26|27
Employee Benefits Guide



LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

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Important Contacts

HPS Benefits Call Center
Higginbotham Public Sector
833-970-2119
laketravisisd@hps.higginbotham.net

LTISD Human Resources
512-533-6024
benefits@ltisdschools.org

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

Pharmacy
Prime Therapeutics
800-423-1973
www.primetherapeutics.com

Prescription Savings
Clever RX
800-873-1195
http://www.cleverrx.com/laketravisisd

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

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

Dental
Humana
866-427-7478
www.humana.com

Vision
EyeMed
866-800-5457
www.eyemed.com

Life/AD&D/Critical Illness
MetLife
800-438-6388
www.metlife.com

Educator Disability/ Accident
The Hartford
888-277-4767
www.thehartford.com

Hospital Indemnity
Aetna
855-513-9865
www.aetna.com

Employee Assistance Program
Alliance Work Partners
800-343-3822
www.awpnow.com

Financial Planning 403(b) Plan
TCG
800-943-9179
www.tcgservices.com

Visit **www.mybenefitshub.com/laketravisisd** for full plan details.

Welcome

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

Availability Of Summary Health Information

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



How to Enroll

Login Process

1. **www.mybenefitshub.com/laketravisisd**
2. Click *Login*.
3. Enter your information:
   - Last name
   - Date of birth
   - Last four digits of your Social Security number

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



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 **833-970-2119** 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 **laketravisisd@hps.higginbotham.net**. Bilingual representatives are available.

How to Enroll

Enrollment FAQs

What if I miss the enrollment deadline?

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

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

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

Where do I find benefit summaries and forms?

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

How do I find an in-network provider?

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

When will I get my ID cards?

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

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

Benefit questions?

- Ask your Benefits Department
- Call Higginbotham Public Sector at **833-970-2119**

Important Limitations and Exclusions Information

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

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

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

Are there FSA/HSA limitations for married couples?

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

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

Eligibility

Who is Eligible for Benefits

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

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

See page 5 for Important Exclusions and Limitations.

About Your Coverage Effective Date

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

New Hire

Who is Eligible

- A regular, full-time employee working an average of 25 hours per week

When to Enroll

- Enroll by the deadline given by Human Resources

When Coverage Starts

- First day of work concurrent with the plan effective date



Employee

Who is Eligible

- A regular, full-time employee working an average of 25 hours per week

When to Enroll

- Enroll during OE or when you have a QLE

When Coverage Starts

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

Dependent(s)

Who is Eligible

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

When to Enroll

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

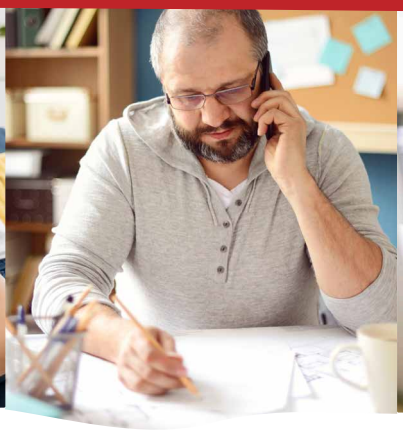
When Coverage Starts

- Based on OE or QLE effective dates

Maximum Dependent Eligibility Age by Plan	
To Age 25	To Age 26
AD&D	Medical/Dental/Vision/Life/ Accident/Hospital Indemnity/ Critical Illness

Qualifying Life Events






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

- Marriage
- Divorce
- Legal separation
- Annulment
- Birth
- Adoption
- Placement for adoption
- Change in benefits eligibility
- Death
- Undergoing FMLA, COBRA event, court judgment, or decree
- Becoming eligible for Medicare, Medicaid, or TRICARE
- Receiving a Qualified Medical Child Support Order
- Gain or loss of benefits coverage
- Change in employment status affecting benefits
- Significant change in cost of spouse's coverage

You must inform Human Resources and make any benefit changes within 30 days of the event.

Medical

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

- **Low Plan** – This HMO plan has a $1,750 Individual and a $5,250 Family in-network deductible.
- **High Plan** – This PPO plan has a $2,000 Individual and a $4,000 Family in-network deductible.
- **High Deductible Health Plan** – This HDHP has a $3,500 Individual and a $7,000 Family in-network deductible.

BlueCross BlueShield of Texas

Health Maintenance Organization (HMO)

With an HMO, you must seek care from in-network providers in the HMO network. The selection of a primary care physician is required and you do need a referral to see a specialist. It is best to confirm that your doctor and all specialists are in-network before seeking care.

Preferred Provider Organization (PPO)

A PPO allows you to see any provider when you need care. When you see in-network providers for care, you will pay less and get the highest level of benefits. You will pay more for care if you use out-of-network providers. When you see in-network providers, your office visits, urgent care visits, and prescription drugs are covered with a copay, and most other network services are covered at the deductible and coinsurance level.

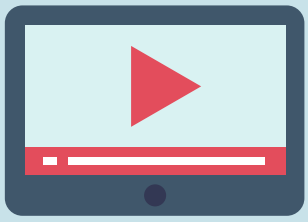
High Deductible Health Plan (HDHP)

An HDHP allows you to see any provider when you need care, and you will pay less for care when you go to in-network providers. In exchange for a lower per-paycheck cost for medical benefits, you must satisfy a higher plan deductible that applies to almost all health care expenses, including prescription drugs. If you enroll in the HDHP, you may be eligible to open a Health Savings Account (see page 12).

Find an In-Network Provider

Visit **www.bcbstx.com**

Call **800-521-2227**



Watch and learn more!



Visit **www.mybenefitshub.com/laketravisisd** for full plan details.

