syndrome, Spina Bifida	100% of benefit amount
Wellness Benefit One per covered person per calendar year	$50

Critical Illness Insurance Rates

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

Critical Illness Insurance

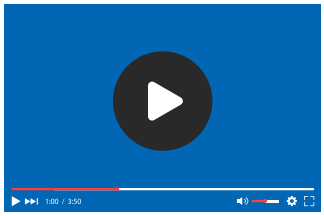
CRITICAL ILLNESS – UNUM			
EMPLOYEE MONTHLY COST			
Age	**$10,000**	**$20,000**	**$30,000**
<25	$2.94	$4.04	$5.14
25–29	$3.24	$4.64	$6.04
30–34	$3.64	$5.44	$7.24
35–39	$4.34	$6.84	$9.34
40–44	$5.24	$8.64	$12.04
45–49	$6.74	$11.64	$16.54
50–54	$8.64	$15.44	$22.24
55–59	$10.64	$19.44	$28.24
60–64	$14.74	$27.64	$40.54
65–69	$22.34	$42.84	$63.34
70-74	$40.14	$78.44	$116.74
75-79	$67.84	$133.84	$199.84
80-84	$115.94	$230.04	$344.14
85+	$211.14	$420.44	$629.74

Spouse rate is based on your Spouse's insurance age, which is their age immediately prior to and including the anniversary/effective date.

Accident Insurance

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

This plan helps offset the direct and indirect expenses such as copayments, deductibles, ambulance, physical therapy, childcare, rent, and other costs not covered by traditional health plans. Do you have kids playing sports? Are you a weekend warrior? Are you accident prone? With this accident plan, you will be paid a specific sum of money directly based on the care and services provided for your covered accident. Use the money any way you see fit.



Watch and learn more!

Accident Insurance Benefits Summary

ACCIDENT – CIGNA		
	Plan 1	**Plan 2**
Emergency Care Treatment	$100	$200
Physician Office Visit (Includes Urgent Care)	$100	$200
Diagnostic Exam (x-ray or lab)	$100	$200
Ground or Water Ambulance / Air Ambulance	$300 / $1,200	$400 / $1,600
Hospital Admission	$500	$1,500
Intensive Care Unit Admission	$500	$1,500
Hospital Stay	$100	$300
Intensive Care Unit Stay	$300	$600
Per covered surgically-repaired fracture	$100-$4,000	$200-$8,000
Per covered non-surgically-repaired fracture	$50-$2,000	$100-$4,000
Chip Fracture (percent of fracture benefit)	25%	25%
Per covered non-surgically-repaired dislocation	$50-$2,000	$100-$3,000
Accidental Death and Dismemberment Benefit	Loss of Life: $25,000-$75,000 / Dismemberment: $1,000-$20,000	Loss of Life: $50,000-$100,000 / Dismemberment: $2,000 - $30,000
RATES (MONTHLY)		
Employee Only	$5.00	$12.44
Employee & Spouse	$7.87	$19.60
Employee & Child(ren)	$8.34	$21.35
Employee & Family	$13.14	$33.27



for a healthy you

Telehealth with Behavioral Health

RECURO HEALTH

This voluntary telehealth program gives you 24/7 access to board-certified doctors, licensed counselors, and psychiatrists via your mobile device or computer – from home, the office, or on the go. Whether you need medical care or support navigating stress and life changes, confidential help is at your fingertips. It is a standalone program that is NOT tied to your medical plan coverage.

While telehealth with behavioral health does not replace your primary care physician, counselor, or psychiatrist, it is a convenient and cost-effective option when you need care and:

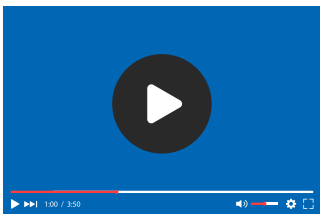
- Have a non-emergency issue and are considering an after-hours health care clinic, urgent care clinic, or emergency room for treatment
- Are on a business trip, vacation, or away from home
- Are unable to see your primary care physician, counselor, or psychiatrist

When to Use Telehealth

For minor conditions such as:

- Sore throat
- Headache
- Stomachache
- Cold/flu
- Allergies
- Fever
- Urinary tract infections
- Behavioral health

TELEHEALTH WITH BEHAVIORAL HEALTH	
MONTHLY RATES	
Employee Only	$14.00
Employee & Family	$14.00



Watch and learn more!

YOUR TELEHEALTH WITH BEHAVIORAL HEALTH COPAY IS $0!*

* For psychiatric care, you may pay a $0 copay.



