

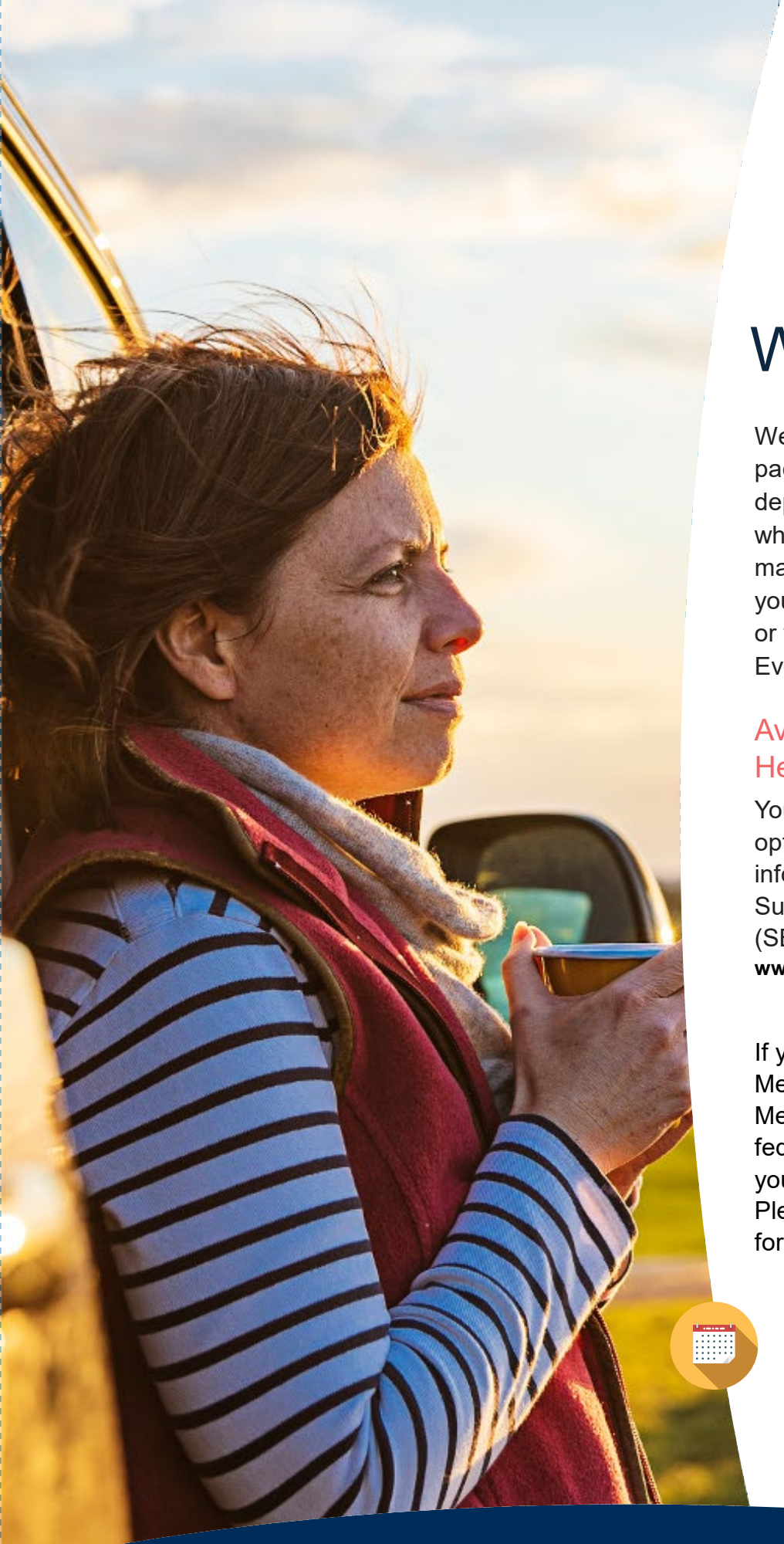
2026
2027

EMPLOYEE BENEFITS GUIDE

for a healthy you

CENTRAL TEXAS EBC

PRIVACY.FLOWCODE.COM



for a healthy you

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.ctxebc.com.**

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

YOUR NEW BENEFITS BEGIN AND END

September 1, 2026 - August 31, 2027

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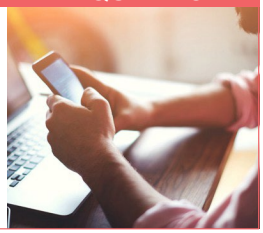

YOUR BENEFITS

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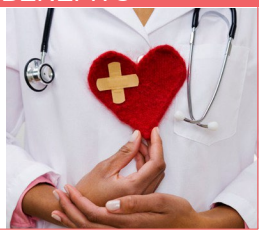




Important Contacts

CTXEBC Benefits
Higginbotham Public Sector
833-931-6514
www.ctxebc.com
ctxebc@hps.higginbotham.net

Hospital Indemnity
CHUBB
888-499-0425
www.chubb.com

Vision
Superior Vision
800-507-3800
www.superiorvision.com

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

Critical Illness
CHUBB
888-499-0425
www.chubb.com

Flexible Spending Account (FSA)
National Benefit Services
855-399-3035
www.nbsbenefits.com

Prescription Savings
Clever RX
Group #1085
800-873-1195
https://cleverrx.com/

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

Disability
UNUM
800-858-6843
www.unum.com

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

Identity Theft
ID Watchdog
800-774-3772
www.idwatchdog.com

Legal Services
LegalShield
800-654-7757
www.legalshield.com

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

Dental
FCL Dental
877-493-6282
www.fcldental.com

Life And AD&D
UNUM
800-445-0402
www.unum.com

Accident
CHUBB
888-499-0425
www.chubb.com

Emergency Medical Transport
MASA
Group #MKTR8
800-970-5182
www.masamts.com

Function Health
https://www.functionhealth.com/aep/higginbotham



How to Enroll

LOGIN PROCESS	
1	Go to **www.ctxebc.com**.
2	Click Login.
3	Enter your information: • Last name • Date of birth • Last four digits of your Social Security number Note: THEbenefitsHUB 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.

Enrollment FAQ

What if I miss the enrollment deadline?

You may only enroll 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.ctxebc.com,** click on benefit information, and then on the benefit you need (e.g., Dental).

How do I find an in-network provider?

Access **www.ctxebc.com** and click on the provider search option.

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?

Call **833-931-6514**

Email **ctxebc@hps.higginbotham.net**

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 Important Exclusions and Limitations for details.

New Hire

Who is Eligible

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

When to Enroll

- Enroll by the deadline given by Human Resources

When Coverage Starts

- First day of work concurrent with the plan effective date

Employee

Who is Eligible

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

When to Enroll

- Enroll during OE or when you have a QLE

When Coverage Starts

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

Dependent(s)

Who is Eligible

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

When to Enroll

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

When Coverage Starts

- Based on OE or QLE effective dates

MAXIMUM DEPENDENT ELIGIBILITY AGE BY PLAN	
Plan	**To Age**
Hospital Indemnity, Dental, Vision, Life, Cancer, Critical Illness, AD&D, Individual Life, Accident, Identity Theft, Emergency Transportation	26
Dependent Care Flexible Spending Account	Under the age of 13 or a qualified individual who is unable to care for themselves and claimed as a dependent on your taxes
Flexible Spending Account	Through age 25 or IRS tax dependent
Health Savings Account	IRS tax dependent

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.

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



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

HSA and FSA Comparison

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

	HEALTH SAVINGS ACCOUNT (HSA)	HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)
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.	• **HealthCare FSA**: Use funds to pay qualified medical, dental, and vision expenses. • **Limited Purpose HealthCare FSA**: Use funds to pay qualified dental and vision expenses only. • **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 Contribution	**2026** • Individual: $4,400 • Family: $8,750 • Age 55+ Additional Catch Up $1,000	**2026** • HealthCare FSA: $3,400 • Limited Purpose HealthCare FSA: $3,400 • Dependent Care FSA: $7,500 (Single parent filing head of household, or married filing jointly) or $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** box above.
Year-to-year rollover of account balance?	Yes. Funds roll over and can be used anytime or saved for future use.	**2026** • HealthCare FSA: Allows for carryover of $680 to the next plan year OR an extended grace period after the end of the plan year (typically 2 ½ months) to spend remaining funds. • Limited Purpose HealthCare FSA: Same as HealthCare FSA • 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

FLIP TO... 14 HSA 49 FSA

Qualified HSA and FSA Expenses





The products and services listed below are examples of medical expenses eligible for payment under your Health Care FSA and/or Health Savings Account. This list is not all-inclusive; additional expenses may qualify, and the items listed are subject to change in accordance with IRS regulations.

Please refer to IRS Publication 502 Medical and Dental Expenses at **www.irs.gov** for a complete description of eligible medical and dental expenses.

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



TRS-ActiveCare
REGION 12

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

LEARN THE TERMS

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

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

How to Calculate Your Monthly Premium

Total Monthly Premium
− Your Employer Contribution

= Your Premium

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

Being Healthy is Easy

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

** Eligibility rules may apply.*

See the Annual Enrollment Guide for more details.

Mental Health

You have in-office and virtual benefits:

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

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

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

Monthly Premiums	Total Premium	Employer Contribution	Your Premium	Total Premium
Employee Only	$555			$654
Employee and Spouse	$1,499			$1,701
Employee and Children	$944			$1,112
Employee and Family	$1,887			$2,159

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

Doctor Visits		
Primary Care	$30 copay	
Specialist	$70 copay	

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

Prescription Drugs		
Drug Deductible	Integrated with medical	$200 deduct
Generics (31-Day Supply/90-Day Supply)	$15/$45 copay; $0 copay for certain generics	
Preferred (Max does not apply if brand is selected and generic is available)	You pay 30% after deductible	You pay You pay
Non-preferred	You pay 50% after deductible	Yo
Specialty (31-Day Max) Call **1-844-367-6108** to see if your specialty medication is covered by SaveOnSP.	You pay 30% after deductible; $0 if SaveOnSP eligible	You pay
Insulin Out-of-Pocket Costs	$25 copay for 31-day supply; $75 for 61- to 90-day supply	$2 $7

TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

Each includes a wide range of wellness benefits.