Medical

Medical Benefits Summary

	High Deductible Health Plan		High Plan		Low Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Calendar Year Deductible • Individual • Family	$3,500 $7,000	$7,000 $14,000	$2,000 $4,000	$2,500 $5,000	$1,750 $5,250
Out-of-Pocket Maximum Includes deductibles • Individual • Family	$6,900 $13,800	$13,800 $27,600	$6,000 $12,000	$9,000 $15,000	$7,000 $14,000
	You Pay		You Pay		You Pay
Preventive Care	$0	40%[1]	$0	40%[1]	$0
Telemedicine	$20 copay	Not covered	$20 copay	Not covered	$20 copay
Primary Care Physician	20%[1]	40%[1]	$30 copay	40%[1]	$40 copay
Specialist	20%[1]	40%[1]	$50 copay	40%[1]	$75 copay
Diagnostic Lab and X-ray	20%[1]	40%[1]	$0	40%[1]	25%[1]
Complex Imaging CT/PET scan, MRI	20%[1]	40%[1]	20%[1]	40%[1]	25%[1]
Urgent Care	20%[1]	40%[1]	$75 copay	40%[1]	$75 copay
Emergency Room	20%[1]		20% after $300 copay		25% after $300 copay
Inpatient Hospital Services	20%[1]	40%[1]	20% of allowable amount	40% of the allowable amount after the pre-admission deductible $250	25%[1]
Outpatient Services	20%[1]	40%[1]	20%[1]	40%[1]	25%[1]
Prescription Drugs – Retail Up to 30-day supply • Generic • Preferred brand name • Non-preferred brand name • Specialty	 20%[1] 20%[1] 20%[1] 20%[1]	 25%[1] 30%[1] 30%[1] Not covered	 $25 copay $40 copay $55 copay 20%	 $30 copay + 30% $55 copay + 30% $60 copay + 30% Not covered	 $25 copay $50 copay $75 copay 25%
Prescription Drugs – Mail Order Up to 90-day supply • Generic • Preferred brand name • Non-preferred brand name	 20%[1] 20%[1] 20%[1]	 Not covered	 $25 copay $40 copay $55 copay	 Not covered	 $25 copay $50 copay $75 copay
Monthly Contributions						
	LTISD	Employee	LTISD	Employee	LTISD	Employee
Employee Only	$500	**$88**	$500	**$354**	$500	**$225**
Employee & Spouse	$500	**$726**	$500	**$968**	$500	**$865**
Employee & Child(ren)	$500	**$560**	$500	**$854**	$500	**$747**
Employee & Family	$500	**$977**	$500	**$1,352**	$500	**$1,269**

[1] The amount you pay after the deductible is met.

Pharmacy

Your medical plan offers benefits for retail and mail order prescription drugs. Use in-network pharmacies to get your plan's highest level of benefits. Both the medical and drug deductible and out-of-pocket expenses are the same. All benefits — including prescription drug benefits — apply to the plan's overall deductible and out-of-pocket maximum.

BlueCross BlueShield of Texas

Keep your prescription drug costs down:

- Fill your prescriptions at an in-network pharmacy
- Ask your doctor if a generic drug is an option
- Use mail order for maintenance drugs
- Use the plan's specialty pharmacy service for specialty drugs

Need More Details?

Visit **www.bcbstx.com**

Call **800-521-2227**

In-Network Pharmacies

- HEB
- Walmart
- Randalls
- Albertsons (and affiliates)
- Walgreens



Clever RX Benefits

With **Clever RX**, you never have to overpay for prescriptions. When you use the Clever RX card or app, you get up to 80% off prescription drugs, discounts on thousands of medications, and usage at most pharmacies nationwide.

Step 1

Download the free Clever RX app and enter these numbers during the onboarding process:

- Group ID 1085
- Member ID 1111

Step 2

Use your ZIP code to find a local pharmacy with the best price for your medication — up to 80% off!

Step 3

Click the voucher with the lowest price, closest location, and/or at your preferred pharmacy and show the voucher to the pharmacist.

Questions?

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

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			
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 and strains	$	15-20 minutes
Retail Clinic Usually lower out-of-pocket cost than urgent care; when you can't see your doctor; located in stores and pharmacies **Hours vary based on store hours**	• Common infections • Minor injuries • Pregnancy tests • Vaccinations	$	15 minutes
Urgent Care When you need immediate attention; walk-in basis is usually accepted **Generally includes evening, weekend and holiday hours**	• Sprains and strains • Minor broken bones • Small cuts that may require stitches • Minor burns and infections	$$	15-30 minutes
Emergency Care			
Hospital ER Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility **24 hours a day, 7 days a week**	• Chest pain • Difficulty breathing • Severe bleeding • Blurred or sudden loss of vision • Major broken bones	$$$$	4+ hours
Freestanding ER Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher **24 hours a day, 7 days a week**	• Most major injuries except trauma • Severe pain	$$$$$	Minimal

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

Health Savings Account

A Health Savings Account (HSA) is a tax-exempt tool to supplement your retirement savings and to cover current and future health costs.

An HSA is a type of personal savings account that is always yours even if you change health plans or jobs. The money in your HSA (including interest and investment earnings) grows tax-free and spends tax-free if used to pay for current or future qualified medical expenses. There is no "use it or lose it" rule — you do not lose your money if you do not spend it in the calendar year — and there are no vesting requirements or forfeiture provisions. The account automatically rolls over year after year.

