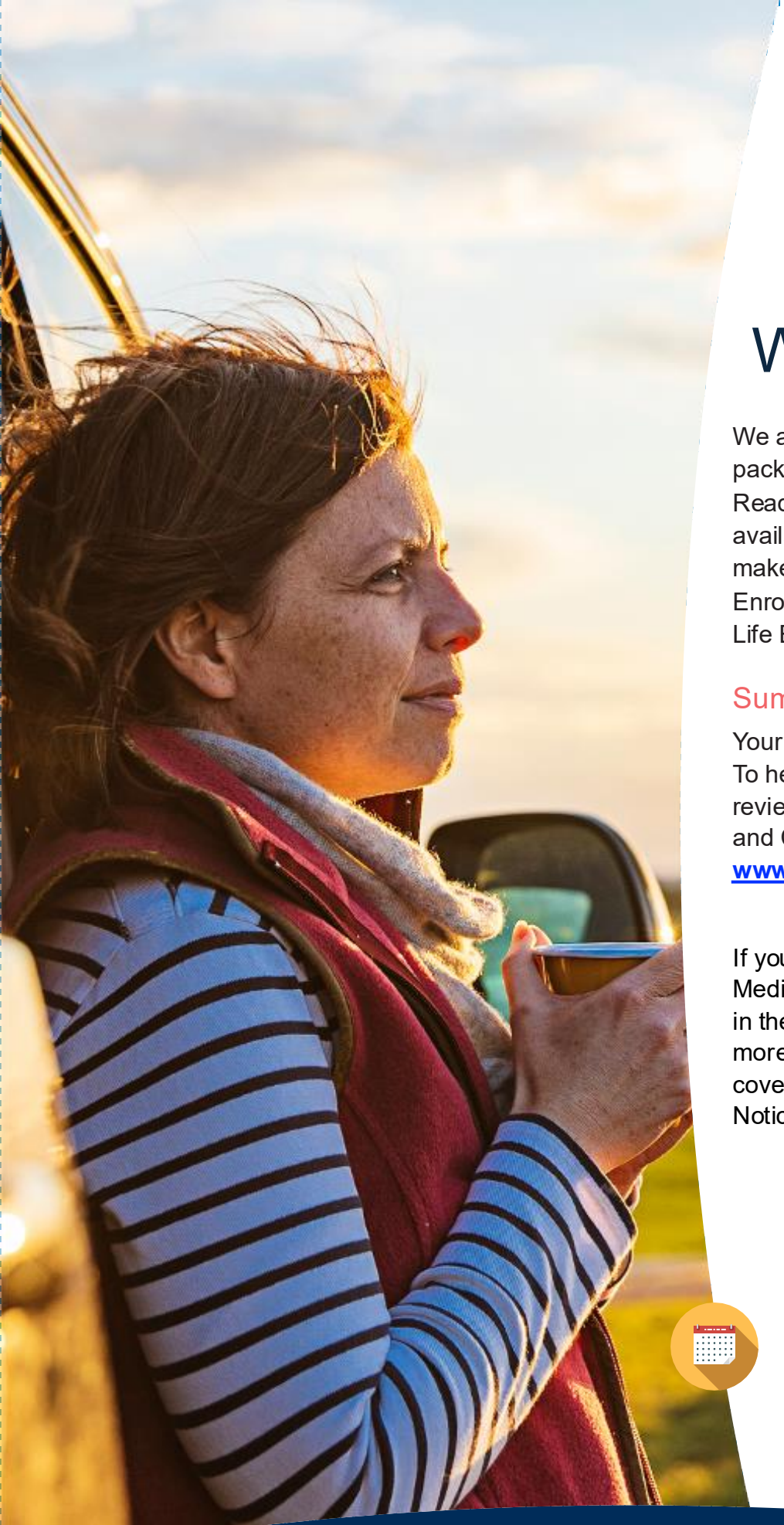
25 26

EMPLOYEE BENEFITS GUIDE

for a healthy you

ETX 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.

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.etxebc.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, 2025 – August 31, 2026

Contents

FLIP TO...

HOW TO ENROLL

5

FREQUENTLY ASKED QUESTIONS

6

LIFE & AD&D INSURANCE

21

Important Contacts

ETXEBC BENEFITS
Higginbotham Public Sector
833-950-1899
etxebc@hps.higginbotham.net
www.etxebc.com

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

HOSPITAL CASH PLAN
CHUBB
Group # 100000127
888-499-0425
educatorclaims@chubb.com

VISION
MetLife
Group # 5374366
855-638-3937
www.metlife.com

ACCIDENT
Lincoln Financial
800-423-2765
www.lfg.com

INDIVIDUAL LIFE
5STAR Life Insurance
Group # FBS03
866-863-9753
www.5starlifeinsurance.com

PRESCRIPTION SAVINGS
Clever RX
800-873-1195
www.partner.cleverrx.com/etxebc

TELEHEALTH
Recuro
855-673-2876
http://www.recurohealth.com

DISABILITY
New York Life
888-842-4462
www.newyorklife.com

CRITICAL ILLNESS
CHUBB
Group # 100000127
888-499-0425
educatorclaims@chubb.com

IDENTITY THEFT PROTECTION
ID Watchdog
Group #1504
800-774-3772
www.idwatchdog.com

FLEXIBLE SPENDING ACCOUNTS
National Benefit Services
800-274-0503
www.nbsbenefits.com