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

Employer Contribution	Your Premium	Total Premium	Employer Contribution	Your Premium
		$570		
		$1,539		
		$969		
		$1,938		

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

$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	
per medical consultation	$30 per medical consultation	
2 per medical consultation	$42 per medical consultation	

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

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

CLEVER RX

partner.cleverrx.com/ctxebc

NEVER OVERPAY FOR PRESCRIPTIONS AGAIN

NOW THAT'S CLEVER.

START SAVING TODAY WITH CLEVER RX

- 100% FREE to use
- Unlock discounts on thousands of medications
- Save up to 80% off prescription drugs – often beats the average copay
- Accepted at most pharmacies nationwide



Download your Clever RX card or Clever RX App to unlock exclusive savings.



Present your Clever RX App or Clever RX card to your pharmacist.



FREE to use. Save up to 80% off prescription drugs and beat copay prices.



STEP 1:

Download the FREE Clever RX App. From your App Store search for "Clever RX" and hit download. Make sure you enter in Group ID 1085 and in Member ID 3945 during the on-boarding process. This will unlock exclusive savings for you and your family!



STEP 2:

Find where you can save on your medication. Using your zip code, when you search for your medication Clever RX checks which pharmacies near you offer the lowest price. Savings can be up to 80% compared to what you're currently paying.



STEP 3:

Click the voucher with the lowest price, closest location, and/or at your preferred pharmacy. Click "share" to text yourself the voucher for easy access when you are ready to use it. Show the voucher on your screen to the pharmacist when you pick up your medication.



STEP 4:

Share the Clever RX App. Click "Share" on the bottom of the Clever RX App to send your friends, family, and anyone else you want to help receive instant discounts on their prescription medication. Over 70% of people can benefit from a prescription savings card.

NOW THAT IS NOT ONLY CLEVER, IT IS CLEVER RX.

DID YOU KNOW?

70%

Over 70% of people can benefit from a prescription savings card due to high deductible health plans, high copays, and being underinsured or uninsured.

30%

Over 30% of prescriptions never get filled due to high costs.

40%

40% of the top ten most prescribed drugs have increased in cost by over 100%

70%

Clever RX prices are lower than competitor prices 70% of the time.

CLEVER RX PRESCRIPTION SAVINGS CARD

CLEVER RX CLEVERRX.COM

SAVE UP TO 80% on prescription drugs at virtually all U.S. pharmacies!

BIN: 020529
PCN: CLEVR
Group: 1085
Member ID: 3945

For even greater savings, download the app for FREE!

Download on the App Store | GET IT ON Google play

Pharmacist Help Line: 800-974-3135
Customer Help Line: 800-873-1195

THIS CARD IS NOT INSURANCE

This card valid exclusively at CVS, Target, Longs Drugs, Walmart, Kroger, Fry's, Harris Teeter, Walgreens, and Duane Reade. For thousands more pharmacies, download the Clever RX App.

EECU Makes It Easy For You To Make The Most Of Your HSA

Enclosed is everything you need to learn how to use your HSA.

Getting Started

Maximize savings for your healthcare and your future with an EECU HSA, getting started is easy.

Step 1: Log In for Online Account Access

A "Register for EECU Online Banking" email will be sent to the email address associated with your account, or call us and ask for one to be sent to you. Open the email and click the "Register" button to easily complete registration. Then, you can check your balance, pay bills, transfer funds, retrieve online account statements and more.

Step 2: Activate Your Debit Card

Activate your new HSA Mastercard® Debit Card immediately by following the instructions on the sticker affixed to the front of the card.

Step 3: Read This Guide

Learn how to make contributions, payments and manage your account.

Now you're ready to maximize your savings!

Have a question? We're here for you! Connect with us your way.

Online/Mobile: Log in for 24/7 account access to check your balance, pay bills and more.

Call/Text: (817) 882-0800. Our dedicated member service representatives are available to assist you with any questions. Our hours of operation are Monday through Friday from 8:00 a.m. to 7:00 p.m. CT, Saturday 9:00 a.m. – 1:00 p.m. CT and closed on Sunday.

Lost/Stolen Debit Card: Call our 24/7 debit card hotline at (800) 333-9934.

Stop by: a local EECU financial center for in-person assistance; find EECU locations & service hours at www.eecu.org/locations.

TCN3S3ZFQAYU-1656369029-372

Here's How We Make Saving For Healthcare Expenses Easy, Convenient and Valuable

Making It Easy

Easy to Contribute

You can make pre-tax, current year contributions through your employer payroll deduction or make post-tax, current year contributions directly online, through a mailed deposit or at an EECU financial center.

Easy to Make Payments

EECU offers three easy ways. You can pay qualified medical expenses[1] with your EECU HSA Debit Mastercard® through EECU's free online banking and bill pay or by writing an HSA check (optional, fees apply[2]). You can also pay out-of-pocket for eligible medical expenses and then reimburse yourself from your HSA.

Easy to Manage Your Account

You can easily access your EECU HSA anytime, anywhere online or from your smartphone or tablet at eecu.org and manage your account on the go. Have a question or need help with a transaction, we're here to help on the phone, online, chat or in person at a financial center.

Easy to Grow

Your EECU HSA is federally insured, pays a dividend rate based on balance amount and has no monthly fees, so you can maximize your savings.

HSA Overview

- Requires a qualifying high deductible health plan (HDHP)
- Used to pay for qualified medical expenses
- Funded by you, your employer or others
- Account funds belong to you

Qualified Medical Expenses

Use your HSA to pay for qualified medical expenses, as defined by the Internal Revenue Service, for yourself, your spouse or tax dependents[1]. Here are some examples:

- Acupuncture
- Ambulance Service
- Chiropractor
- Dental Care
- Doctor's Fees
- Hearing Aids
- Laboratory Fees
- Prescription Drugs
- Surgery
- Vaccines
- Vision Care
- Wheel Chairs
- X-Rays

A list of Eligible Medical Expenses can be found in IRS Publication 502 - Medical and Dental Expenses.[1]

Save your receipts –

for all qualified medical expenses. EECU does not verify eligibility. You are responsible for making sure payments are for qualified medical expenses.

Hospital Cash

It's not easy to pay hospital bills, especially if you have a high deductible medical plan. Chubb Hospital Cash pays money directly to you if you are hospitalized so you can focus on your recovery. And since the cash goes directly to you, there are no restrictions on how you use your money.

$30,000
average three-day hospitalization cost.[1]

5.4 days
average hospital stay.[2]



Choose from 1 of 2 plans

	Plan 1	Plan 2
Hospitalization Benefits	**Payable Benefit**	**Payable Benefit**
Hospital Admission Benefit This benefit is for admission to a hospital or hospital sub-acute intensive care unit.	• $1,500 • Maximum Benefit Per Calendar Year: 3	• $3,000 • Maximum Benefit Per Calendar Year: 3
Hospital Admission ICU Benefit This benefit is for admission to a hospital intensive care unit.	• $3,000 • Maximum Benefit Per Calendar Year: 3	• $6,000 • Maximum Benefit Per Calendar Year: 3
Hospital Confinement Benefit This benefit is for confinement in hospital or hospital sub-acute intensive care unit.	• $200 Per Day • Maximum Days Per Calendar Year: 30	• $200 Per Day • Maximum Days Per Calendar Year: 30
Hospital Confinement ICU Benefit The benefit for confinement in a hospital intensive care unit.	• $400 Per Day • Maximum Days Per Calendar Year: 30	• $400 Per Day • Maximum Days Per Calendar Year: 30
Newborn Nursery Benefit This benefit is payable for an insured newborn baby receiving newborn nursery care and who is not confined for treatment of a physical illness, infirmity, disease or injury.	• $500 Per Day • Maximum Days per Confinement - Normal Delivery: 2 • Maximum Days per Confinement - Caesarean Section: 2	• $500 Per Day • Maximum Days per Confinement - Normal Delivery: 2 • Maximum Days per Confinement - Caesarean Section: 2
Observation Unit Benefit This benefit is for treatment in a hospital observation unit for a period of less than 20 hours.	• $500 • Maximum Benefit Per Calendar Year: 2	• $500 • Maximum Benefit Per Calendar Year: 2
Rehabilitation Unit Admission Benefit This benefit is for admission to a rehabilitation unit as an inpatient.	• $200 • Maximum Benefit Per Calendar Year: 3	• $500 • Maximum Benefit Per Calendar Year: 3

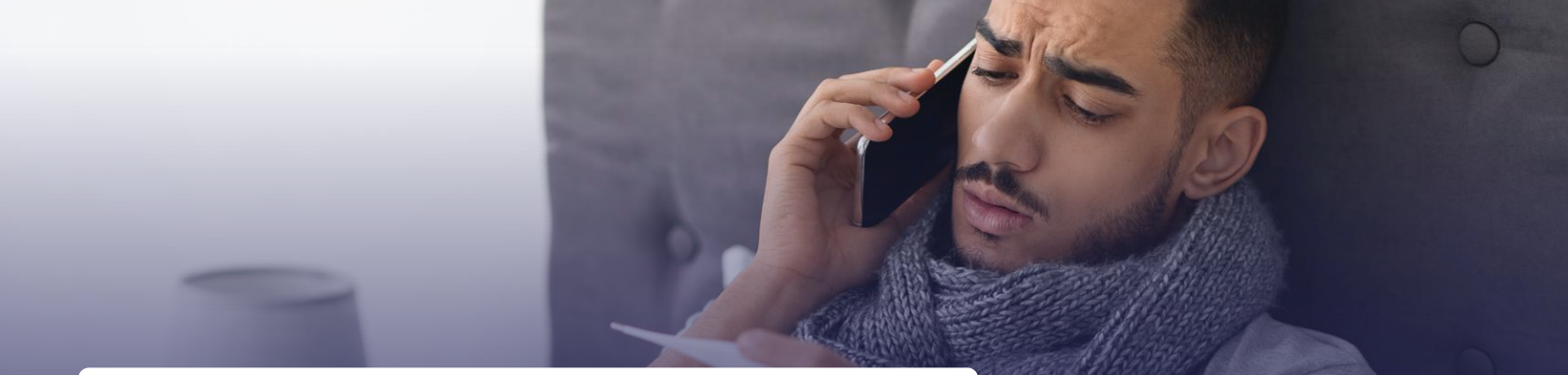
[1] www.healthcare.gov; accessed Jan. 2023
[2] data.oecd.org; accessed Jan. 2023

	Plan 1	Plan 2
Hospitalization Benefits (cont.)	**Payable Benefit**	**Payable Benefit**
Rehabilitation Unit Confinement Benefit This benefit is for confinement in a rehabilitation unit.	• $200 Per Day • Payable Per Day for Days 2 Through 11 • Maximum Days Per Calendar Year: 10	• $400 Per Day • Payable Per Day for Days 2 Through 11 • Maximum Days Per Calendar Year: 10
Waiver of Premium Benefits	**Payable Benefit**	**Payable Benefit**
Waiver of Premium for Confinement This benefit waives premium when the employee or spouse is confined for more than 30 continuous days.	Included	Included

Rates

	Plan 1	Plan 2
Monthly Premiums		
Employee	$14.09	$26.77
Employee + Spouse	$29.81	$55.92
Employee + Children	$19.89	$37.98
Family	$32.51	$61.52

Please refer to your Certificate of Insurance at https://www.ctxebc.com for a complete listing of available benefits, limitations and exclusions.
Underwritten by ACE Property & Casualty Company, a Chubb company.
This information is a brief description of the important benefits and features of the insurance plan. It is not an insurance contract. This is a supplement to health insurance and is not a substitute for Major Medical or other minimal essential coverage. Hospital indemnity coverage provides a benefit for covered loss; neither the product name nor benefits payable are intended to provide reimbursement for medical expenses incurred by a covered person or to result in any payment in excess of loss.