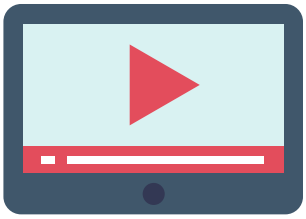
You Decide How To Use Your HSA Funds

Use it Now

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

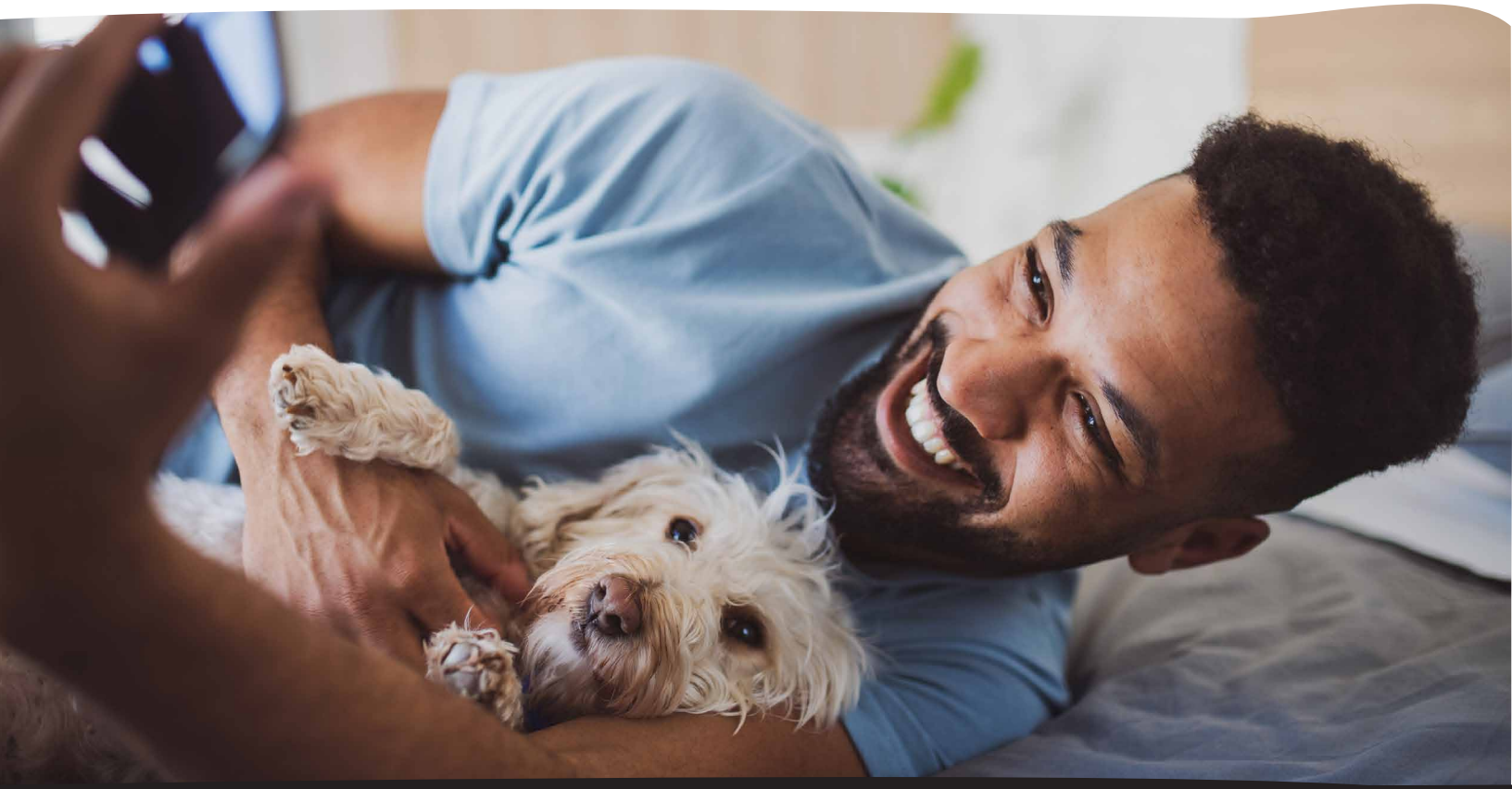
Let it Grow

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



Watch and learn more!

If you are age 55 or older, you may make a yearly catch-up contribution of up to $1,000 to your HSA. If you turn 55 at anytime during the plan year, you are eligible to make the catch-up contribution for the entire plan year.



Health Savings Account

HSA Contacts

- **Open an Account** – Sign up for 24/7 account access at **https://www.eecu.org**.
- **Online/Mobile** – Visit **https://www.eecu.org** or download the mobile app to find a local financial center, check your balance, pay bills, and more.
- **Call/Text** – **817-882-0800** for EECU member service.
- **Lost/Stolen Debit Card** – Call the 24/7 debit card hotline at **800-333-9934**.

Important HSA Information

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

HSA Eligibility

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

- Enrolled in an HSA-eligible HDHP
- Not covered by another plan that is not a qualified HDHP, such as your spouse's health plan
- Not enrolled in a Health Care 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

Maximum HSA Contributions	
2026	2027
$4,400 Individual	$4,500 Individual
$8,750 Family	$9,000 Family



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

Withdrawals for qualifying medical expenses are tax-free.

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.

How to Access Funds/Pay or Get Reimbursed

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

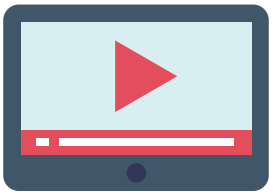
OR

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

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.



Watch and learn more!



Visit **www.mybenefitshub.com/laketravisisd** for full plan details.

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.

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

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

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)
Carryover	$610	No carryover (Use it or lose it)

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 (HSA)		Flexible Spending Account (FSA)
Internal Revenue Code	Section 223		Section 125
Description	An HSA is an actual bank account in your name that allows you to save and pay for unreimbursed qualified medical expenses tax-free.		An FSA allows you to pay out-of-pocket expenses tax-free for: • copays, deductibles, and certain services not covered by medical plan • qualifying dependent care
Employer Eligibility	A qualified High Deductible Health Plan		All employers
Contribution Source	You and/or your employer		You and/or your employer
Account Owner	Individual		Employer
Underlying Insurance Requirement	High Deductible Health Plan		None
Insurance Plan Minimum Deductible	**2026** • $1,700 single • $3,400 family	**2027** • $1,750 single • $3,500 family	N/A