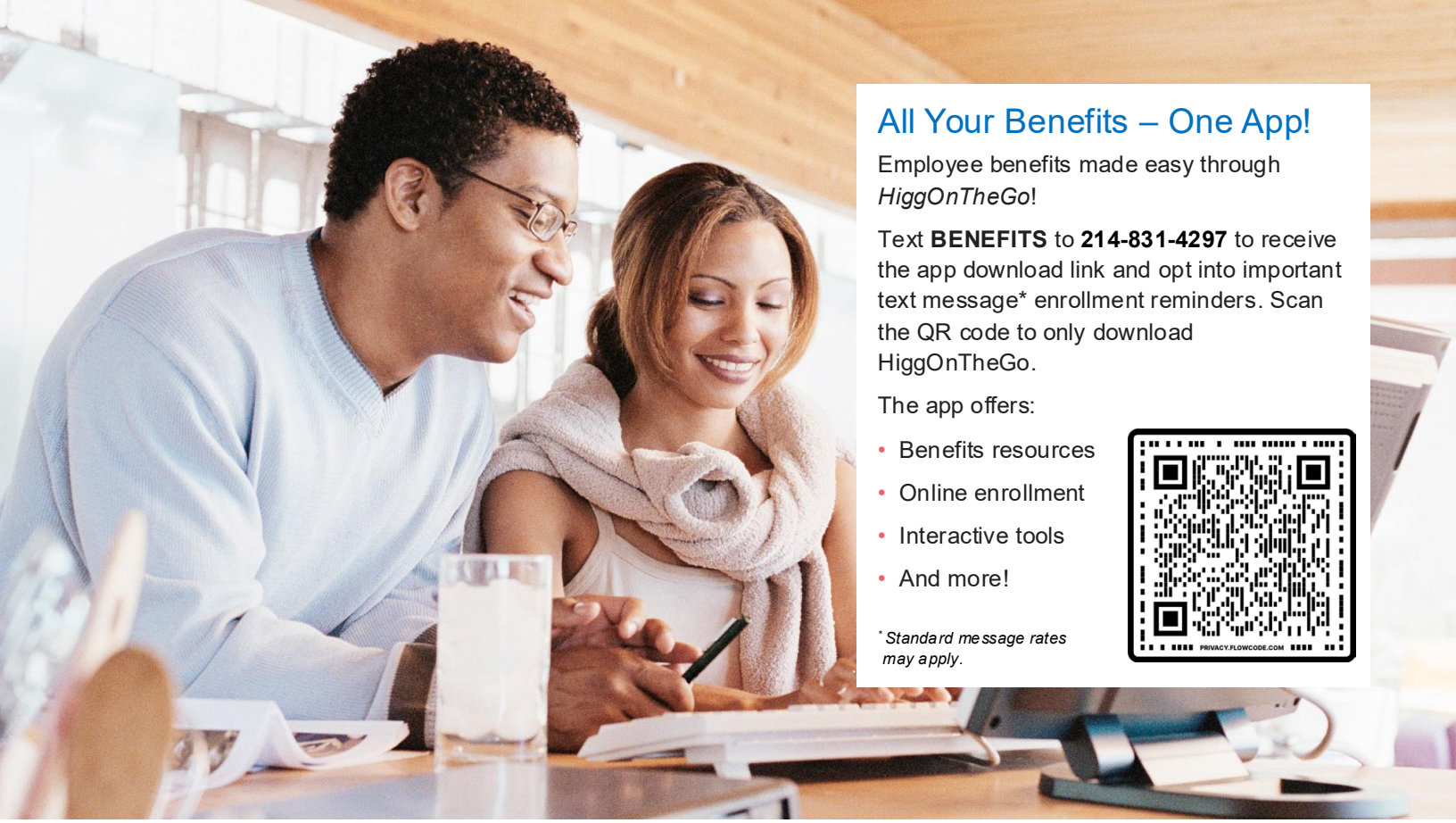
HEALTH SAVINGS ACCOUNT
EECU
817-882-0800
www.eecu.org

DENTAL
Lincoln Financial
800-423-2765
www.lfg.com/

CANCER
CHUBB
Group # 100000127
888-499-0425
educatorclaims@chubb.com

TERM LIFE AND AD&D
CHUBB
Group # 100000127
833-530-3711
www.chubb.com

EMERGENCY TRANSPORTATION
MASA
Group # ETEBC
800-423-3226
www.masamts.com



All Your Benefits – One App!

Employee benefits made easy through *HiggOnTheGo*!

Text **BENEFITS** to **214-831-4297** to receive the app download link and opt into important text message* enrollment reminders. Scan the QR code to only download HiggOnTheGo.

The app offers:

- Benefits resources
- Online enrollment
- Interactive tools
- And more!

Standard message rates may apply.

How to Enroll

LOGIN PROCESS	
1	Go to **www.etxebc.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

Enrollment FAQs

What if I miss the enrollment deadline?

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

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

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

Where do I find benefit summaries and forms?

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

How do I find an in-network provider?

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

When will I get my ID cards?

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

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

Benefit questions?

Ask your Benefits Department.

Call Higginbotham Public Sector at **833-950-1899**

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.