RECURO HEALTH

24/7 On-Demand Care Access

Don't wait to speak with a doctor, get the care when you need it

Getting sick is never planned. Here at Recuro we provide quality care around the clock to fit within your busy lifestyle.

Call 1.855.6RECURO

Common Conditions Treated

- Sore Throat
- Congestion
- Cough
- Cold & Flu
- Yeast Infection
- Insect Bites
- Allergies
- More



Call us, or download our app to speak with a doctor today!

- Visit Us Online
- Speak With an Agent
- Download Our App

Passive PPO Dental Plan (100/80/50)

Annual Benefit - Per Person $1,000

Percentage of Covered Benefits Per Policy Year

	TYPE I	TYPE II	TYPE III*
DURING THE 1ST YEAR	**100%**	**80%**	**0%**
2ND YEAR AND THEREAFTER	**100%**	**80%**	**50%**

* 12-month waiting period

Calendar Year Deductible, Per Person $50/150

This deductible applies to Type II and III services

Dependent Children Covered to Age 26

Payment is based upon allowable charges in the area in which service is rendered.

Services provided at a non-contracting provider are paid at the 90th percentile.

TYPE I (PREVENTIVE SERVICES)

Including:

- No waiting period
- Routine Exams (one per 6 months)
- Prophylaxis (cleanings-one per 6 months)
- Emergency exams for dental pain (minor procedures)
- Fluoride treatments for dependent children under age 19 (one per 12 months)
- Bitewing X-rays (once per 6 months)

TYPE II (BASIC SERVICES)

Including:

- No waiting period
- Periapical X-rays
- Simple restorative services (fillings)
- Simple extractions
- Palliative treatment for dental pain, local anesthesia
- Endodontics/root canal therapy
- Periodontics
- Oral Surgery
- Sealants for children ages 6-15 (one per tooth)
- Periapical X-rays
- Full mouth or panorex X-rays (one per 36 months)

TYPE III (MAJOR SERVICES)

Including:

- 12 month waiting period
- Major restorative services (crowns and inlays)
- Prosthetics (bridges, dentures)
- Replacement of prosthodontics, dentures, crowns and inlays
- Denture relines
- General anesthesia (for services dentally necessary)
- Space Maintainers

ORTHODONTIC SERVICES

- 12 month waiting period
- 50% coverage – children under 19
- $1,000 lifetime maximum benefit

Renewal Date: September 1, 2025

Employee	$24.84
Employee + Spouse	$51.75
Employee +Child(ren)	$57.36
Employee + Family	$88.51

Marketed, Administered and Underwritten By:

FIRST CONTINENTAL LIFE & ACCIDENT INSURANCE CO.
101 Parklane Blvd, Suite 301
Sugar Land, TX 77478
(281) 313-7150 - (877) 493-6282
Fax (281) 313-7155

Limitations and Exclusions

Covered Expenses Will Not Include and No Benefits Will be Payable:

1. For any treatment which is for cosmetic purposes or to correct congenital malformations, except for medically necessary care and treatment of congenital cleft lip and palate.
2. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items, unless required because of an accidental bodily injury sustained while the Insured is covered. Replacement is not covered if the item can be repaired.
3. For initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of natural teeth during the same period of continuous coverage. But the extraction of a third molar (wisdom tooth) will not qualify the item for payment. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth. Coverage does not include the part of the cost that aplies specifically to replacement of teeth extracted prior to the period of coverage.
4. For addition of teeth to an existing prosthetic appliance or fixed bridge unless for replacement of natural teeth extracted during the same period of continuous coverage.
5. For any expense incurred or procedure begun before the Insured's current period of continuous coverage.
6. For any expense incurred or procedure begun after the Insured's insurance under this section terminates, except for a prosthetic appliance, fixed bridge, crown, or inlay or onlay restoration for which both (a) the procedure begins before insurance ends and (b) the item's final placement is within 90 days after insurance ends.
7. To duplicate appliances or replace lost or stolen appliances.
8. For appliances, restorations or procedures to:
   a. alter vertical dimension;
   b. restore or maintain occlusion;
   c. splint or replace tooth structure lost as a result of abrasion or attrition; or
   d. treat jaw fractures or disturbances of the temporomandibular joint.
9. For education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
10. For broken appointments or the completion of claim forms.
11. For orthodontia service or for any services associated with orthodontic therapy when this optional coverage is not elected and the premium is not paid.
12. For sealants which are:
    a. not applied to a permanent molar;
    b. applied before age 6 or after attaining age 16; or
    c. reapplied to a molar within three years from the date of a previous sealant application.
13. For subgingival curettage or root planing (procedure numbers 4220 and 4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.
14. Because of an Insured's injury arising out of, or in the course of, work for wage or profit.
15. For an Insured's sickness, injury or condition for which he or she is eligible for benefits under any Workers Compensation Act or similar laws.
16. For charges for which the Insured is not liable or which would not have been made had no insurance been in force.
17. For services which are not recommended by a dentist, not required for necessary care and treatment, or do not have a reasonably favorable prognosis.
18. Because of war or any act of war, declared or not, or while on full-time active duty in the armed forces of any country.
19. To an Insured if payment is not legal where the Insured is living when expenses are incurred.
20. For any services related to: equilibration, bite registration or bite analysis.
21. For crowns for the purpose of periodontal splinting.
22. For charges for: any implants; overdentures; precision or semi-precision attachments and associated endodontic treatment; other customized attachments; or specialized prosthodontic techniques or characterizations.
23. For charges for myofunctional therapy, orthognathic surgery or athletic mouthguards.
24. For procedures for which benefits are payable under the employer's medical expense benefits plan for employees and their dependents.
25. Services or supplies provided by a family member or a member of the Insured's household.

Note: This is a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the policy. See your certificate for details.

Predetermination of Benefits: As a service to protect the Insured, First Continental Life & Accident Insurance Co. will provide predetermination of benefits for recommended treatment plans that exceed $300. This predetermination of benefits explains which of the recommended procedures will be covered and at what amount. This benefit helps Insured's better understand their coverage. The Insured should submit the treatment plan to First Continental Life & Accident Insurance Co. for review and predetermination of benefits before the service begins.

TAKEOVER BENEFITS

Takeover means that you are given credit for waiting periods for like coverage's accumulated under your existing plan. No credit is given for deductibles satisfied under your existing plan.

1. In order to provide Takeover Benefits your employer's current dental plan must have been in effect continuously for at least 12 months prior to the effective date of this plan.
2. All employees insured on the effective date with continuous coverage from the prior group dental contract are eligible for Takeover Benefits. Waiting periods will be reduced by the amount of time insured under the prior plan.
3. A minimum of three (3) enrolled members are needed for an employer to be eligible for Takeover Benefits.
4. Takeover Benefits must be requested and are subject to the approval of First Continental Life & Accident Insurance Co.

Submission of Claims:
First Continental Life & Accident Insurance Co.
ATTN: Claims Department
101 Parklane Blvd, Suite 301
Sugar Land, TX. 77478

SuperiorVision®

Vision plan benefits for Central Texas Employee Benefits

Copays	
Exam[1]	$10
Eyewear[2]	$25

Monthly premiums	
Emp. only	$6.65
Emp. + spouse	$11.36
Emp. + child(ren)	$12.01
Emp. + family	$18.01

Services/frequency	
Exam	12 months
Frame	12 months
Lenses	12 months
Contact lenses	12 months

(Based on date of service)

Benefits through Superior Select Southwest network

	In-network	Out-of-network
Exam	Covered in full	Up to $35 retail
Frames	$150 retail allowance	Up to $70 retail
Lenses (standard) per pair		
Single vision	Covered in full	Up to $25 retail
Bifocal	Covered in full	Up to $40 retail
Trifocal	Covered in full	Up to $45 retail
Progressive	See description[3]	Up to $45 retail
Contact lenses[4]	$150 retail allowance	Up to $80 retail
Medically necessary contact lenses	Covered in full	Up to $150 retail
LASIK vision correction[5]	$200 allowance	

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

[1] Eye exam copay is a single payment due to the provider at the time of service

[2] Eyewear copay applies to eyeglass lenses / frame and contact lenses. Eyewear copay is a single payment that applies to the entire purchase of eyeglasses (frame and lenses)

[3] Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay

[4] Contact lenses and related professional services (fitting, evaluation and follow-up) are covered in lieu of eyeglass lenses and frames benefit

[5] Lasik Vision Correction is in lieu of eyewear benefit, subject to routine regulatory filings and certain exclusions and limitations

Discount features

superiorvision.com

(800) 507-3800

Discounts on covered materials[6]

These discounts apply to the glasses and contacts that are covered under the vision benefits.