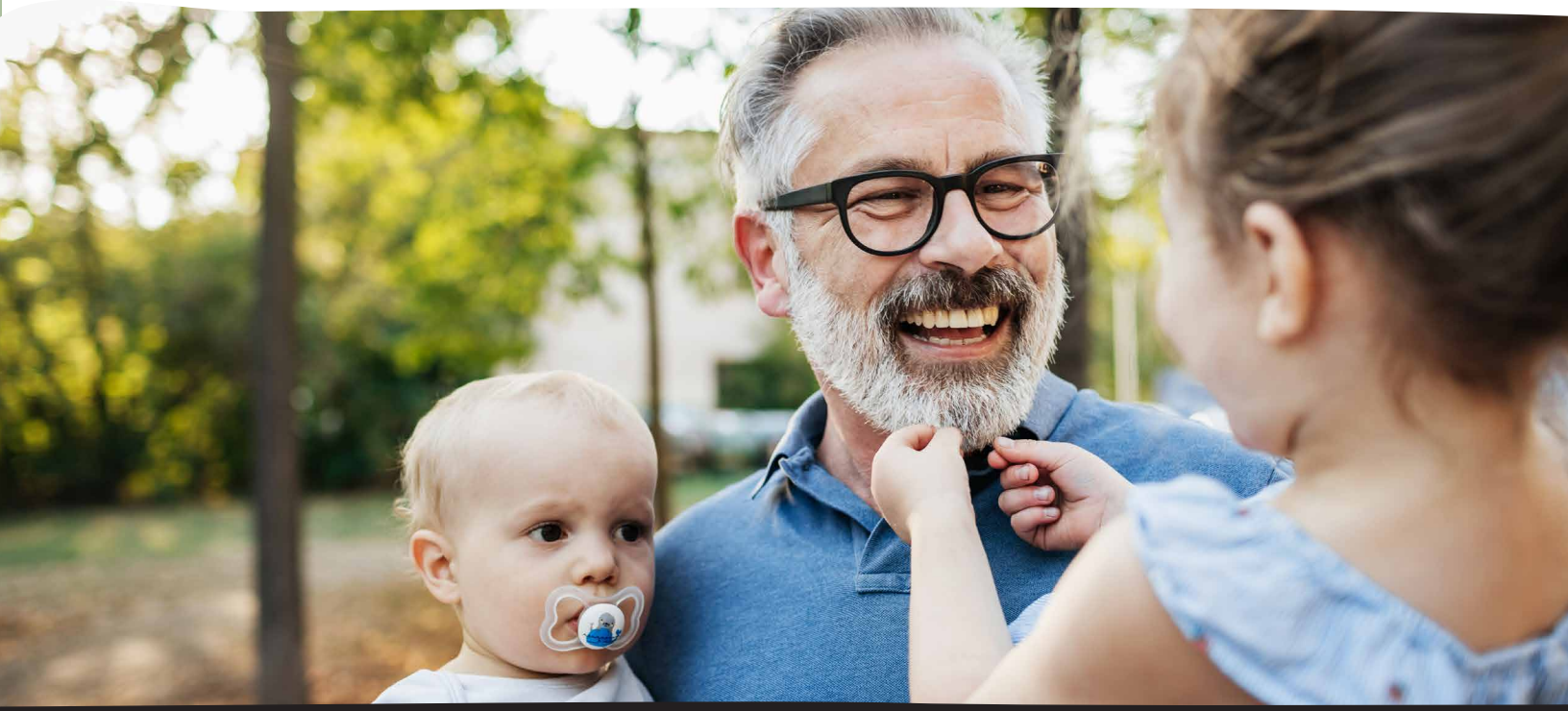
Visit **www.mybenefitshub.com/laketravisisd** for full plan details.

HSA and FSA Comparison

Flip to... 12 HSA 14 FSA



	Health Savings Account (HSA)		Flexible Spending Account (FSA)
Maximum Contribution	**2026** • $4,400 single • $8,750 family • $1,000 age 55+ catch-up	**2027** • $4,500 single • $9,000 family • $1,000 age 55+ catch-up	$3,500
Permissible Use of Funds	Use any way you wish. If used for non-qualified medical expenses, funds are subject to the current tax rate plus a 20% penalty.		Reimbursement for qualified medical expenses as defined in Section 213(d) of the Internal Revenue Code.
Cash-Outs of Unused Amounts (if no medical expenses)	Permitted, but subject to current tax rate plus 20% penalty (waived after age 65).		Not permitted
Year-to-year rollover of account balance?	Yes, it will roll over to use for subsequent year's health coverage.		No. Access to some funds may be extended if your employer's plan contains a 2½-month grace period or $640 (2025)/$660 (2026) rollover provision.
Does the account earn interest?	Yes		No
Portable?	Yes, it is portable year-to-year and between jobs.		No



Dental

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

Humana

Dental Benefits Summary

	Low Plan	High Plan
	In-Network[1]	In-Network[1]
Calendar Year Deductible • Individual • Family	$50 $150	$50 $150
Calendar Year Benefit Maximum Per Individual	$750	$1,000
	You Pay	You Pay
Preventive Services Cleanings, exams	$0	$0
Basic Services Fillings, extractions, X-rays	20% after deductible	20% after deductible
Major Services Bridges, dentures	75% after deductible	50% after deductible
Orthodontia Children only	Not covered	50% $1,000 lifetime maximum
Employee Monthly Contributions		
Employee	$19.71	$47.56
Employee & Spouse	$39.45	$91.34
Employee & Child(ren)	$52.88	$118.40
Employee & Family	$83.65	$162.12

[1] Refer to your plan documents for out-of-network coverage.

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.

Find an In-Network Provider

Visit **www.humana.com**

Call **800-233-4013**



Watch and learn more!

Visit **www.mybenefitshub.com/laketravisisd** for full plan details.

Vision

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

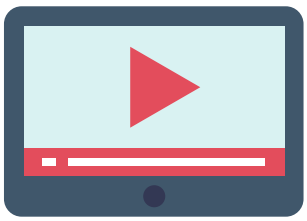
You may seek care from any vision provider, but the plan will pay the highest level of benefits when you see in-network providers, which include Target Optical, Pearle Vision, LensCrafters, and thousands of independent providers.

Vision Benefits Summary

	Vision Plan	
	In-Network You Pay	Out-of-Network Reimbursement
Exam	$10 copay	Up to $40
Lenses		
• Single vision	$25 copay	Up to $30
• Lined bifocals	$25 copay	Up to $50
• Lined trifocals	$25 copay	Up to $70
• Lenticular	$25 copay	Up to $70
• Standard progressive	$80 copay	Up to $50
• Premium progressive	$110-$240 copay	Up to $50
Frames	20% off balance over $130 allowance	Up to $65
Contacts		
In lieu of frames and lenses		
• Conventional	15% off balance over $130 allowance	Up to $65
• Disposable	Balance over $130 allowance	Up to $65
• Medically necessary	$0	Up to $300
Benefit Frequency		
Exam	Once every plan year	
Lenses	Once every plan year	
Frames	Once every plan year	
Contacts	Once every plan year	
Employee Monthly Contributions		
Employee	$5.91	
Employee & Spouse	$11.23	
Employee & Child(ren)	$11.82	
Employee & Family	$17.40	

Discounts

- 40% off additional complete pair of prescription eyeglasses
- 20% off non-covered items, including non-prescription sunglasses



Watch and learn more!



Find an In-Network Provider

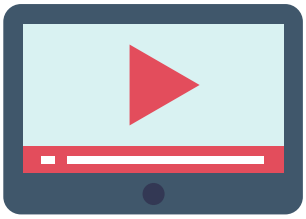
Visit **www.eyemed.com**

Call **866-800-5457**

Life and AD&D Insurance

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

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



Watch and learn more!