About Your Coverage Effective Date

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

New Hire

Who is Eligible

- A regular, full-time employee working 15 or more regularly scheduled hours per work 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 15 or more regularly scheduled hours per work week

When to Enroll

- Enroll during OE or when you have a QLE

When Coverage Starts

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

Dependent(s)

Who is Eligible

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

When to Enroll

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

When Coverage Starts

- Based on OE or QLE effective dates

MAXIMUM DEPENDENT ELIGIBILITY AGE BY PLAN
To Age 26
Medical, Telehealth, Dental, Vision, Dependent Flex, Health Care Flexible Savings Account, Health Savings Account, Life and AD&D, Individual Life, Accident, Cancer, Critical Illness, Hospital Cash

Qualifying Life Events

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

- Marriage
- Divorce
- Legal separation
- Annulment

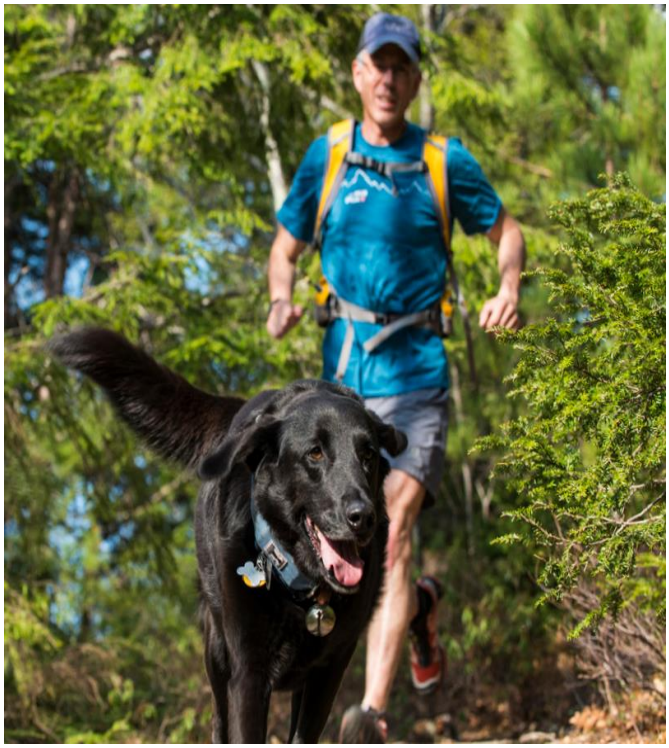
- Birth
- Adoption
- Placement for adoption
- Change in benefits eligibility
- Death

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

- Gain or loss of benefits coverage
- Change in employment status affecting benefits
- Significant change in cost of spouse's coverage

You 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.

Medical Coverage



Click the link below to access your TRS medical plan highlight for your region.

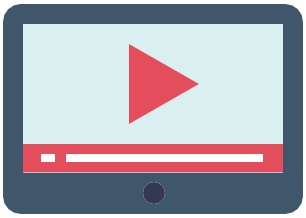
- Region 3 2025-2026 Plan Highlights
- Region 4 2025-2026 Plan Highlights
- Region 5 2025-2026 Plan Highlights
- Region 6 2025-2026 Plan Highlights
- Region 7 2025-2026 Plan Highlights
- Region 8 2025-2026 Plan Highlights
- Region 10 2025-2026 Plan Highlights
- Region 11 2025-2026 Plan Highlights
- Region 12 2025-2026 Plan Highlights

Preferred Provider Organization (PPO)

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

High Deductible Health Plan (HDHP)

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



Watch and learn more!

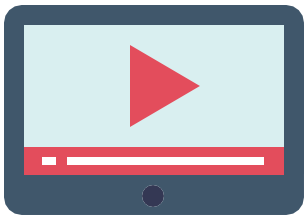
Find an In-Network Provider

Visit **www.trs.texas.gov**

Call **866-355-5999**

TRS Medical Rates

Our medical plans protect you and your family from major financial hardship in the event of illness or injury. For full plan details, options, and rates, visit **www.wtxebc.com** or your benefit website. Please note, the rates below do not include your district's medical contribution.



Watch and learn more!

TRS MEDICAL				
Region 3	**ActiveCare Primary**	**ActiveCare Primary+**	**ActiveCare HD**	**ActiveCare 2**
Employee Only	$516	$606	$529	$1,013
Employee and Spouse	$1,394	$1,576	$1,429	$2,402
Employee and Child(ren)	$878	$1,031	$900	$1,507
Employee and Family	$1,755	$2,000	$1,799	$2,841
Region 4				
Employee Only	$507	$596	$521	$1,013
Employee and Spouse	$1,369	$1,550	$1,407	$2,402
Employee and Child(ren)	$862	$1014	$886	$1,507
Employee and Family	$1,724	$1,967	$1,772	$2,841
Region 5				
Employee Only	$526	$617	$540	$1,013
Employee and Spouse	$1,421	$1,605	$1,458	$2,402
Employee and Child(ren)	$895	$1,049	$918	$1,507
Employee and Family	$1,789	$2,037	$1,836	$2,841
Region 6				
Employee Only	$495	$580	$508	$1,013
Employee and Spouse	$1,337	$1,508	$1,372	$2,402
Employee and Child(ren)	$842	$986	$864	$1,507
Employee and Family	$1,638	$1,914	$1,728	$2,841
Region 7				
Employee Only	$528	$621	$546	$1,013
Employee and Spouse	$1,426	$1,615	$1,475	$2,402
Employee and Child(ren)	$898	$1,056	$929	$1,507
Employee and Family	$1,796	$2,050	$1,857	$2,841
Region 8				
Employee Only	$540	$633	$556	$1,013
Employee and Spouse	$1,458	$1,646	$1,502	$2,402
Employee and Child(ren)	$918	$1,077	$946	$1,507
Employee and Family	$1,836	$2,089	$1,891	$2,841
Region 10				
Employee Only	$556	$653	$570	$1,013
Employee and Spouse	$1,502	$1,698	$1,539	$2,402
Employee and Child(ren)	$946	$1,111	$969	$1,507
Employee and Family	$1,891	$2,155	$1,938	$2,841
Region 11				
Employee Only	$556	$650	$570	$1,013
Employee and Spouse	$1,496	$1,690	$1,539	$2,402
Employee and Child(ren)	$942	$1105	$969	$1,507
Employee and Family	$1,848	$2,145	$1,938	$2,841
Region 12				
Employee Only	$509	$598	$521	$1,013
Employee and Spouse	$1,375	$1,555	$1,407	$2,402
Employee and Child(ren)	$866	$1,017	$886	$1,507
Employee and Family	$1,731	$1,974	$1,772	$2,841

