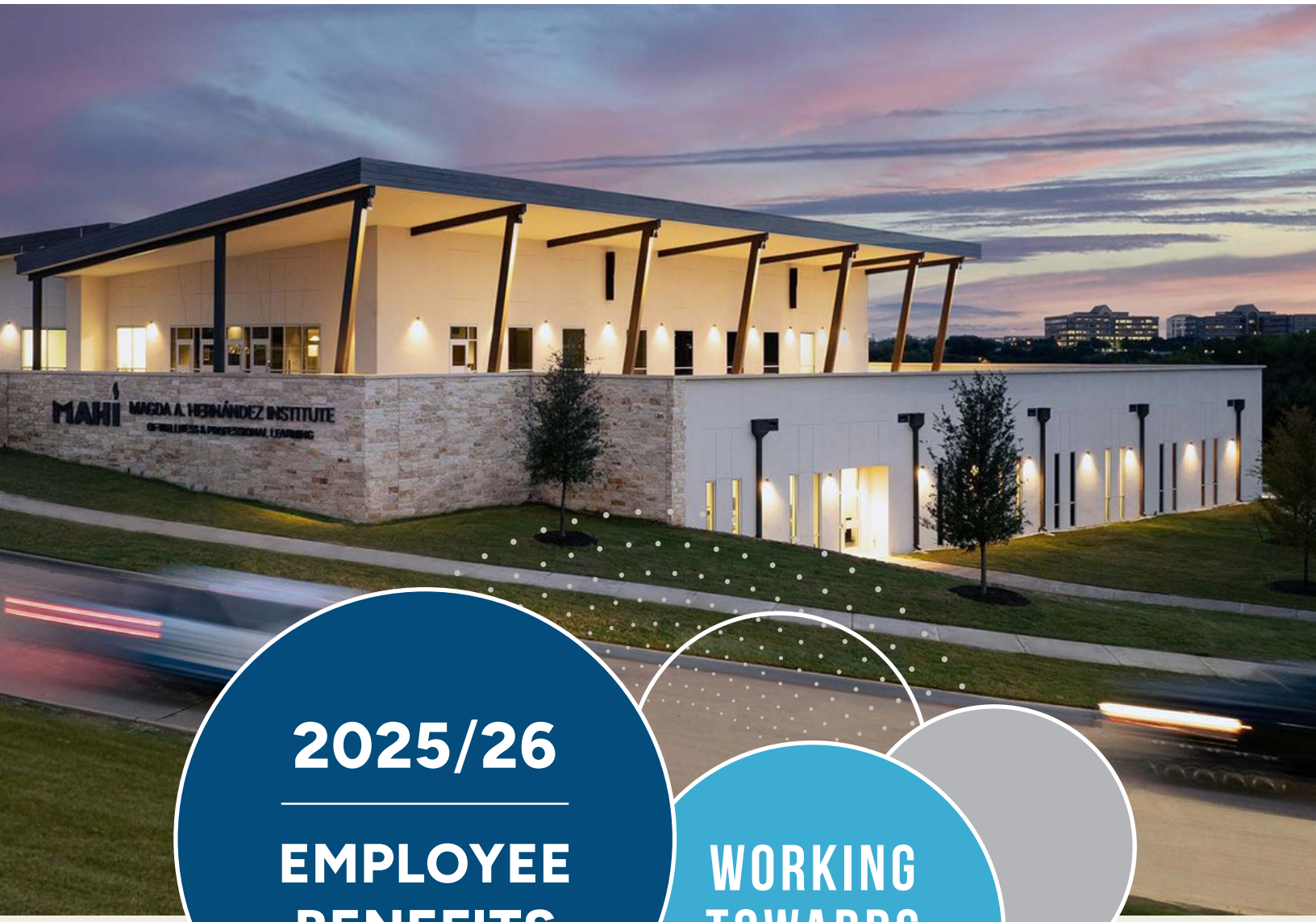
IRVING
Independent School District



2025/26

EMPLOYEE BENEFITS

WORKING TOWARDS WELLNESS

A comprehensive guide to understanding your 2025-2026 employee benefits program

What's Inside

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 page 38 for more details.

Welcome

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

Availability Of Summary Health Information

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

Flip to...

4 How to Enroll
5 FAQ
8 Medical Benefits

Important Contacts

WORKING TOWARDS ANSWERS

Irving ISD Benefits
Irving ISD
972-600-5241
hr-benefitsandleaves@irvingisd.net

TRS Medical Coverage
Blue Cross Blue Shield of Texas
866-355-5999
www.bcbstx.com/trsactivecare

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

Prescription Savings
Clever RX
800-873-1195
www.cleverrx.com

Health Savings Account
EECU
800-333-9934
www.eecu.org

Flexible Spending Accounts
Higginbotham
866-419-3519
https://flexservices.higginbotham.net

Dental
Cigna
Group #3337017
Total Cigna DPPO Network
Cigna Dental Care DHMO Network
800-244-6224
www.mycigna.com

Vision
Superior Vision
Group #30908
Superior Vision Network
800-507-3800
www.superiorvision.com

Life/AD&D
New York Life
Life Group #FLX-964086
AD&D Group #OK965703
800-362-4462
www.newyorklife.com

Educator Disability
New York Life
Group #SLH10016
800-362-4462
www.newyorklife.com