Frames:	20% off amount over allowance
Conventional contacts	20% off amount over allowance
Disposable contact	10% off amount over allowance

Lens type*	Member out-of-pocket[6]
Scratch coat	$15
Ultraviolet coat	$12
Tints, solid	$15
Tints, gradient	$18
Polycarbonate	$40
Blue light filtering	$15
Digital single vision	$30
Progressive lenses	
Standard/Premium/Ultra/Ultimate	$55 / $110 / $150 / $225
Anti-reflective coating	
Standard/Premium/Ultra/Ultimate	$50 / $70 / $85 / $120
Polarized lenses	$75
Plastic photochromic lenses	$80
High Index (1.67 / 1.74)	$80 / $120

* The above table highlights some of the most popular lens type and is not a complete listing. This table outlines member out-of-pocket costs[5] and are not available for premium/upgraded options unless otherwise noted.

Discounts on non-covered exam, services and materials[6]

Exams, frames, and prescription lenses:	30% off retail
Contacts, miscellaneous options:	20% off retail
Disposable contact lenses:	10% off retail
Retinal imaging:	$39 maximum out-of-pocket

Laser vision correction (LASIK)[6]

Laser vision correction (LASIK) is a procedure that can reduce or eliminate your dependency on glasses or contact lenses. This corrective service is available to you and your eligible dependents at a special discount (20-50%) with your Superior Vision plan. Contact QualSight LASIK at (877) 201-3602 for more information.

Hearing discounts[6]

A National Hearing Network of hearing care professionals, featuring Your Hearing Network, offers Superior Vision members discounts on services, hearing aids and accessories. These discounts should be verified prior to service.

All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.

[6]Not all providers participate in Superior Vision Discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if he/she offers the discount and member out-of-pocket features. The discount and member out-of-pocket features are not insurance. Discounts and member out-of-pocket are subject to change without notice and do not apply if prohibited by the manufacturer. Lens options may not be available from all Superior Vision providers/all locations.

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your vision plan. Please check with your Human Resources department if you have any questions.

Central Texas Employee Benefits Cooperative

Long Term Disability Insurance



How does it work?

This coverage provides a monthly benefit if you have a covered illness or injury and you can't work for a few months — or even longer.

You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

Voluntary Disability Insurance can replace part of your income if a disability keeps you out of work for a long period of time

What else is included?

Survivor Benefit

If you die while you've been disabled and receiving benefits for at least 180 days, your family could get a benefit equal to 3 months of your gross disability payment.

Waiver of premium

If you're disabled and receiving benefit payments, Unum waives your cost until you return to work.

Consider your expenses

Utilities	$
Housing	$
Groceries	$
Transportation	$
Child care/Elder care	$
Medical/Personal care	$
Education	$
Insurance	$

How much coverage can I get?

You*	You are eligible for coverage if you are an active employee in the United States working a minimum of 20 hours per week. Choose to cover 45%, 55% or 65% of your monthly income, up to a maximum payment of $8,000. The monthly benefit may be reduced or offset by other sources of income. *See the Legal Disclosures for more information.

If you didn't get coverage when you were first eligible, you'll have to answer health questions now. If you're newly eligible, you may not have to answer health questions. If you already have coverage, you can increase it up to the maximum available. You may have to answer health questions. New coverage may be subject to pre-existing condition limitations.

Elimination period (EP) Options:
Option 1: 0 days/7 days first day hospital
Option 2: 14 days/14 days first day hospital
Option 3: 30 days/30 days first day hospital
Option 4: 90 days/90 days
Option 5: 180 days/180 days

This is the number of days that must pass after a covered accident or illness before you can begin to receive benefits.

If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement. Inpatient means that you are confined to a hospital room due to your sickness or injury for 23 or more consecutive hours. Your admission and discharge dates and time must be 23 or more consecutive hours apart. (Applies to Elimination Periods of 30 days or less).

This is the maximum length of time you can receive benefits while you're disabled. You can receive benefits up to the Social Security (SS) normal retirement age. If you become disabled after your normal retirement age, check with your employer for the maximum length of time applicable to you.

Since our founding in 1848, Unum has been a leader in the employee benefits business.

Innovation, integrity and an unwavering commitment to our customers has helped us become a global leader in financial protection benefits.

Central Texas Employee Benefits Cooperative

Term Life and Accidental Death & Dismemberment (AD&D) Insurance



How does it work?

You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also available, which pays a benefit if you survive an accident but have certain serious injuries. It pays an additional amount if you die from a covered accident.

Why is this coverage so valuable?

If you previously purchased coverage, you can increase it up to $250,000 to meet your growing needs — with no medical underwriting.

What else is included?

A 'Living' Benefit — If you are diagnosed with a terminal illness with less than 12 months to live, you can request 75% of your life insurance benefit (up to $500,000) while you are still living. This amount will be taken out of the death benefit, and may be taxable. **These benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements, and may be taxable.** Recipients should consult their tax attorney or advisor before utilizing living benefit payments.

Waiver of premium — Your cost may be waived if you are totally disabled for a period of time.

Portability — You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Who can get Term Life coverage?

If you are actively at work at least 20 hours per week, you may apply for coverage for:

You:	Choose from $10,000 to $500,000 in $10,000 increments, up to 7 times your earnings. If you previously purchased coverage, you can increase it up to $250,000 with no medical underwriting. If you previously declined coverage, you may have to answer some health questions.
Your spouse:	Get up to $500,000 of coverage in $5,000 increments. Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself. If you previously purchased coverage for your spouse, they can increase their coverage up to $50,000 with no medical underwriting, if eligible (see delayed effective date). If you previously declined spouse coverage, some health questions may be required.
Your children:	Get up to $10,000 of coverage in $1,000 increments if eligible (see delayed effective date). One policy covers all of your children until their 26th birthday. The maximum benefit for children live birth to 6 months is $1,000.

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You:	Get up to $500,00 of AD&D coverage for yourself in $10,000 increments.
Your spouse:	Get 50% of employee coverage amount up to $250,000 of AD&D coverage for your spouse in $5,000 increments if eligible (see delayed effective date).
Your children:	Get 10% of employee coverage up to $50,000 of AD&D coverage for your children if eligible (see delayed effective date).

The maximum benefit for children live birth to 6 months is $1,000.

No medical underwriting is required for AD&D coverage.

How much coverage can I get?

Calculate your costs

1. Enter the coverage amount you want.
2. Divide by the amount shown.
3. Multiply by the rate. Use the rate table (at right) to find the rate based on age.
   (Choose the age you will be when your coverage becomes effective. See your plan administrator for your plan effective date. To determine your spouse rate, choose the age the employee will be when coverage becomes effective. See your plan administrator for your plan effective date.)
4. Enter your cost.

	1	2	3	4
Employee	$_____,000	÷ $10,000 = $_____	X $_____	= $_____
Spouse	$_____,000	÷ $5,000 = $_____	X $_____	= $_____
Child	$_____,000	÷ $10,000 = $_____	X $_____	= $_____
			Total cost	

Employee monthly rate		Spouse monthly rate	Child monthly rate
Age	Per $10,000 of coverage	Per $5,000 of coverage	$1.800 per $10,000 of coverage
	Cost	Cost	
15-24	$0.600	$0.300	
25-29	$0.600	$0.300	
30-34	$0.700	$0.350	
35-39	$0.900	$0.450	
40-44	$1.000	$0.500	
45-49	$1.600	$0.800	
50-54	$2.700	$1.350	
55-59	$4.200	$2.100	
60-64	$6.800	$3.400	
65-69	$12.600	$6.300	
70-74	$20.400	$10.200	
75+	$30.200	$15.100	

1. Enter the AD&D coverage amount you want.
2. Divide by the amount shown.
3. Multiply by the rate. Use the AD&D rate table (at right) to find the rate.
4. Enter your cost.

AD&D				
	1	2	3	4
Employee	$_____,000	÷ $1,000 = $_____	X $0.040	= $_____
Family	$_____,000	÷ $1,000 = $_____	X $0.070	= $_____
			Total cost	

AD&D monthly rates		
	Coverage amount	Rate
Employee	per $1,000 of coverage	$0.040
Family	per $1,000 of coverage	$0.070

Billed amount may vary slightly.
If you apply for coverage above the guaranteed issue amount, you may be subject to medical underwriting which may affect your ability to get the larger coverage amount. In order to purchase coverage for your dependents, you must buy coverage for yourself. Coverage amounts cannot exceed 100% of your coverage amounts.



Family Protection Plan

Group Term Life Insurance to age 121 with Quality of Life
underwritten by 5Star Life Insurance Company

Make a smart choice to help protect your loved ones and your future.

Life doesn't come with a lesson plan

Help protect your family with the Family Protection Plan Group Level Term Life Insurance to age 121. You can get coverage for your spouse even if you don't elect coverage on yourself. And you can cover your financially dependent children and grandchildren (14 days to 19 years old or up to their 26th birthday if full-time student). The coverage lasts until age 121 for all insured,* so no matter what the future brings, your family has peace of mind.



44% of American households would encounter significant financial difficulties within six months if they lost the primary family wage earner.

Forbes Life Insurance Statistics, Data and Industry Trends 2024.

Why buy life insurance when you're young?

Buying life insurance when you're younger allows you to take advantage of lower premium rates while you're generally healthy, which may allow you to purchase more insurance coverage for the future. This is especially important if you have dependents who rely on your income, or you have debt that would need to be paid off.

Portable

Coverage continues with no loss of benefits or increase in cost if you terminate employment after the first premium is paid. We simply bill you directly.

Why is portability important?

Life moves fast so having a *portable life insurance allows you to keep your coverage if you leave your school district. Keeping the coverage helps you ensure your family is protected even into your retirement years.

*As long as premiums are paid.

Underwritten and administered by 5Star Life Insurance Company (a Lincoln, Nebraska company); Mail: PO Box 5005, Batavia, IL 60510-5005. Product not available in all states. Policy #: ICC18-GFPPPOL

Family Protection Plan

Group Term Life Insurance to age 121 with Quality of Life
underwritten by 5Star Life Insurance Company

Terminal illness acceleration of benefits

Coverage pays 30% (25% in CT and MI) of the coverage amount in a lump sum upon the occurrence of a terminal condition that will result in a limited life span of less than 12 months (24 months in IL).

Protection you can count on

Within one business day of notification, payment of 50% of coverage or $10,000 whichever is less is mailed to the beneficiary, unless the death is within the two-year contestability period and/or under investigation. This coverage has no war or terrorism exclusions.

Convenient

Easy payment through payroll deduction.