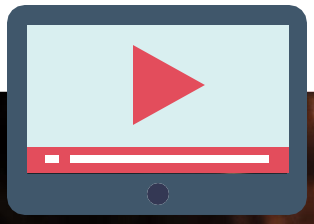
Telemedicine

Your benefit coverage offers access to quality telehealth services. Connect anytime day or night with a board-certified doctor via your mobile device or computer for free or for the same or less cost than a visit to your regular physician.

While telemedicine does not replace your primary care physician, it is a convenient and cost-effective option when you need care and:

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

Watch and learn more!



Registration is Easy

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

Visit Member Login

Call **855-673-2876**

Scan QR Code to Download App

When to Use Telemedicine

Use telemedicine for minor conditions such as:

- Sore throat
- Headache
- Stomachache
- Cold
- Flu
- Mental health issues
- Allergies
- Fever
- Urinary tract infections

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

Health Care Options

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

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

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

Pharmacy

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

Step 1

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

Group ID: **1085** Member ID: **3917**

Step 2

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

Step 3

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

Questions?

Call Clever RX Customer Service.

Need More Details?

Visit Clever RX

Call **800-873-1195.**

Preventive Care

Your benefits plan offers $0 preventive care for every age and sex. Preventive care is the care you receive to help prevent chronic illness or disease. It includes exams, lab work, screenings, immunizations, and counseling to prevent health problems, such as diabetes or heart disease. Visit **https://www.healthcare.gov/coverage/preventive-care-benefits** for a full list.

Check Out All the Preventive Care You Can Get For $0!

PREVENTIVE CARE COVERAGE INCLUDES		
Adults	Teens	Children
Cholesterol screening	Physical exam	Autism screening
Blood pressure screening	Blood tests for iron and cholesterol	Blood screening
Colorectal cancer screening	Anxiety screening	Depression screening
Lung cancer screening	Growth screening	Developmental screening
Hepatitis B screening	Hearing screening	Hearing screening
Well visits	Hepatitis B screening	Obesity screening and counseling
Bone density screenings	Depression screening	Hypothyroidism screening
Obesity screening	Sexually transmitted infection prevention counseling	Behavioral assessments
Diabetes Type 2 screening	Alcohol, tobacco, and drug use assessments	Well visits
Depression screening	Tuberculosis screening	Immunizations
Mammograms	Immunizations	Dental cleanings
Cervical cancer screening	Dental cleaning and exams	Oral health risk assessment
Immunizations	Vision screening	Vision screening
Dental cleanings		
Vision screening		

Preventive Care FAQ

Why should I get preventive care?

Preventive care is the fastest and best way to uncover potential risks and avoid chronic health conditions.

Are all screenings, tests, and procedures covered under preventive care?

No. Your doctor will be able to advise you as to the preventive care you need or should obtain, based on your medical and family history.

Why did I get a bill for preventive care?

The insurance company has codes that must be met on the doctor's bill for it to be processed as preventive and covered at 100 percent. If you have a medical complaint or your doctor finds a specific medical issue during your preventive care doctor's visit, a diagnosis code for that issue or complaint will be on your bill. As a result, the insurance company may process the bill for a specific medical condition, not preventive care. In this case, you must pay the copay or portion of your deductible.

Health Savings Account

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

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

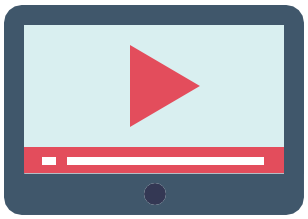
You Decide How To Use Your HSA Funds

Use it Now

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

Let it Grow

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



Watch and learn more!

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

Health Savings Account

HSA Contacts

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

Important HSA Information

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

HSA Eligibility

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

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

MAXIMUM HSA CONTRIBUTIONS	
2025	2026
$4,300 Individual	$4,400 Individual
$8,550 Family	$8,750 Family

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

Withdrawals for qualifying medical expenses are tax-free.

Flexible Spending Accounts

A Flexible Spending Account (FSA) allows you to set aside pretax dollars from each paycheck to pay for certain IRS-approved health and dependent care expenses.

Health Care FSA

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

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

You may not contribute to a Health Care FSA if you enrolled in a High Deductible Health Plan (HDHP) and contribute to a Health Savings Account (HSA).

Limited Purpose Health Care FSA

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

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

Dependent Care FSA

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

Dependent Care FSA Guidelines

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

How the Health Care and Limited Purpose FSAs Works

You can access the funds in your Health Care or Limited Purpose FSA two different ways:

- Use your NBS Smart Debit Card to pay for qualified expenses, doctor visits, and prescription copays.
- Pay out-of-pocket and submit your receipts for reimbursement.
  - » Fax **844-438-1496**
  - » Email **service@nbsbenefits.com**
  - » Online **NBS Portal**

Note: Some employers allow you to use your NBS Smart Card to pay your dependent care provider.

Flexible Spending Accounts

ANNUAL MAXIMUM FSA CONTRIBUTIONS		
2025	HEALTHCARE FSA LIMITED PURPOSE FSA	DEPENDENT CARE FSA
Maximum	$3,300	$5,000 if filing jointly or head of household and $2,500 if married filing separately.
Carryover*	** Please see your District information	No carryover — use it or lose it

You are entitled to the full election from day one of the plan year.