Basic Term Life and AD&D

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

Supplemental Term Life

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

Designating a Beneficiary

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



Life and AD&D Insurance

Supplemental AD&D

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

Supplemental AD&D Coverage Amounts

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

Supplemental Coverage Highlights

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

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

Supplemental Term Life and AD&D Insurance	
Employee	• Increments of $10,000 up to five times basic annual earnings not to exceed $250,000
Spouse	• Increments of $5,000 up to $60,000 not to exceed 50% of employee amount
Child(ren)	• Birth to six months – $1,000 • Six months to age 26 – Increments of $1,000 up to $10,000

Supplemental Term Life Rates per $1,000		
Age	Employee	Spouse[1]
<20	$0.020	$0.040
20-24	$0.030	$0.040
25-29	$0.030	$0.040
30-34	$0.030	$0.040
35-39	$0.050	$0.060
40-44	$0.070	$0.080
45-49	$0.110	$0.130
50-54	$0.170	$0.220
55-59	$0.260	$0.410
60-64	$0.360	$0.850
65-69	$0.670	$1.830
70-74	$1.090	$3.460
75+	$1.850	N/A

Child(ren)	
To age 26	$0.180

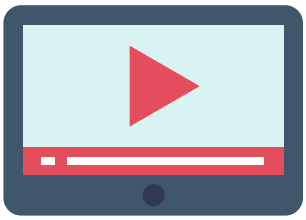
Supplemental AD&D Rates per $1,000		
Employee	Spouse	Child(ren)
$0.020	$0.020	$0.020

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

Educator Disability

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

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Watch and learn more!

Educator Disability	
Benefits Begin The first number indicates the number of days you must be disabled due to **Injury** and the second number indicates the number of days you must be disabled due to **Sickness**.	0/7[1] 14/14[1] 30/30[1] 60/60 90/90 180/180
Percentage of Earnings You Receive	Up to 66 2/3%
Maximum Weekly Benefit	Between $200 and $8,000
Maximum Benefit Period	Varies based on schedule selected and age at disability
Pre-existing Condition Exclusion	3/12[2]

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

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



Educator Disability FAQ

What is disability insurance?

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

Does this plan have pre-existing condition limitations?

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

Will I get all of my disability benefit?

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

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

File a Disability Claim

Call **888-277-4767**

Access **www.mybenefitshub.com/laketravisisd**

Educator Disability

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

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

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

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

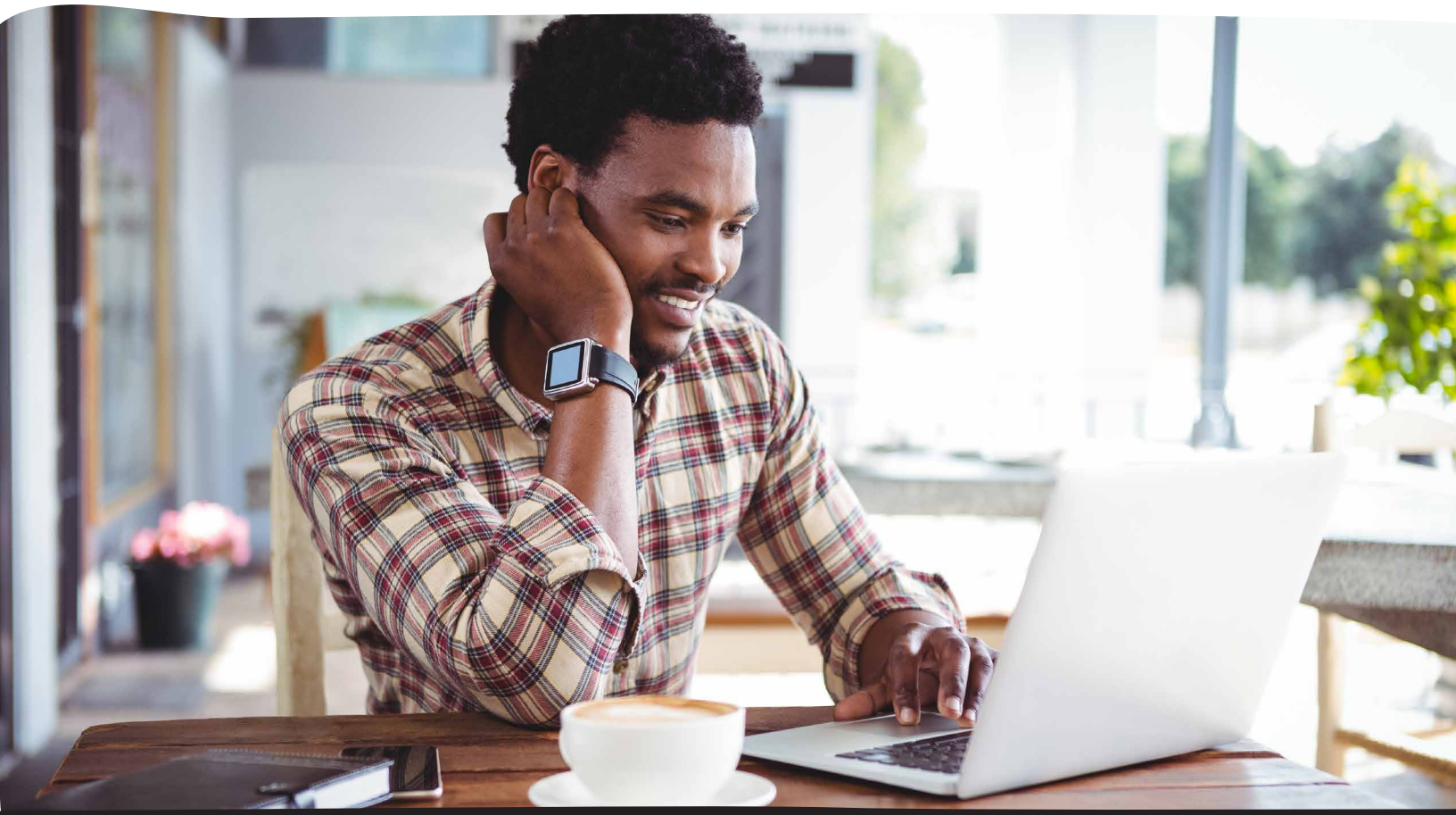
  When choosing your elimination period, determine how long you could go without a paycheck. Choose your elimination period based on your answer.