Quality of Life benefit

Optional benefit that accelerates a portion of the death benefit on a monthly basis, up to 75% of your benefit, and is payable directly to you on a tax favored basis* for the following:

- Permanent inability to perform at least two of the six Activities of Daily Living (ADLs) without substantial assistance; or
- Permanent severe cognitive impairment, such as dementia, Alzheimer's disease and other forms of senility, requiring substantial supervision.

How does Quality of Life help?

Many individuals who can't take care of themselves require special accommodations to perform ADLs and would need to make modifications to continue to live at home with physical limitation. The proceeds from the Quality of Life benefit can be used for any purpose, including costs for infacility care, home healthcare professionals, home modifications, and more.

2026 Enrollment Plan Year

Guaranteed Issue is offered to all eligible applicants regardless of health status. No Doctor exams or physicals.

Employee: $150,000 | Spouse: $50,000 | Child: $10,000

LEARN MORE

About the coverage

The Family Protection Plan offers a lump-sum cash benefit if you die before age 121. The initial death benefit is guaranteed to be level for at least the first ten policy years. Afterward, the company intends to provide a non-guaranteed death benefit enhancement which will maintain the initial death benefit level until age 121. The company has the right to discontinue this enhancement. The death benefit enhancement cannot be discontinued on a particular insured due to a change in age, health, or employment status.

Accelerated benefits may, or may not, be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, you should consult your personal tax advisor to assess any potential impacts of this benefit. Underwritten and administered by 5Star Life Insurance Company (a Lincoln, Nebraska company); Mail: PO Box 5005, Batavia, IL 60510-5005. Product not available in all states. Policy #: ICC18-GFPPPOL

Cash benefits when you need them most – **Cancer Insurance from Chubb**

A cancer diagnosis and treatment can be an emotionally and physically difficult time. Chubb is there to help support you by providing cash benefits paid directly to you. Benefits are paid if you are diagnosed with cancer, but also help cover many other cancer-related services such as doctor's visits, treatments, specialty care, and recovery. However, there are no restrictions on how to use these cash benefits—so you can use them as you see fit.

Choose the right level of coverage during the enrollment period to better protect your family.

Cash benefits for every step of the way

Cancer Insurance Benefits	Low Plan	High Plan
First cancer benefit	$100 paid upon receipt of first covered claim for Cancer; only one payment per certificate	$100 paid upon receipt of first covered claim for Cancer; only one payment per certificate
Diagnosis of cancer	$5,000 employee or spouse $7,500 child(ren) Waiting period: 0 days Benefit reduction: none	$10,000 employee or spouse $15,000 child(ren) Waiting period: 0 days Benefit reduction: none
Hospital confinement	$100 per day – days 1 through 30 Additional days: $200 Maximum days per confinement: 31	$200 per day – days 1 through 30 Additional days: $400 Maximum days per confinement: 31
Hospital confinement ICU	$600 per day – days 1 through 30 Additional days: $600 Maximum days per confinement: 31	$600 per day – days 1 through 30 Additional days: $600 Maximum days per confinement: 31
Radiation therapy, chemotherapy, immunotherapy	Maximum per covered person per 12-month period: $10,000	Maximum per covered person per 12-month period: $20,000
Alternative care	$75 per visit Maximum visits per calendar year: 4	$75 per visit Maximum visits per calendar year: 4
Medical imaging	$500 per imaging study Maximum studies per calendar year: 2	$500 per imaging study Maximum studies per calendar year: 2
Skin cancer initial diagnosis	$100 per diagnosis Lifetime Maximum: 1	$100 per diagnosis Lifetime Maximum: 1

Cash benefits for every step of the way (cont.)

Cancer Insurance Benefits	Low Plan	High Plan
Attending physician	$30 per visit Maximum visits per confinement: 2 Maximum visits per calendar year: 4	$50 per visit Maximum visits per confinement: 2 Maximum visits per calendar year: 4
Hospital confinement sub-acute ICU	$300 per day – days 1 through 30 Additional days: $300 Maximum days per confinement: 31	$300 per day – days 1 through 30 Additional days: $300 Maximum days per confinement: 31
Family care	Childcare: $100 per day Maximum days per calendar year: 30 Adult day care or home healthcare: $100 per day Maximum days per calendar year: 30	Childcare: $100 per day Maximum days per calendar year: 30 Adult day care or home healthcare: $100 per day Maximum days per calendar year: 30
Prescription drug in-patient	Per day of confinement: $150 Maximum confinements per calendar year: 6	Per day of confinement: $150 Maximum confinements per calendar year: 6
Private full-time nursing services	$150 per day Maximum days per confinement: 5	$150 per day Maximum days per confinement: 5
U.S. government or charity hospital	Days 1 through 30: $100 Additional days: $100 Maximum days per confinement: 31	Days 1 through 30: $200 Additional days: $400 Maximum days per confinement: 31
Specialty Care Benefits	**Low Plan**	**High Plan**
Family member transportation and lodging	Family transportation: $100 per trip Maximum trips per calendar year: 12 Family lodging: $100 per day Maximum days per calendar year: 100	Family transportation: $100 per trip Maximum trips per calendar year: 12 Family lodging: $100 per day Maximum days per calendar year: 100
Home health care	$100 per day not to exceed the number of days confined Maximum days per calendar year: 30	$200 per day not to exceed the number of days confined Maximum days per calendar year: 30
Hospice care	$100 per day	$200 per day
Skilled nursing care facility	$100 per day Maximum days per calendar year: 30	$200 per day Maximum days per calendar year: 30
Cancer Treatment Benefits	**Low Plan**	**High Plan**
Air ambulance	$2,000 per trip Maximum trips per confinement: 2	$2,000 per trip Maximum trips per confinement: 2
Ambulance	$200 per trip Maximum trips per confinement: 2	$200 per trip Maximum trips per confinement: 2
Blood, plasma, and platelets	$300 per transfusion Maximum transfusions per calendar year: 2	$300 per transfusion Maximum transfusions per calendar year: 2

Cash benefits for every step of the way (cont.)

Cancer Treatment Benefits	Low Plan	High Plan
Bone marrow or stem cell donation	$200 per day of confinement Lifetime maximum donations: 2	$300 per day of confinement Lifetime maximum donations: 2
Bone marrow or stem cell transplant	First bone marrow transplant: $6,000 Additional transplant: 50% Lifetime maximum transplant(s): 2 First stem cell transplant: $600 Additional transplant: 50% Lifetime maximum transplant(s): 2	First bone marrow transplant: $9,000 Additional transplant: 50% Lifetime maximum transplant(s): 2 First stem cell transplant: $900 Additional transplant: 50% Lifetime maximum transplant(s): 2
Hormonal therapy	$50 per calendar month Maximum months per calendar year: 12	$50 per calendar month Maximum months per calendar year: 12
National Cancer Institute designated comprehensive cancer treatment center evaluation/consultation benefit	$750 Lifetime Maximum Consultation(s): 1	$750 Lifetime Maximum Consultation(s): 1
Cancer Recovery Benefits	**Low Plan**	**High Plan**
Counseling	$75 per visit Maximum visits per calendar year: 6	$75 per visit Maximum visits per calendar year: 6
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
Non-surgical prosthesis	$100 Lifetime maximum number of devices: 1	$100 Lifetime maximum number of devices: 1
Recovery at home	$150 per day not to exceed the number of days confined Maximum days per calendar year: 15	$150 per day not to exceed the number of days confined Maximum days per calendar year: 15
Therapy	$25 per day of therapy Maximum days per calendar year: 40	$25 per day of therapy Maximum days per calendar year: 40
Transportation and lodging	Transportation: $100 per trip Maximum trips per calendar year: 12 Lodging: $100 per day Maximum days per calendar year: 100	Transportation: $100 per trip Maximum trips per calendar year: 12 Lodging: $100 per day Maximum days per calendar year: 100
Preventative and Wellness Benefits	**Low Plan**	**High Plan**
Cancer wellness	$50 Maximum days of service, per covered person per calendar year: 1 day(s) Follow-up test benefit amount: $100 Waiting period: 0 days	$50 Maximum days of service, per covered person per calendar year: 1 day(s) Follow-up test benefit amount: $100 Waiting period: 0 days

Cash benefits for every step of the way (cont.)

Preventative and Wellness Benefits	Low Plan	High Plan
Genetic tumor testing	$100 per test Maximum tests per calendar year: 2	$100 per test Maximum tests per calendar year: 2
Heritable cancer screening	$100 Maximum tests per calendar year: 1	$100 Maximum tests per calendar year: 1
Pharmacogenomic (PGX) screening test	$100 per test Maximum tests per calendar year: 2	$100 per test Maximum tests per calendar year: 2
Heart Attack or Stroke Benefit	**Low Plan**	**High Plan**
Heart attack or stroke	$5,000 employee or spouse $7,500 child(ren) Recurrence benefit: $2,500 employee or spouse $3,750 child(ren) Waiting period: 0 days Benefit reduction: none	$10,000 employee or spouse $15,000 child(ren) Recurrence benefit: $5,000 employee or spouse $7,500 child(ren) Waiting period: 0 days Benefit reduction: none
Specified Disease Benefits	**Low Plan**	**High Plan**
	Waiting Period: 0 days Benefit Reduction: None	Waiting Period: 0 days Benefit Reduction: None
Hospital Confinement for Specified Disease Benefit	$100 Per Day – Days 1 through 30 Additional Days: $100 Maximum Days per Confinement: 31	$200 Per Day – Days 1 through 30 Additional Days: $400 Maximum Days per Confinement: 31
Surgical Treatment Benefits	**Low Plan**	**High Plan**
Waiting period	0 days	0 days
Surgery	Up to $4,125	Up to $4,125
Anesthesia	General anesthesia: 25% of surgery benefit	General anesthesia: 25% of surgery benefit
Outpatient surgery facility service	$200 per day Maximum benefits per calendar year: 4	$400 per day Maximum benefits per calendar year: 4
Preventative surgery	$250 Lifetime maximum: 1	$250 Lifetime maximum: 1
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: $500
Second and third opinion	$300 Lifetime maximum: 2	$300 Lifetime maximum: 2
Skin cancer surgery	$100	$100
Surgical prosthesis	$1,000 per device Lifetime maximum benefit amount: $1,000	$1,000 per device Lifetime maximum benefit amount: $1,000

Cash benefits for every step of the way (cont.)