NBS Participant Portal and Mobile App

To get the most out of your benefits, register for the NBS Participant Portal and/or download the app. On the portal and app, you can:

- Access plan documents and account information.
- Update your personal information.
- Look up qualified expenses.
- Submit claims.
- Check balances.
- And more.

Visit NBS Portal click Register. Your employee ID is your Social Security Number.

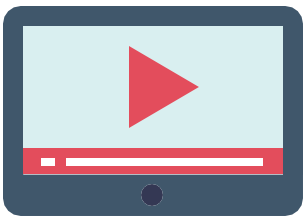
**Contact NBS at 855-399-3035, option 2, to confirm if your employer offers a Carryover or Grace period for unused funds.*

Questions?

If you have any questions or concerns, contact the NBS Service Center:

- Call **855-399-3035, option 2.**
- Email **service@nbsbenefits.com**
- Fax **844-428-1496.**

Representatives are available Monday through Friday from 7:00 a.m. to 7:00 p.m. CT.



Watch and learn more!

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)
Internal Revenue Code	Section 223		Section 125
Description	An HSA is an actual bank account in your name that allow you to save and pay for unreimbursed qualified medical expenses tax-free.		An FSA allows you to pay out-of-pocket expenses tax-free for: • copays, deductibles, and certain services not covered by medical plan • qualifying dependent care
Employer Eligibility	A qualified High Deductible Health Plan		All employers
Contribution Source	You and/or your employer		You and/or your employer
Account Owner	Individual		Employer
Underlying Insurance Requirement	High Deductible Health Plan		None
Insurance Plan Minimum Deductible	**2025** • $1,650 single • $3,300 family	**2026** • $1,650 single • $3,300 family	N/A
Maximum Contribution	**2025** • $4,300 single • $8,500 family • $1,000 age 55+ catch-up	**2026** • $4,400 single • $8,750 family • $1,000 age 55+ catch-up	$3,300
Permissible Use of Funds	Use any way you wish. If used for non-qualified medical expenses, funds are subject to the current tax rate plus a 20% penalty.		Reimbursement for qualified medical expenses as defined in Section 213(d) of the Internal Revenue Code.
Cash-Outs of Unused Amounts (if no medical expenses)	Permitted, but subject to current tax rate plus 20% penalty (waived after age 65).		Not permitted
Year-to-year rollover of account balance?	Yes, it will roll over to use for subsequent year's health coverage.		No. Access to some funds may be extended if your employer's plan contains a 2½-month grace period or **$660 (2025)** rollover provision.
Does the account earn interest?	Yes		No
Portable?	Yes, it is portable year-to-year and between jobs.		No

FLIP TO... 15 HSA 17 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, Limited Purpose Health Care FSA, and/or HSA. This list is not all-inclusive; additional expenses may qualify, and the items listed are subject to change in accordance with IRS regulations.

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

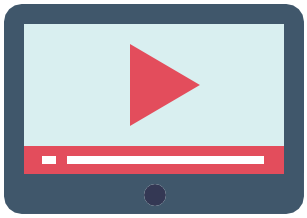
Abdominal supports
Acupuncture
Ambulance
Anesthetist
Arch supports
Artificial limbs
Blood tests
Braces
Cardiographs
Chiropractor
Crutches
Dental treatment
Dentures
Dermatologist
Diagnostic fees
Eyeglasses
Gynecologist
Healing services
Hearing aids and batteries
Hospital bills
Insulin treatment
Lab tests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

Dental Coverage

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

DPPO Plan

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



Watch and learn more!

Dental Benefits Summary

DENTAL PLAN		
	High PPO	Low PPO
	In-Network or Out-of-Network	In-Network Only
Calendar Year Deductible • Individual • Family	$50 $150	$50 $150
Calendar Year Benefit Maximum Per Individual	$1,700	$1,200
	You Pay	You Pay
Preventive and Diagnostic Care	$0	$0
Basic Restorative Care	20% after deductible	50% after deductible
Major Restorative Care	50% after deductible	50% after deductible
Orthodontia Adults included.	50% $1,000 lifetime maximum	Not covered
Employee Contributions		
Employee Only	$34.64	$23.80
Employee and Spouse	$73.64	$50.58
Employee and Child(ren)	$95.32	$65.44
Employee and Family	$129.96	$89.24

Find an In-Network Provider

Email **Claims@lfg.com**

Call **800-423-2765**

Vision Coverage

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

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

Find an In-Network Provider

Visit **http://www.metlife.com**

Call **855-638-3931**

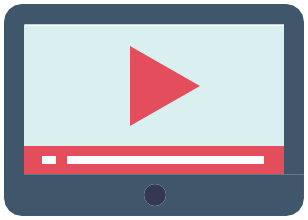
Vision Benefits Summary

VISION PLAN				
	HIGH PLAN		LOW PLAN	
	In-Network You Pay	Out-of-Network Reimbursement	In-Network You Pay	Out-of-Network Reimbursement
Exam	$10 copay	Up to $45	$10 copay	Up to $45
Lenses • Single vision • Lined bifocals • Lined trifocals • Lenticular	 $10 copay $10 copay $10 copay $10 copay	 Up to $30 Up to $50 Up to $65 Up to $100	 $10 copay $10 copay $10 copay $10 copay	 Up to $30 Up to $50 Up to $65 Up to $100
Frames	Balance over $150 allowance	Up to $70	Balance over $150 allowance	Up to $70
Contacts In lieu of frames and lenses • Fitting and evaluation • Elective • Medically necessary	 $60 copay $150 allowance Covered in full after copay	 Applied to allowance Up to $105 Up to $210	 $60 copay $150 allowance Covered in full after copay	 Applied to allowance Up to $105 Up to $210
Benefit Frequency				
Exam	Once every 12 months		Once every 12 months	
Lenses	Once every 12 months		Once every 12 months	
Frames	Once every 12 months		Once every 12 months	
Contacts	Once every 12 months		Once every 12 months	
Employee Contributions				
Employee Only	$8.12		$7.40	
Employee and Spouse	$18.02		$16.38	
Employee and Child(ren)	$18.08		$16.44	
Employee and Family	$23.38		$21.26	