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

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

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

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

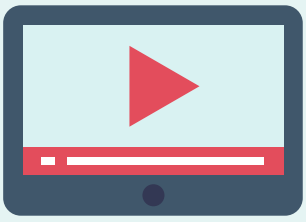


Hospital Indemnity Insurance

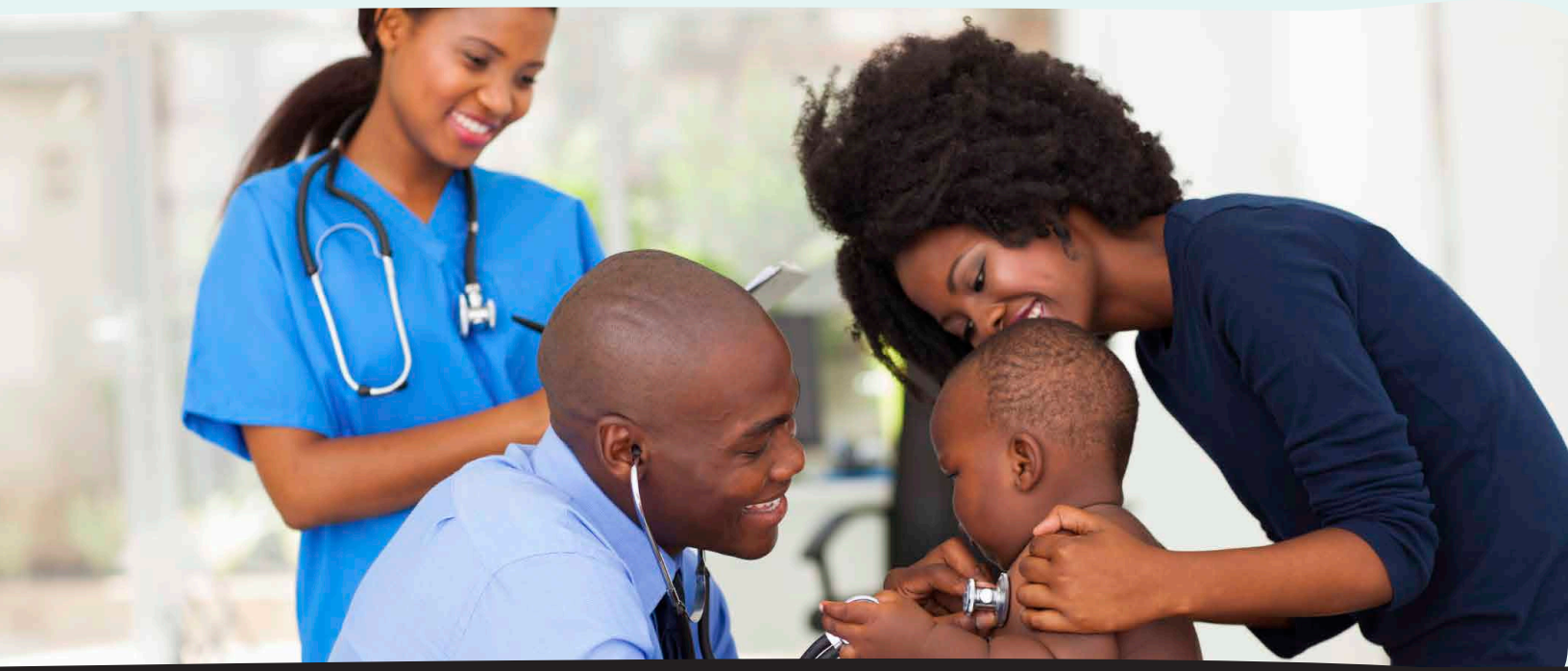
The Hospital Indemnity plan helps you with the high cost of medical care by paying you a cash benefit when you have an inpatient hospital stay. Unlike traditional insurance which pays a benefit to the hospital or doctor, this plan pays you directly. It is up to you how you want to use the cash benefit.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

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Hospital Indemnity Insurance		
	Low Plan	High Plan
Hospital Admission	$750	$1,500
Hospital Confinement	$50 per day up to 30 days	$100 per day up to 30 days
ICU Confinement	$100 per day up to 30 days	$200 per day up to 30 days
Employee Monthly Contributions		
Employee	$8.83	$17.24
Employee & Spouse	$18.64	$36.61
Employee & Child(ren)	$13.94	$27.13
Employee & Family	$22.35	$43.63



Watch and learn more!



Visit **www.mybenefitshub.com/laketravisisd** for full plan details.