Accident and Sickness Benefits	Low Plan	High Plan
Hospital intensive care for accident or sickness	Hospital confinement ICU for accident or sickness benefit: $100 Maximum number of days per confinement: 30	Hospital confinement ICU for accident or sickness benefit: $200 Maximum number of days per confinement: 30
Advocacy Package	**Low Plan**	**High Plan**
Kindly Human™ Participants can talk for up to six hours total per year for pre-clinical peer-to-peer connections and navigation across real-life issues.	Included	Included

Additional plan benefits

Portability	Employees can keep their coverage if they change jobs or retire.
Continuity of coverage	Included
Pre-existing conditions limitation	A condition for which a covered person received medical advice or treatment within the 12 months preceding the certificate effective date.
Waiver of premium	Included

Definitions and provisions

Continuity of coverage	If the certificate replaced another cancer indemnity certificate or individual policy, your coverage under the certificate shall not limit or exclude coverage for a pre-existing condition or waiting period that would have been covered under the policy being replaced. Benefits payable for a pre-existing condition or during the waiting period will be the higher of the benefits that would have been payable under the terms of the prior coverage if it had remained in force; or the benefits payable under the certificate. Time periods applicable to pre-existing conditions and waiting periods will be waived to the extent that similar limitations or exclusions were satisfied under the coverage being replaced. Continuity of coverage is only extended to the benefits provided under the certificate. The certificate may not include all the benefits provided under the prior coverage.
Definition of cancer	Cancer means carcinoma in situ, leukemia, or a malignant tumor characterized by uncontrolled cell growth and invasion or spread of malignant cells to distant tissue. Cancer is also defined as cancer which meets the diagnosis criteria of malignancy established by the American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. Carcinoma in situ means a malignant tumor which is typically classified as Stage 0 cancer, where the tumor cells still lie within the tissue of the site of origin without having invaded neighboring tissue. The following are not considered cancer: Pre-malignant conditions or conditions with malignant potential; non-invasive basal cell carcinoma of the skin; non-invasive squamous cell carcinoma of the skin; or melanoma diagnosed as Clark's Level I or II or Breslow less than .75mm.
Plan descriptions	Refer to the Certificate of Coverage for details specific to each plan.

Exclusions and limitations

No benefits will be paid for a date of diagnosis or treatment of cancer prior to the coverage effective date, except where continuity of coverage applies.

No benefits will be paid for services rendered by a member of the immediate family of a covered person.

We will not pay benefits for other conditions or diseases, except losses due directly from cancer or skin cancer.

We will not pay benefits for cancer or skin cancer if the diagnosis or treatment of cancer is received outside of the territorial limits of the United States and its possessions. Benefits will be payable if the covered person returns to the territorial limits of the United States and its possessions, and a physician confirms the diagnosis or receives treatment.

Rates

Monthly Premiums	Low Plan	High Plan
Employee only	$17.20	$27.92
Employee + spouse	$32.90	$53.22
Employee + child(ren)	$21.40	$34.64
Family	$32.90	$53.22

*Please refer to your Certificate of Insurance at www.mybenefitshub.com/centraltexasebc for a complete listing of available benefits, limitations and exclusions. Underwritten by ACE Property & Casualty Company, a Chubb company.
This information is a brief description of the important benefits and features of the insurance plan. It is not an insurance contract. This policy does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy a person's individual obligation to secure the requirement of minimum essential coverage under the Affordable Care Act (ACA). For more information about the ACA, please refer to http://www.HealthCare.gov.

Accident

You do everything you can to stay active and healthy, but accidents happen every day. An injury that hurts an arm or a leg can hurt your finances too. Chubb Accident pays cash benefits directly to you regardless of any other coverage you have. Benefits can be used to help cover health plan gaps for out-of-pocket expenses like deductibles, copays, and coinsurance.

Accident Insurance

Coverage Type	24-Hour
Sports Package	Up to $1,000 per person/ per year
First Accident	$100
Initial Care Benefits	**Payable Benefit**
Emergency Room	$225
Urgent Care	$225
Initial Dr. Visit	$150
Hospital/Facility Benefits	**Payable Benefit**
Standard Hospital Admission	$1,500
ICU Hospital Admission	$2,000
Hospital Confinement (per day, up to 365 days)	$400
ICU Confinement (per day, up to 30 days)	$600
Outpatient Surgery Facility	$225
Rehab Confinement (per day, up to 30 days)	$300
Recovery Benefit (per day)	$25
No. of Days	7
Additional Benefits	**Payable Benefit**
Accidental Death	
Employee	$50,000
Spouse	$25,000
Child	$12,500
Ambulance (air)	$2,000
Ambulance (ground)	$500
Appliance	$200
Blood, Plasma, Platelets	$600
Burns	Up to $15,000
Skin Graft	25%
Chiropractic Care (per visit)	$50
Coma	$17,000
Dislocations (up to)	$7,700
Emergency Dental	Up to $450

[1] www.healthcare.gov; accessed Jan. 2023
[2] Centers for Disease Control and Prevention; Jan. 2023

Additional Benefits (cont.)	Payable Benefit
Eye Injury	$500
Family Care (up to 30 days)	$25 per day, per child in child care center
Follow-up Treatment (per visit)	$100
Fractures (up to)	$8,000
Herniated Disc Surgery	$1,200
Knee Cartilage - Torn	$800
Lacerations	$30-$500
Lodging (per night, 100 or more miles)	$180
Loss of Hands, Feet, Sight	$50,000
Loss of Fingers or Toes	$1,800
Major Diagnostic Exam (CT, MRI, etc.)	$300
Paralysis	
Two Limbs (paraplegia or hemiplegia)	$16,000
Four Limbs (quadriplegia)	$24,000
Prosthetics	$1,500
Surgery - Abdominal, Cranial, or Thoracic	$3,000
Hernia	$400
Tendon, Ligament, Rotator Cuff	$825
Therapy – Physical, Occupational, or Speech	$50
Transportation (per trip, 100 or more miles)	$750
Traumatic Brain Injury	$225
X-Ray	$100

Rates

Coverage Type	24-Hour
Monthly Premiums	
Employee	$10.98
Employee + Spouse	$17.09
Employee + Children	$17.90
Family	$24.02

Please refer to your Certificate of Insurance at https://www.ctxebc.com for a complete listing of available benefits, limitations and exclusions.
Underwritten by ACE Property & Casualty Company, a Chubb company.
This information is a brief description of the important benefits and features of the insurance plan. It is not an insurance contract.
This is an accident only policy and does not pay benefits for loss from sickness.

Critical Illness

Heart attacks, cancer and strokes happen every day and often unexpectedly. They don't give you time to prepare and can take a serious toll on both your physical and financial well-being. Chubb Critical Illness pays cash benefits directly to you that you can use to help with your bills, your mortgage, your rent, your childcare—you name it—so you can focus on recovery.

Every 40 seconds

someone has a heart attack.[1]

1 in 3

Americans don't have enough money readily available to cover an unexpected $400 expense.[2]



Available coverage choices

Employee	$10,000; $20,000; $30,000; or $40,000 face amounts
Spouse	$5,000; $10,000; $15,000; or $20,000 face amounts
Child	Included in the employee rate

There is no pre-existing conditions limitation. No benefits will be paid for a date of diagnosis that occurs prior to the coverage effective date. Covered individuals must be treatment free from cancer for 12 months prior to diagnosis date and in complete remission. All amounts are Guaranteed Issue — no medical questions are required for coverage to be issued.

Critical Illness Insurance

Covered conditions	Payable benefit as a percentage of face amount
ALS	100%
Alzheimer's disease	100%
Benign brain tumor	100%
Breast cancer carcinoma in situ	100%
Cancer (see below for skin cancer)	100%
Carcinoma in situ	25%
Coma	100%
Coronary artery obstruction	25%
End stage renal failure	100%

[1] Centers for Disease Control and Prevention, Jan. 2023
[2] The Federal Reserve, June 2022

Covered conditions	Payable benefit as a percentage of face amount
Heart attack	100%
Loss of sight, speech, or hearing	100%
Major organ failure	100%
Multiple sclerosis	100%
Paralysis or dismemberment	100%
Parkinson's disease	100%
Stroke	100%
Sudden cardiac arrest	100%
Transient ischemic attacks	10%
Skin Cancer Benefit - Payable once per insured per year	$1,000
Occupational package Pays 100% of the face amount; Benefits payable for HIV or Hepatitis B, C, or D, MRSA, rabies, tetanus or tuberculosis contracted on the job.	Included
Childhood conditions Pays 100% of the dependent child face amount; Provides benefits for childhood conditions (autism spectrum disorder; cerebral palsy; congenital birth defects: heart, lung, cleft lip, palate, etc; cystic fibrosis; Down's syndrome; Gaucher disease; muscular dystrophy; type 1 diabetes).	Included
Miscellaneous Disease Rider + COVID-19 The Miscellaneous Disease Rider is payable once per covered condition. Covered conditions include: Addison's disease; cerebrospinal meningistis; diptheria; Hungtington's chorea; legionnaire's disease; malaria; myasthenia gravis; meningitis; necrotizing fasciitis; osteomyelitis; polio; rabies; sclerodema; systematic lupus; tetanus; tuberculosis. COVID-19 means a disease resulting in a positive COVID-19 diagnostic screening and 5 consecutive days of hospital confinement.	100% misc. diseases excluding Covid-19 50% Covid- 19
Recurrence Benefit	
Benefits are payable for a subsequent diagnosis of benign brain tumor; cancer; coma; coronary artery obstruction; heart attack; major organ failure; stroke; or sudden cardiac arrest.	100%
Advocacy Package	
Diabetes Benefit Diabetes Diagnosis Benefit Pays a benefit once for Covered Person's diabetes diagnosis.	$500
Additional Benefits	
Waiver of Premium Waives premium while the insured is totally disabled.	Included
Wellness Benefit - Payable once per insured per year	$50

Rates

Riders are included in all the rates listed below: **Waiver of Premium, Wellness Benefit, Diabetes Benefit**