High Plan Advantages

This benefit gives you additional eyewear coverage. You can get:

- Two pairs of prescription eyeglasses, or
- One pair of prescription eyeglasses and an allowance toward contact lenses, or
- Double your contact lens allowance



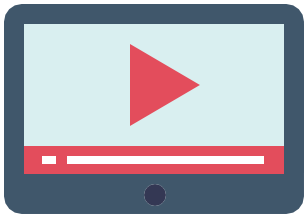
Watch and learn more!

Term Life and AD&D Insurance

CHUBB®

Group Term Life is the least expensive way to buy life insurance. Term Life and Accidental Death and Dismemberment (AD&D) insurance is important to your financial security, especially if others depend on you for support or vice versa.

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



Watch and learn more!

Educator Group Term Life Insurance

Voluntary Term Life and AD&D Insurance is available to purchase for you and your family. You must be actively at work for at least 15 hours per week to be eligible to enroll for coverage.

You and your eligible dependents may enroll in amounts up to $300,000 for employee and $75,000 for spouse without answering health questions. Amounts over the Guaranteed Issue will require medical underwriting. If you buy at least $10,000 of coverage during initial enrollment, you may buy up to the Guaranteed Issue in subsequent re-enrollments without medical underwriting. Benefits will reduce 50% at age 70.

Designating a Beneficiary

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

Term Life and AD&D Insurance

CHUBB®

Coverage Highlights

- **Portable** – keep your supplemental coverage if you leave your current employer.
- **Convertible** – convert your group term life insurance benefits to an individual whole life policy if your coverage ends.
- **Accelerated Benefits Option** – get up to 50% of your life insurance benefit.
- **Employee Assistance Program** – get six visits.
- **Financial Wellness** – this program is included.
- **AD&D Covered Losses and Benefits** – offers additional protection for you and your family if an accidental bodily injury results in death or dismemberment.

TERM LIFE INSURANCE	
Employee	• Increments of $10,000 up to 10 times basic annual earnings not to exceed $500,000 • Guaranteed Issue: $300,000
Spouse	• Increments of $5,000 up to 100% of the employee's amount, not to exceed $500,000 • Guaranteed Issue: $75,000
Child(ren)	• Six months to age 26: $10,000 • Guaranteed Issue: $10,000

Term Life Monthly Rates		
Age	Employee (per $10,000)	Spouse[1] (per $5,000)
<25	$0.33	$1.65
25-29	$0.33	$1.65
30-34	$0.50	$0.250
35-39	$0.59	$0.295
40-44	$0.84	$0.630
45-49	$1.26	$0.965
50-54	$1.93	$1.800
55-59	$3.60	$2.765
60-64	$5.53	$4.980
65-69	$9.96	$7.950
70+	$15.90	

Child(ren) Rate per $10,000	
To age 26	$1.60

TERM AD&D INSURANCE	
Term AD&D Monthly Rates per $10,000	
Employee	$0.17
Spouse	$0.17
Child(ren)	$0.17

Calculate Your Monthly Cost

Term Life Insurance

$_____ (coverage amount) ÷ $10,000 = $_____ X

$_____ (rate) = $_____ (monthly cost)

Term AD&D Insurance

$_____ (coverage amount) ÷ $1,000 = $_____ X

$_____ (rate) = $_____ (monthly cost)

Individual Life Insurance

The Family Protection Plan Group Level Term Life Insurance from 5STAR Life Insurance helps protect your family.

You do not have to elect coverage for yourself. You may elect coverage for:

- Your spouse
- Your financially independent children and grandchildren (14 days to age 26).

Coverage lasts until age 121 for all insured, so your family can be protected into their retirement years as long as your premiums are paid.

This coverage is portable, which means you may continue with no loss of benefits or increase in cost if you terminate employment after the first premium is paid. You will simply be billed directly.

Buy When You Are Young!

Buying life insurance when you are younger allows you to take advantage of lower premium rates while you are generally healthy. This allows you to buy more insurance coverage for the future and still pay less than you would if you were older and trying to buy the same coverage amount. This is especially important if you have dependents who rely on your income, or you have debt that would need to be paid off.

Watch and learn more!

Disability Insurance

Disability insurance protects one of your most valuable assets: your paycheck. This insurance replaces a portion of your income if you are unable to work for a period of time due to a covered disability.

If you had an unexpected illness or injury and were unable to work, how long would you be able to pay your bills?

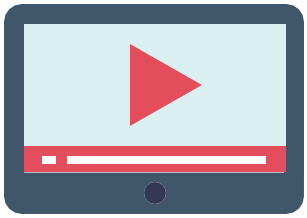
Some plans vary by district within ETXEBC. Check your district benefit website at www.etxebc.com for details about your specific plan.

Watch and learn more!