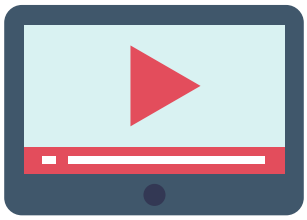
Accident Insurance

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

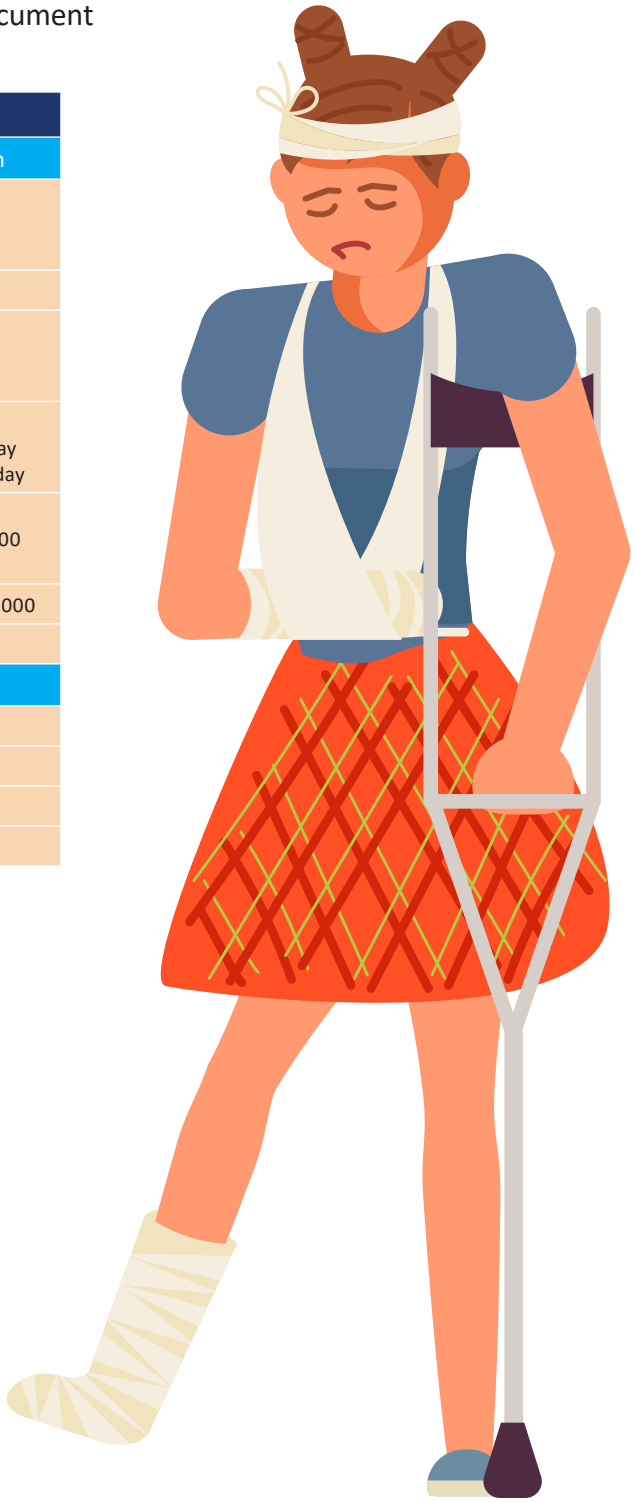
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Accident Insurance		
	Low Plan	High Plan
Ambulance • Ground • Air	 $750 $1,500	 $1,000 $2,000
Emergency Room	$250	$300
Admission • Hospital • ICU	 $1,500 $3,000	 $2,000 $4,000
Confinement • Hospital – up to 90 days per accident • ICU – up to 15 days	 $250 per day $500 per day	 $500 per day $1,000 per day
Specific Sum Injuries Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, and more	$100-$8,000	$200-$10,000
Accidental Death & Dismemberment[1]	$13,000-$50,000	$20,000-$80,000
Health Screening Benefit	$50	$50
Employee Monthly Contributions		
Employee	$6.12	$10.83
Employee & Spouse	$10.28	$17.92
Employee & Child(ren)	$11.48	$20.90
Employee & Family	$18.16	$32.77

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



Watch and learn more!



Critical Illness Insurance

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

Critical Illness Insurance	
Employee	Increments of $5,000 up to $50,000
Spouse	50% of employee amount
Children	50% of employee amount
First Occurrence Benefit	
Full Coverage Benign brain tumor, invasive cancer, coma, loss of speech, loss of hearing, loss of sight, heart attack, kidney failure, major organ transplant, ALS, Alzheimer's disease, multiple sclerosis, muscular dystrophy, advanced Parkinson's disease, systemic lupus erythematosus (SLE), severe burns, stroke	100% of benefit amount
Partial Coverage Non-invasive cancer, coronary artery bypass, sudden cardiac arrest, infectious diseases	25%-50% of benefit amount
Childhood Diseases Cerebral palsy, cleft lip/palate, cystic fibrosis, Type 1 diabetes, Down syndrome, sickle cell anemia, spina bifida	100% of benefit amount

Watch and learn more!

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



Employee Assistance Program

An Employee Assistance Program (EAP) helps you and family members cope with a variety of personal or work-related issues. **Get confidential counseling and support services from licensed professionals at little or no cost to help with:**

- Relationships
- Work/life balance
- Stress and anxiety
- Grief and loss
- Childcare and eldercare resources
- Substance abuse
- Addiction
- And more

Get 24/7 Support

Visit **www.awpnow.com/main**

Call **800-343-3822**



Financial Planning

403(b) Retirement Plan

A 403(b) plan can be a powerful tool to help you reach your investment goals and be financially secure in retirement.

How the Plan Works

You are eligible to participate in the plan if you are a full-time employee, age 18 or older, and have 90 days of service with the company. You may contribute up to the IRS annual limits.

You decide how much you want to contribute, and you can change your contribution amount anytime. All changes are effective as soon as administratively feasible and remain in effect until you update or stop your contributions. You also decide how to invest the assets in your account.