Face amount: Employee $10,000 Spouse $5,000 Children $5,000	Employee	Employee + spouse	Employee + children	Family
Attained age	**Monthly premiums**			
18-25	$4.50	$6.75	$4.50	$6.75
26-30	$4.50	$6.75	$4.50	$6.75
31-35	$5.20	$7.80	$5.20	$7.80
36-40	$5.20	$7.80	$5.20	$7.80
41-45	$9.50	$14.25	$9.50	$14.25
46-50	$9.50	$14.25	$9.50	$14.25
51-55	$19.70	$29.55	$19.70	$29.55
56-60	$19.70	$29.55	$19.70	$29.55
61-65	$30.90	$46.35	$30.90	$46.35
66-70	$40.00	$60.00	$40.00	$60.00
71-75	$55.90	$83.85	$55.90	$83.85
76-80	$55.90	$83.85	$55.90	$83.85
81+	$55.90	$83.85	$55.90	$83.85

Face amount: Employee $20,000 Spouse $10,000 Children $10,000	Employee	Employee + spouse	Employee + children	Family
Attained age	**Monthly premiums**			
18-25	$9.00	$13.50	$9.00	$13.50
26-30	$9.00	$13.50	$9.00	$13.50
31-35	$10.40	$15.60	$10.40	$15.60
36-40	$10.40	$15.60	$10.40	$15.60
41-45	$19.00	$28.50	$19.00	$28.50
46-50	$19.00	$28.50	$19.00	$28.50
51-55	$39.40	$59.10	$39.40	$59.10
56-60	$39.40	$59.10	$39.40	$59.10
61-65	$61.80	$92.70	$61.80	$92.70
66-70	$80.00	$120.00	$80.00	$120.00
71-75	$111.80	$167.70	$111.80	$167.70
76-80	$111.80	$167.70	$111.80	$167.70
81+	$111.80	$167.70	$111.80	$167.70

Rates (continued)

Riders are included in all the rates listed below: **Waiver of Premium, Wellness Benefit, Diabetes Benefit**

Face amount: Employee $30,000 Spouse $15,000 Children $15,000	Employee	Employee + spouse	Employee + children	Family
Attained age	**Monthly premiums**			
18-25	$13.50	$20.25	$13.50	$20.25
26-30	$13.50	$20.25	$13.50	$20.25
31-35	$15.60	$23.40	$15.60	$23.40
36-40	$15.60	$23.40	$15.60	$23.40
41-45	$28.50	$42.75	$28.50	$42.75
46-50	$28.50	$42.75	$28.50	$42.75
51-55	$59.10	$88.65	$59.10	$88.65
56-60	$59.10	$88.65	$59.10	$88.65
61-65	$92.70	$139.05	$92.70	$139.05
66-70	$120.00	$180.00	$120.00	$180.00
71-75	$167.70	$251.55	$167.70	$251.55
76-80	$167.70	$251.55	$167.70	$251.55
81+	$167.70	$251.55	$167.70	$251.55

Face amount: Employee $40,000 Spouse $20,000 Children $20,000	Employee	Employee + spouse	Employee + children	Family
Attained age	**Monthly premiums**			
18-25	$18.00	$27.00	$18.00	$27.00
26-30	$18.00	$27.00	$18.00	$27.00
31-35	$20.80	$31.20	$20.80	$31.20
36-40	$20.80	$31.20	$20.80	$31.20
41-45	$38.00	$57.00	$38.00	$57.00
46-50	$38.00	$57.00	$38.00	$57.00
51-55	$78.80	$118.20	$78.80	$118.20
56-60	$78.80	$118.20	$78.80	$118.20
61-65	$123.60	$185.40	$123.60	$185.40
66-70	$160.00	$240.00	$160.00	$240.00
71-75	$223.60	$335.40	$223.60	$335.40
76-80	$223.60	$335.40	$223.60	$335.40
81+	$223.60	$335.40	$223.60	$335.40

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idwatchdog®

IDENTITY THEFT PROTECTION

Because There's Only One You.



Your identity is important — it's what makes you, you. You've spent a lifetime building your name and financial reputation. Let us help you better protect it. And, we'll even go one step further and help you better protect the identities of your family.

1 in 18 consumers were victims of identity theft in 2018.[1]

Easy & Affordable Identity Protection

With ID Watchdog®, you have an easy and affordable way to help better protect and monitor the identities of you and your family. You'll be alerted to potentially suspicious activity and enjoy the peace of mind that comes with the support of dedicated resolution specialists. And, a customer care team that's available any time, every day.

WHY CHOOSE ID WATCHDOG

Credit Lock

With our online and in-app feature, lock your Equifax® credit report[2] — and your child's Equifax credit report — to help provide additional protection against unauthorized access to your credit.

More for Families

Our family plan helps you better protect your loved ones, with each adult getting their own account with all plan features. And, we offer more features that help protect minors than any other provider.

Dedicated Resolution Specialists

If you become a victim, you don't have to face it alone. One of our certified resolution specialists will fully manage the case for you until your identity is restored.

ID Watchdog Is Here for You

ID Watchdog is everywhere you can't be — monitoring credit reports, social media, transaction records, public records and more — to help you better protect your identity. And don't worry, we're always here for you. In fact, our U.S.-based customer care team is available 24/7/365 at 866.513.1518.

JAVELIN IDENTITY PROTECTION SERVICE PROVIDER BEST IN CLASS 2018

A Leader in Detection & Prevention for 3 years running

See our **unique features and pricing** and take a step to help better protect your identity today.

(Features and pricing tables on reverse.)

[1]2019 Identity Fraud Study, Javelin Research, March 2019

[2]Locking your Equifax credit report will prevent access to it by certain third parties. Locking your Equifax credit report will not prevent access to your credit report at any other credit reporting agency. Entities that may still have access to your Equifax credit report include: companies like ID Watchdog, which provide you with access to your credit report or credit score, or monitor your credit report as part of a subscription or similar service; companies that provide you with a copy of your credit report or credit score, upon your request; federal, state and local government agencies and courts in certain circumstances; companies using the information in connection with the underwriting of insurance, or for employment, tenant or background screening purposes; companies that have a current account or relationship with you, and collection agencies acting on behalf of those whom you owe; companies that authenticate a consumer's identity for purposes other than granting credit, or for investigating or preventing actual or potential fraud; and companies that wish to make pre-approved offers of credit or insurance to you. To opt out of such pre-approved offers, visit www.optoutprescreen.com

IDENTITY THEFT PROTECTION

The Powerful Features You Want — All at an Affordable Price

UNIQUE FEATURES INCLUDED IN ALL ID WATCHDOG PLANS

Monitor & Detect

- Dark Web Monitoring[1] ◆
- High-Risk Transactions Monitoring[2] ◆
- Subprime Loan Monitoring[2] ◆
- Public Records Monitoring ◆
- USPS Change of Address Monitoring
- Identity Profile Report

Manage & Alert

- Child Credit Lock[3] | 1 Bureau ◆
- Financial Accounts Monitoring
- Social Network Alerts ◆
- Registered Sex Offender Reporting ◆
- Customizable Alert Options
- Breach Alert Emails
- Mobile App

Support & Restore

- Identity Theft Resolution Specialists (Resolution for Pre-existing Conditions) ◆
- 24/7/365 U.S.-based Customer Care Center
- Lost Wallet Vault & Assistance
- Deceased Family Member Fraud Remediation
- Fraud Alert & Credit Freeze Assistance

◆ Helps better protect children | 1 Bureau = Equifax® | Multi-Bureau = Equifax, TransUnion® | 3 Bureau = Equifax, Experian®, TransUnion

What You Need to Know

The credit scores provided are based on the VantageScore® 3.0 model. For three-bureau VantageScore credit scores, data from Equifax, Experian, and TransUnion are used respectively. Any one-bureau VantageScore uses Equifax data. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.

PLAN OPTIONS	ID WATCHDOG® 1B	ID WATCHDOG® PLATINUM
Credit Report(s)[4] & VantageScore Credit Score(s)	1 Bureau Monthly	1 Bureau Daily & 3 Bureau Annually
Credit Score Tracker	1 Bureau Monthly	1 Bureau Daily
Credit Report Monitoring[5]	1 Bureau	3 Bureau
Credit Report Lock[6]	1 Bureau	Multi-Bureau
Identity Theft Insurance[7]	Up to $1M	Up to $1M
401K/HSA Stolen Funds Reimbursement[7]	-	Up to $500k
SPECIAL EMPLOYEE PRICING PER MONTH	**ID WATCHDOG® 1B**	**ID WATCHDOG® PLATINUM**
Employee (Includes 1 child <18)	$7.95	$11.95
Employee + Family	$14.95	$22.95

Take steps to help better protect your identity. **Enroll in this valuable benefit today.**

[1]Dark Web Monitoring scans thousands of internet sites where consumers' personal information is suspected of being bought and sold, and is constantly adding new sites to those it searches. However, the internet addresses of these suspected internet trading sites are not published and frequently change, so there is no guarantee that ID Watchdog is able to locate and search every possible internet site where consumers' personal information is at risk of being traded.
[2]The monitored network does not cover all businesses or transactions.
[3]Locking your child's Equifax credit report helps prevent access to it by lenders and creditors. It will not prevent access to your child's credit report at any other credit reporting agency.
[4]Under certain circumstances, access to your Equifax Credit Report may not be available as certain consumer credit files maintained by Equifax contain credit histories, multiple trade accounts, and/or an extraordinary number of inquiries of a nature that prevents or delays the delivery of your Equifax Credit Report. If a remedy for the failure is not available, the product subscription will be cancelled and a full refund will be made.
[5]Monitoring from TransUnion® and Experian® will take several days to begin.
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[7]The Identity Theft Insurance is underwritten and administered by American Bankers Insurance Company of Florida, an Assurant company. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions. Review the Summary of Benefits (www.idwatchdog.com/terms/insurance).

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masaAccess

Stay prepared with MASA® Emergent Plus

Coverage for medical transportation and care in the event of an emergency

Plan includes:

Emergency Ground Ambulance Coverage
MASA provides coverage for emergency ground transportation in the U.S. or Canada to a medical facility.

Emergency Air Ambulance Coverage
MASA provides coverage up to $20,000 for emergency air transportation in the U.S. or Canada to a medical facility.

Hospital to Hospital Ambulance Coverage
If specialized care is required but not available at the initial emergency facility in the U.S. or Canada, MASA provides coverage for ground medical transfer or up to $20,000 for air ambulance transfer to the nearest appropriate medical facility.