Get More Information and Register

Skip the trip to your doctor! Set up your account so you can get on-demand medical care.

Visit **www.recurohealth.com.**

Call **855-673-2876**.

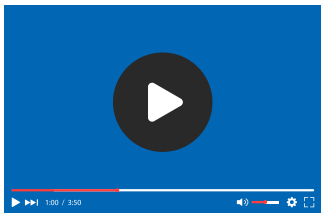
Download the **Recuro app.**

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

Emergency Medical Transport

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

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



Watch and learn more!

For More Information

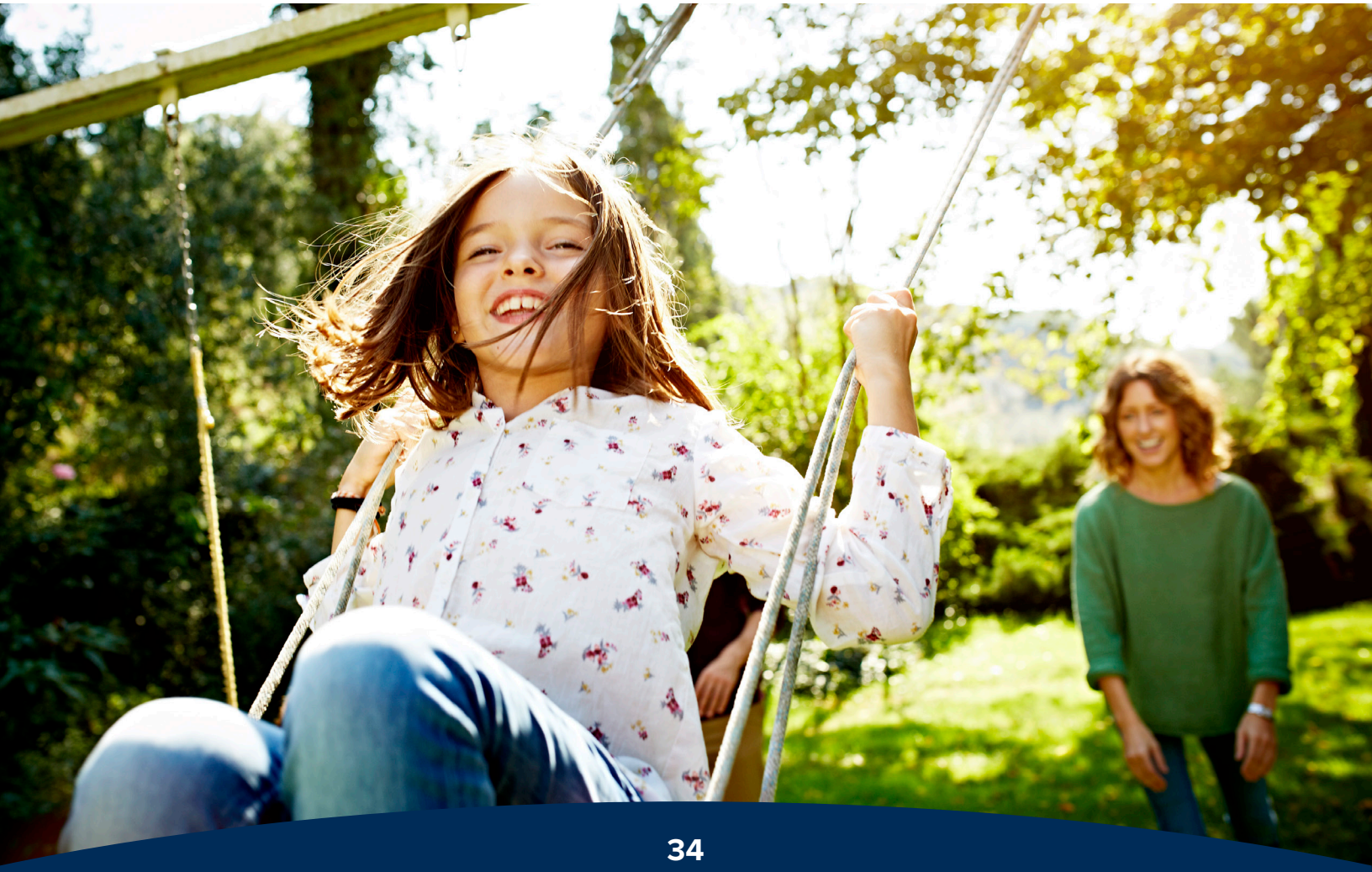
Visit **www.masamts.com**.

Call **800-423-3226**.

Download the **MASA Global app**.