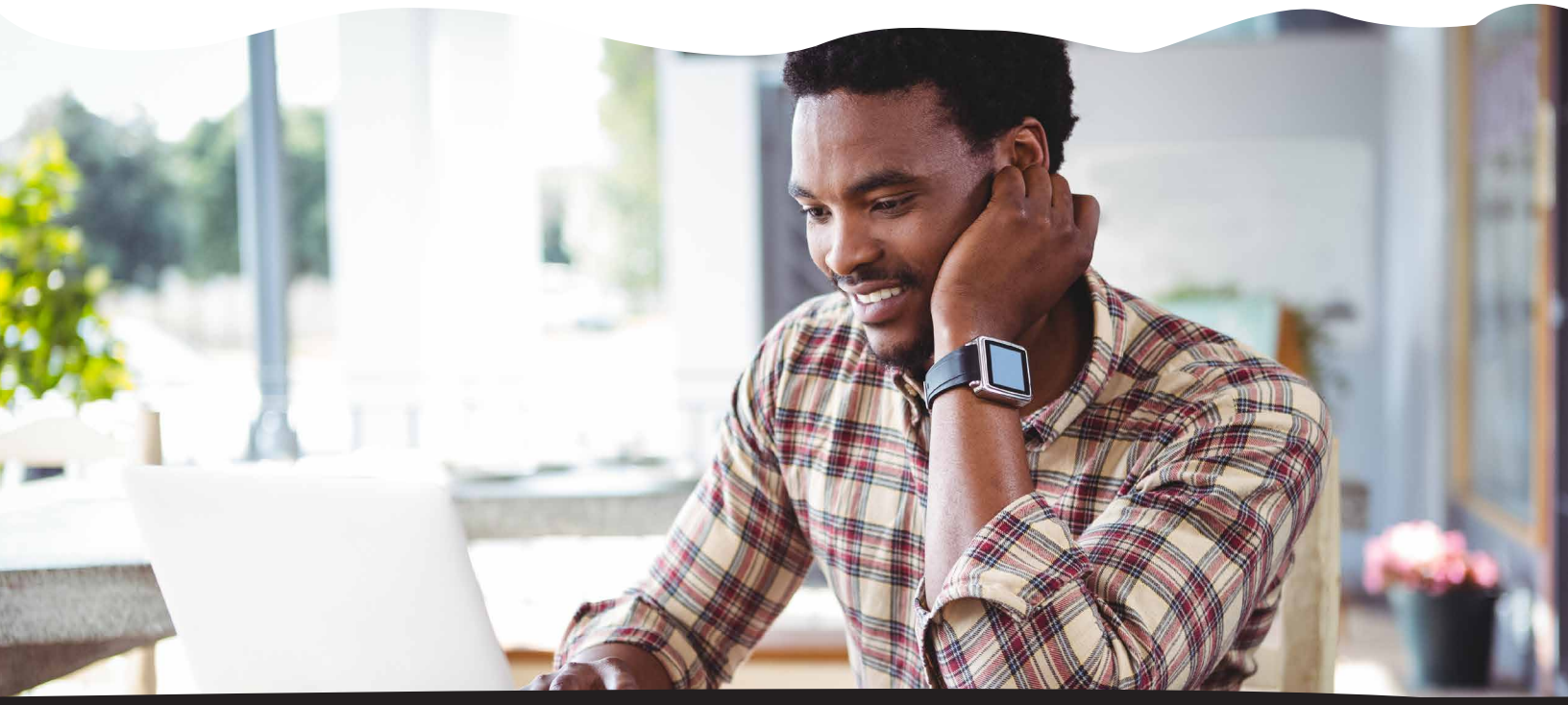
To Enroll and Get More Information

Visit **www.tcgservices.com**

Call **800-943-9179**

2026 IRS Contribution Limits

- $24,500
- $8,000 additional catch-up contribution (ages 50-59 and 64+)
- $11,250 additional catch-up contribution (ages 60-63)



Glossary

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

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

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

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

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

Employer Contribution – The amount Lake Travis ISD contributes to the cost of your benefits.

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



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

Generic Drugs – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding brand name versions. The color or flavor of a generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.

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

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

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

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

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

Over-the-Counter (OTC) Medications – Medications typically made available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier.

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

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

SSNRA – Social Security Normal Retirement Age.

Important Legal Notices

Women's Health and Cancer Rights Act of 1998

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

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

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

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

Special Enrollment Rights

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

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

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

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

Marriage, Birth or Adoption

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

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Lake Travis ISD
Human Resources
3322 Ranch Road 620 S.
Austin, TX 78738
512-533-6024

Medicare Part D Non-Creditable Coverage Notice

Important Notice from Company about 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 Lake Travis ISD and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Lake Travis ISD has determined that the prescription drug coverage offered by the Lake Travis ISD is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Lake Travis ISD plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from Lake Travis ISD. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

When Can You Join A Medicare Drug Plan?

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

Important Legal Notices

However, if you decide to drop your current coverage with [Insert Name of Entity], since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Plan.

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

Since the coverage under Lake Travis ISD, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, your current coverage will be affected. Coverage between the Lake Travis ISD plan and Medicare Part D may be coordinated. For employers with fewer than 20 employees, Medicare will be the primary payer and group health plan coverage could be impacted.

If you do decide to join a Medicare drug plan and drop your current Lake Travis ISD coverage, be aware that you and your dependents may not be able to get this coverage back until open enrollment or if a HIPAA special enrollment right is triggered.

For More Information about This Notice or Your Current Prescription Drug Coverage

Contact the Human Resources office for further information, or call the phone number on the back of your medical insurance ID card. Please note you will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, as well as if this coverage through Lake Travis ISD changes. You also may request a copy of this notice at any time.

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'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

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

Newborns' and Mother's Health Protection Act

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

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 describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

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

Important Legal Notices

Your Choices

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

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

Our Uses And Disclosures

We may use and share your information as we:

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

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no," for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

Important Legal Notices

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

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

1. Help manage the health care treatment you receive
   - » We can use your health information and share it with professionals who are treating you.

     Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
2. Run our organization
   - » We can use and disclose your information to run our organization and contact you when necessary.
   - » We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

     Example: We use health information about you to develop better services for you.
3. Pay for your health services
   - » We can use and disclose your health information as we pay for your health services.

     Example: We share information about you with your dental plan to coordinate payment for your dental work.
4. Administer your plan
   - » We may disclose your health information to your health plan sponsor for plan administration.

     Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

1. Help with public health and safety issues

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

   We can use or share your information for health research.
3. Comply with the law

   We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
4. Respond to organ and tissue donation requests and work with a medical examiner or funeral director
   - » We can share health information about you with organ procurement organizations.
   - » We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
5. Address workers' compensation, law enforcement, and other government requests

   We can use or share health information about you:
   - » For workers' compensation claims
   - » For law enforcement purposes or with a law enforcement official
   - » With health oversight agencies for activities authorized by law
   - » For special government functions such as military, national security, and presidential protective services
6. Respond to lawsuits and legal actions

   We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Important Legal Notices

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the Terms of This Notice

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

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:

Lake Travis ISD
Human Resources
3322 Ranch Road 620 S.
Austin, TX 78738
512-533-6024

Effective Date

This Notice is effective February 15, 2026.

Patient Protection and Choice of Providers

In cases where the Lake Travis ISD Group Health Plan allows or requires a participant to designate a primary care provider, the participant has the right to designate any primary care provider who participates in the network and who is available to accept the participant or participant's family members.

Until you make this designation, Lake Travis ISD Group Health Plan may designate a primary care provider automatically. For information on how to select a primary care provider, and for a list of the participating primary care providers, you can contact your Employer Representative.

For children, you may designate a pediatrician as the primary care provider.

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

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

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

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

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

Important Legal Notices

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

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

Continuation of Coverage Rights Under COBRA

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

Lake Travis ISD
Human Resources
3322 Ranch Road 620 S.
Austin, TX 78738
512-533-6024

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

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

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

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

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

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

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



Higginbotham™
Public Sector

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