Hospital Cash Plan

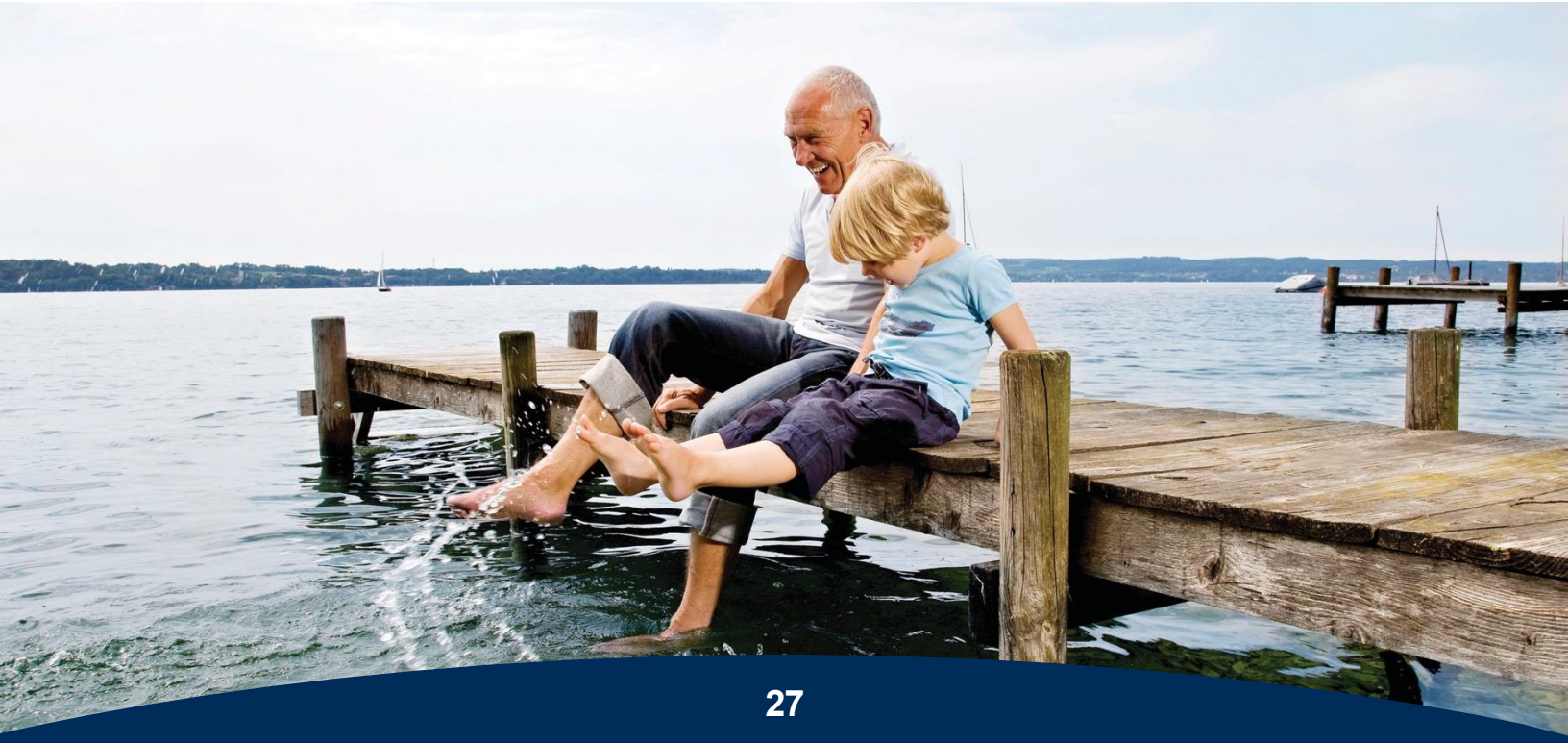
CHUBB®

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



Watch and learn more!

HOSPITAL CASH PLAN			
	Plan 1	Plan 2	Plan 3
Hospital Admission	$1,500 (maximum five per year)	$3,000 (maximum five per year)	$5,000 (maximum five per year)
Hospital Confinement	$150 per day up to 30 days	$150 per day up to 30 days	$200 per day up to 30 days
ICU Confinement	$300 per day up to 30 days	$300 per day up to 30 days	$400 per day up to 30 days
Newborn Nursery	$500 per day up to two days	$500 per day up to two days	$500 per day up to two days
Employee Contributions			
Employee Only	$20.74	$34.22	$54.35
Employee and Spouse	$43.31	$69.72	$110.19
Employee and Child(ren)	$29.50	$48.25	$76.39
Employee and Family	$47.82	$77.68	$122.86



Accident Insurance

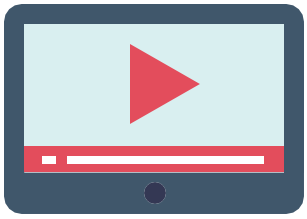
Accident insurance provides affordable protection against a sudden, unforeseen accident. The Accident plan helps offset the direct and indirect expenses resulting from an accident such as copayments, deductible, ambulance, physical therapy, childcare, rent, and other costs not covered by traditional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

This coverage provides you a lump sum cash benefit to help manage unexpected expenses. How you spend it is completely up to you — from everyday bills or childcare to other expenses.

**Receive a cash benefit every year you and any of your covered family members complete a single covered health/wellness assessment.

ACCIDENT INSURANCE	
Ambulance • Ground • Air	 $400 $2,400
Emergency Room	$200
Admission • Hospital • ICU	 $1,600 $5,000
Confinement • Hospital • ICU	 $325 per day $1,000 per day
Specific Sum Injuries Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, and more	$200-$20,000
Accidental Death & Dismemberment[1]	$5,000-$50,000
Employee Contributions	
Employee Only	$12.96
Employee and Spouse	$19.20
Employee and Child(ren)	$17.48
Employee and Family	$23.74

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

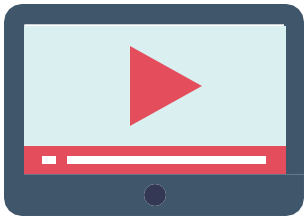


Watch and learn more!