Monthly Rate

$14.00 for both you and your family



Employee Assistance Program

The EmployeeConnect Employee Assistance Program (EAP) helps you and family members cope with a variety of personal and work-related issues.

This program provides confidential counseling and support services at little or no cost to you to help with:

- Relationships
- Work-life balance
- Stress and anxiety
- Will preparation and estate resolution
- Grief and loss
- Childcare and eldercare issues
- Substance abuse
- Financial and legal matters
- And more



For 24/7 Support and More Information

Visit **www.guidanceresources.com**.

Call **888-628-4824**.

Download the **GuidanceNow**.

Support at Any Hour of the Day or Night!

The EAP also offers up to five face-to-face counseling sessions per person, per issue, per calendar year.

Identity Theft Protection and Financial Wellness

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



To Learn More

Visit **www.experian.com**.

Call **855-797-0052**.

Download the **Experian.**

Identity Theft Protection

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

Financial Wellness Tools

- Link all accounts for complete financial visibility
- AI-powered budgeting and cashflow tracking
- Spending summaries, payment reminders, and goal planning
- Credit education and personalized improvement tips

IDENTITY THEFT – EXPERIAN		
RATES (MONTHLY)	**Elite Plan**	**Premium Plan**
Employee Only	$7.50	$4.50
Employee & Family	$14.00	$10.50

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Glossary of Terms

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

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

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

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

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

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

THE*benefits*HUB – This is the benefits enrollment system used by HPS.

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

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

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

Important Legal Notices

Women's Health and Cancer Rights Act of 1998

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

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

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

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

Special Enrollment Rights

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

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

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

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

Marriage, Birth or Adoption

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

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Barbers Hill ISD
Human Resources
9600 Eagle Drive
Mont Belvieu, TX 77523
281-576-2221

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 Barbers Hill 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. Barbers Hill ISD has determined that the prescription drug coverage offered by the Barbers Hill 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 not considered Creditable Coverage.

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

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

Important Legal Notices

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting Barbers Hill 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 Barbers Hill 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 **281-576-2221**.

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
Barbers Hill ISD
Human Resources
9600 Eagle Drive
Mont Belvieu, TX 77523
281-576-2221

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 Barbers Hill 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:

Important Legal Notices

Barbers Hill ISD
Human Resources
9600 Eagle Drive
Mont Belvieu, TX 77523
281-576-2221

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.

Important Legal Notices

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.

Important Legal Notices

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.

Important Legal Notices

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**.

Important Legal Notices

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2026. Contact your State for more information on eligibility.

Alabama – Medicaid

Website: http://www.myalhipp.com/
Phone: 1-855-692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

Arkansas – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

California– Medicaid

Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

Colorado – Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+)

Health First Colorado website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

Florida – Medicaid

Website: https://www.flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

Georgia – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

Indiana – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

Iowa – Medicaid and CHIP (Hawki)

Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

Kansas – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

Important Legal Notices

Kentucky – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

Louisiana – Medicaid

Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

Maine – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

Massachusetts – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

Minnesota – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

Missouri – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

Montana – Medicaid

Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

Nebraska – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

Nevada – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

New Hampshire – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

New York – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

North Carolina – Medicaid

Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

North Dakota – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

Oklahoma – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

Oregon – Medicaid

Website: https://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

Pennsylvania – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/chip/pages/chip.aspx
CHIP Phone: 1-800-986-KIDS (5437)

Rhode Island – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

South Carolina – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

South Dakota – Medicaid

Website: https://dss.sd.gov
Phone: 1-888-828-0059

Important Legal Notices

Texas – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493
Utah – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
Vermont– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427
Virginia – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
Washington – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
West Virginia – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
Wisconsin – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
Wyoming – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

Continuation of Coverage Rights Under COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you are covered under the Barbers Hill ISD group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the Barbers Hill 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

Barbers Hill ISD
Human Resources
9600 Eagle Drive
Mont Belvieu, TX 77523
281-576-2221

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.

Important Legal Notices

- 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.

Important Legal Notices

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, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact 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: Barbers Hill ISD		
5. Employer Address: 9600 Eagle Drive	**6. Employer Phone Number:** 281-576-2221	
7. City: Mont Belvieu	**8. State:** TX	**9. ZIP Code:** 77523
10. Who can we contact at this job?: Hope Rhodes		
11. Phone Number (if different from above): 281-576-2221	**12. E-Mail Address:** hope.rhodes@bhisd.net	

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.

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This brochure highlights the main features of the Barbers Hill 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. Barbers Hill ISD reserves the right to change or discontinue its employee benefits plans anytime.