Repatriation Near Home Coverage
If you're traveling in the U.S. or Canada and experience an emergency that requires extensive inpatient care and your care provider has approved continued care at a hospital nearer to your home, MASA coordinates your transfer and provides coverage for medical transportation to the approved medical facility.

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



Did you know?

54.1M

medical emergencies occur each year in the U.S.

Source: NEMSIS, 2024 (National EMS Information Systems)

About MASA

MASA is coverage and care you can count on to protect you from the unexpected — no network needed. Simply send us your emergency transport bill when it arrives, and we'll work to resolve the claim and provide your coverage. Plus, we offer expert coordination services to manage many of the complex needs that can arise after an emergency.

Offering you cost savings and well-being with a Flexible Spending Account (FSA)



nbs national benefit services

Signing up for a Flexible Spending Account (FSA) puts more money in your pocket.

You can pay less in taxes and reduce your medical expenses simply by signing up for an FSA!

A Flexible Spending Account (FSA) lets you set aside a portion of your paycheck—before taxes—into an account to help you pay for medical expenses. An FSA is a planning tool with great tax benefits. With an FSA, you must use the account balance in full before the end of the plan year or it will be forfeited.

A Flexible Spending Account (FSA):

- **Two Types of FSAs.** To take advantage of a health FSA, start by choosing an annual election amount. This amount will be available on day one of your plan year for eligible medical expenses. Payroll deductions will then be made throughout the plan year to fund your account. A dependent care FSA works differently than a health FSA. Dependent care FSA money only becomes available as it is contributed, and can only be used to pay expenses for the care of your dependents while you work. Both are pre-tax benefits your employer offers through a cafeteria plan. Choose one or both — whichever is right for you.

- **Reduces your taxable income.** Your FSA contributions are deducted from your paycheck by your employer before taxes are withheld. These deductions lower your taxable income, which can save you money on income taxes.

- **Enrollment Consideration.** After the enrollment period ends, you may increase, decrease or stop your contribution only when you experience a qualifying “change in status” event (e.g. marriage, divorce, employment change, dependent change). Be conservative in the total amount you elect to avoid forfeiting money at the end of the plan year.

- **What if I don’t use it all?** You must use the account balance in full before the end of the plan year or it will be forfeited. This is known as the “use it or lose it” rule. Your employer may offer a grace period or a rollover to help if you miss the mark a little bit. Check your Summary Plan Description for specifics on your employer's plan, and make sure to plan carefully when you enroll.



Spending is easy

Our convenient NBS Smart Debit Card allows you to avoid out-of-pocket expenses, cumbersome claim forms and reimbursement delays. You may also utilize the “pay a provider” option on our web portal.



Account access is easy

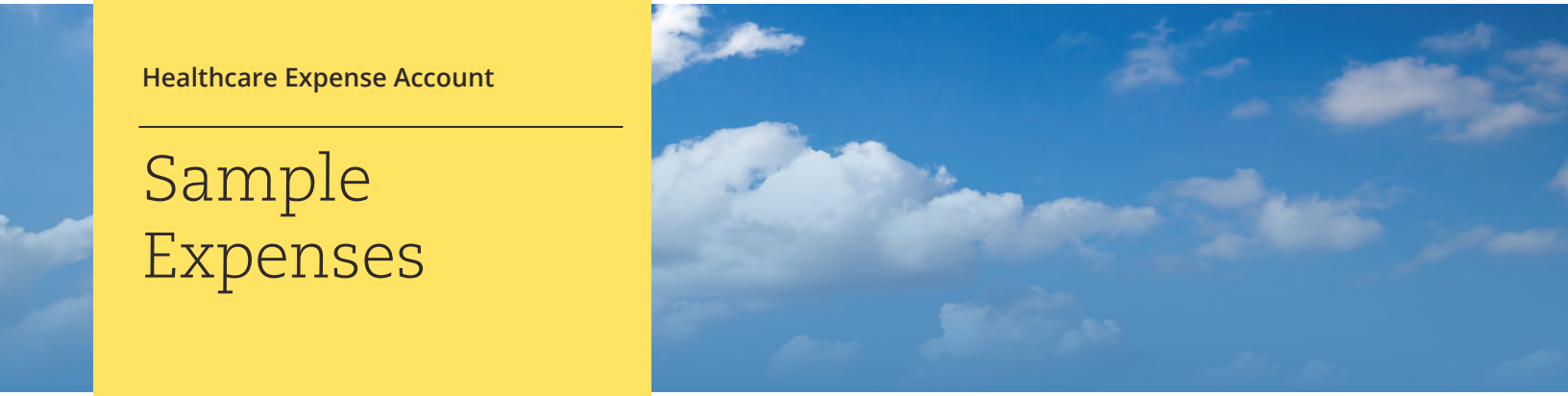
Get account information from our easy-to-use online portal and mobile app. You can submit claims online, and see your account balance, contributions, and account history in real time.

Eligible Expenses

Expenses can be reimbursed from your health FSA if the expenses are for the diagnosis, cure, mitigation, treatment or prevention of disease and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Expenses solely for cosmetic reasons generally are not considered expenses for medical care. Also, expenses that are merely beneficial to your general health are not eligible.

The following list shows common examples of qualified medical expenses. Complete lists of eligible and non-eligible expenses can be found in IRS Publication 502, which can be ordered from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or by visiting www.irs.gov.





Healthcare Expense Account

Sample Expenses

Medical Expenses

- Acupuncture
- Addiction programs
- Adoption (medical expenses for baby birth)
- Alternative healer fees
- Ambulance
- Body scans
- Breast pumps
- Care for mentally handicapped
- Chiropractor
- Copayments
- Crutches
- Diabetes (insulin, glucose monitor)
- Eye patches
- Fertility treatment
- First aid (e.g., bandages, gauze)
- Hearing aids & batteries
- Hypnosis (for treatment of illness)
- Incontinence products (e.g., Depends, Serene)
- Joint support bandages and hosiery
- Lab fees
- Menstrual Products*
- Monitoring device (blood pressure, cholesterol)
- Non-prescription medicines or drugs (vitamins/supplements without a prescription are not eligible)*
- Physical exams
- Pregnancy tests
- Prescription medicines or drugs
- Psychiatrist/psychologist (for mental illness)
- Physical therapy
- Speech therapy
- Vaccinations
- Vaporizers or humidifiers
- Weight loss program fees (if prescribed by physician)
- Wheelchair

**After January 1, 2020*

Dental Expenses

- Artificial teeth
- Copayments
- Deductible
- Dental work
- Dentures
- Orthodontia expenses
- Preventative care at dentist office
- Bridges, crown, etc.

Vision Expenses

- Braille - books & magazines
- Contact lenses
- Contact lens solutions
- Eye exams
- Eyeglasses
- Laser surgery
- Office fees
- Guide dog and upkeep/ other animal aid

Items that generally do not qualify for reimbursement

- Personal hygiene (e.g., deodorant, soap, body powder, sanitary products. Does not include menstrual products)
- Addiction products**
- Cosmetic surgery**
- Cosmetics (e.g., makeup, lipstick, cotton swabs, cotton balls, baby oil)
- Counseling (e.g., marriage/family)
- Dental care - routine (e.g., toothpaste, toothbrushes, dental floss, anti-bacterial mouthwashes, fluoride rinses, teeth whitening/bleaching)**
- Exercise equipment**
- Haircare (e.g., hair color, shampoo, conditioner, brushes, hair loss products)
- Health club or fitness program fees**
- Homeopathic supplement or herbs**
- Household or domestic help
- Laser hair removal
- Massage therapy**
- Nutritional and dietary supplements (e.g., bars, milkshakes, power drinks, Pedialyte)**
- Skin care (e.g., moisturizing lotion, lip balm)
- Sleep aids (e.g., snoring strips)**
- Vitamins**
- Weight reduction aids (e.g., Slimfast, appetite suppressant)**

***Portions of these expenses may be eligible for reimbursement if they are recommended by a licensed medical professional as medically necessary for treatment of a specific medical condition.*



Have You Ever...

- ☐ Signed a contract?
- ☐ Received a moving traffic violation?
- ☐ Needed your Will prepared or updated?
- ☐ Had concerns regarding child support?
- ☐ Had trouble with a warranty or defective product?
- ☐ Been overcharged for a repair or paid an unfair bill?

The LegalShield Membership Includes:

Dedicated Law Firm Direct access, no call center

Legal Advice/Consultation on unlimited personal issues

Letters/Calls made on your behalf

Contracts/Documents Reviewed up to 15 pages

Residential Loan Document Assistance for the purchase of your primary residence

Will Preparation - Will/Living Will/Health Care Power of Attorney

Traffic Ticket Consultation

IRS Audit Assistance (begins with the tax return due April 15th of the year you enroll)

Trial Defense (if named defendant/respondent in a covered civil action suit)

Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment)

25% Preferred Member Discount (bankruptcy, criminal charges, DUI, personal injury, etc.)

24/7 Emergency Access for covered situations

Put your law firm in the palm of your hand with the LegalShield mobile app!

Plan	Family Price (Per Month)
LegalShield	$15.95

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under the age 18 for whom the member is the legal guardian; never married dependent children up to age 26 if a full-time college student; or physically or mentally disabled dependent children. LegalShield provides access to identity theft protection and restoration services.

LegalShield®

If you have questions about setting up your account or need your member number, please call Member Services at 1-800-654-7757. Member Services is available 7 a.m.-7 p.m. CT, Monday-Friday.

Advanced Lab Tests and Health Screenings

Function

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

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

The membership includes:

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

HOW THE PROCESS WORKS

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



Advanced Lab Tests and Health Screenings

Function

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

FSA/HSA ELIGIBLE

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

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

How to Enroll

Enroll anytime during the year.

You will pay the membership fee(s) directly to Function.

Visit https://www.functionhealth.com/aep/higginbotham.

Test More. Know More.

Advanced testing across:

1. Heart
2. Immunity
3. Metabolics
4. Hormones
5. Nutrients
6. Heavy Metals
7. Liver
8. Kidneys
9. Pancreas
10. Prostate
11. Sexual Health
12. Electrolytes
13. Thyroid
14. Autoimmunity
15. Urine
16. Blood



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 medica 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.

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.

Glossary of Terms

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.

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.

Glossary of Terms

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.

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.

Glossary of Terms

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.

for a healthy you

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