Critical Illness Insurance

CHUBB

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



Watch and learn more!

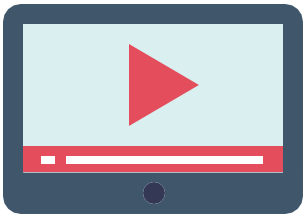
No benefit will be paid for a date of diagnosis that occurs prior to the coverage effective date. You must be treatment free from cancer for 12 months prior to diagnosis date and in complete remission. There is no pre-existing condition limitation. All amounts are Guaranteed Issue. No medical questions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

CRITICAL ILLNESS INSURANCE	
Employee	Increments of $10,000 up to $50,000
Spouse	Increments of $10,000 up to $50,000
Children	Included in Employee coverage
First Occurrence Benefit	
Full Coverage Benign brain tumor, coma, loss of speech, loss of hearing, loss of sight, heart attack, kidney failure, major organ transplant, ALS, Alzheimer's disease, multiple sclerosis, advanced Parkinson's disease, severe burns, stroke	100% of benefit amount
Partial Coverage Carcinoma in situ, coronary artery obstruction, Addison's disease, diphtheria, malaria, meningitis, polio, systemic lupus	25%-50% of benefit amount
Childhood Diseases Cerebral palsy, cleft lip/palate, cystic fibrosis, Type 1 diabetes, Down Syndrome	100% of benefit amount

Cancer Insurance

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.



Watch and learn more!

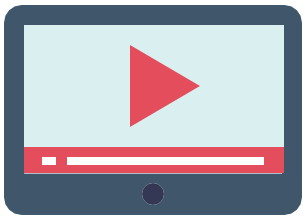
CANCER INSURANCE		
	Low Plan	High Plan
Cancer Diagnosis • Employee/Spouse • Child(ren)	 $5,000 $7,500	 $10,000 $15,000
Radiation, Chemotherapy & Immunotherapy Per covered individual per calendar year	$15,000	$20,000
Hospital Confinement	$100 per day up to 30 days per confinement	$300 per day up to 30 days per confinement
Employee Contributions		
Employee Only	$20.18	$29.98
Employee and Spouse	$38.04	$57.28
Employee and Child(ren)	$25.64	$38.94
Employee and Family	$39.00	$60.20

Emergency Transport Services

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

Consider buying emergency transport services to greatly reduce or completely cover the cost of emergency transportation. After your medical crisis, contact **MASA MTS** to negotiate with your medical plan provider and cover the balance on your medical transportation bills.

	Premier Plan	Platinum Plan
Employee and Family	$15.50	$33



Watch and learn more!

For More Details

Visit www.masamts.com (Group# ETEBC)

Call **800-423-3226.**

ID Theft Protection

idwatchdog® from Equifax

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

Protect yourself and restore your identity with coverage that includes:

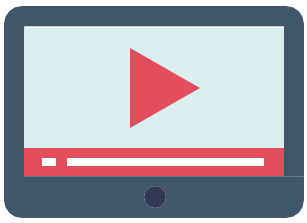
- Identity consultation and advice
- Licensed private investigators
- Identity and credit monitoring
- Social media monitoring
- Identity restoration
- Credit freeze assistance
- Dark web monitoring
- Threat and credit alerts
- 24/7 emergency ID protection access
- Mobile app
- And more!

For More Information

Visit www.idwatchdog.com

Call **866-513-1518**.

Watch and learn more!



	Platinum Plan	Ultimate Plan
Employee Only	$8.50	$10.30
Employee and Family	$14.90	$17.05

Important Legal Notices

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer benefits:

All stages of reconstruction of theRights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

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

- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

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

Special Enrollment Rights

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

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

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

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

Marriage, Birth or Adoption

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

For More Information or Assistance

To request special enrollment or obtain more information, contact your human resources department.

ETXEBC
2175 N Glenville Dr
Richardson, TX 75082
833-950-1899

Your Prescription Drug Coverage and Medicare

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

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

Please note, however, that later notices might supersede this notice.

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

Important Legal Notices

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

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

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

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

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

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

Contact the Human Resources Department at **833-950-1899**

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

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available.

Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

ETXEBC
2175 N Glenville Dr
Richardson, TX
75082
833-950-1899

Important Legal Notices

Notice of HIPAA Privacy Practices

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

Effective Date of Notice: September 23, 2013

ETXEBC Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1 – Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including
fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care.
Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

Important Legal Notices

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.
6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In which case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Important Legal Notices

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

Section 2 – Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

Protected Health Information (PHI)

Includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set

Includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Important Legal Notices

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3 – The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted, you will also receive a copy of the Notice or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Important Legal Notices

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4 – Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5 – Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at:

ETXEBC
2175 N Glenville Dr
Richardson, TX
75082
833-950-1899

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of March 17, 2025. Contact your State for more information on eligibility.

Important Legal Notices

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

To see if any other States have added a premium assistance program since **March 17, 2025**, or for more information on special enrollment rights, you can contact either:

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

Continuation of Coverage Rights Under COBRA

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

Plan Contact Information:

ETXEBC
2175 N Glenville Dr
Richardson, TX 75082
833-950-1899

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

Important Legal Notices

You are protected from balance billing for:

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

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

Notes

Notes

for a healthy you

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