Hospital Indemnity
Cigna
Group #HC960777
800-362-4462
www.cigna.com

Critical Illness
New York Life
800-362-4462
www.mynylgbs.com

Cancer Insurance
Chubb
Group #1000000223
888-499-0425
educatorclaims@chubb.com

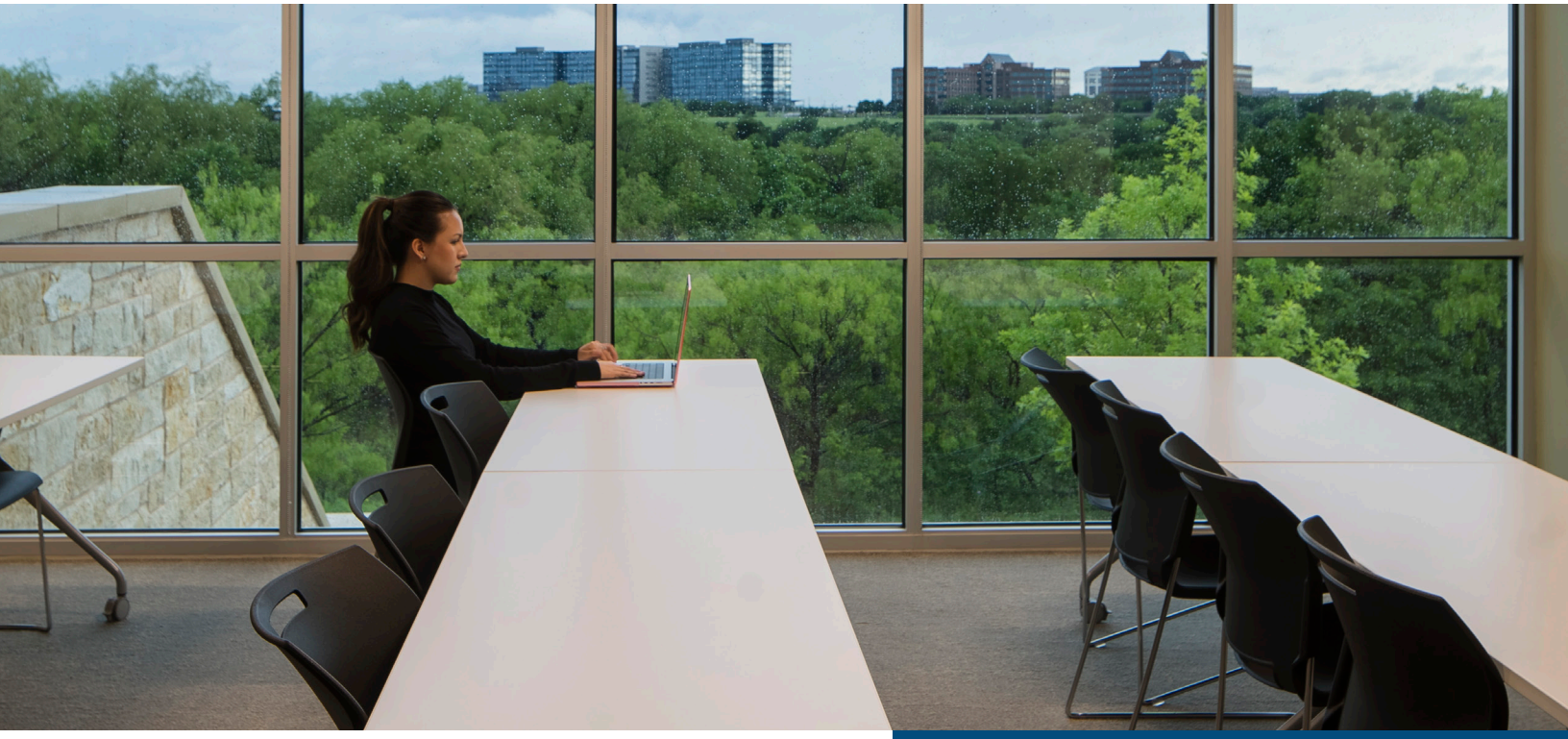
Employee Assistance Program
New York Life
800-344-9752
WEB ID #NYLGBS
www.guidanceresources.com

457(b) Retirement Plan
TCG Administrators
800-943-9179
www.tcgservices.com

403(b) Retirement Plan
NBS
855-399-0335
www.nbsbenefits.com

Benefits Assistance
Higginbotham Public Sector
833-900-1491
irvingisd@hps.higginbotham.net

How to Enroll



All Your Benefits – One App!

Employee benefits made easy through *HiggOnTheGo*!

Text **BENEFITS** to **214-831-4265** to receive the app download link and opt into important text message* enrollment reminders. Scan the QR code to only download *HiggOnTheGo*.

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

* Standard message rates may apply.

GET IT ON Google Play

Download on the App Store

BENEFIT QUESTIONS?

- Ask your Benefits Department.
- Call **833-900-1491** for Higginbotham Public Sector.

Login Process

1. Go to **www.mybenefitshub.com/irvingisd**. Scan the QR code below.
2. Click *Login*.
3. Log in with **Microsoft**.
4. If you need assistance, contact Irving ISD Tech Support at **972-600-5260**.

How to Enroll

Enrollment FAQs

What if I miss the enrollment deadline?

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

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

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

Where do I find benefit summaries and forms?

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

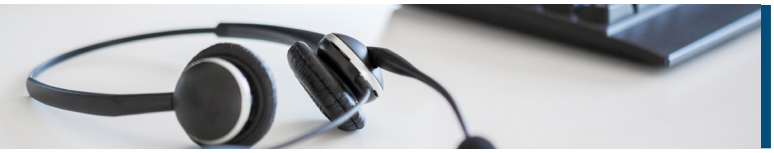
How do I find an in-network provider?

Access **www.mybenefitshub.com/irvingisd** 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 **833-900-1491** for Higginbotham Public Sector.

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)

Status	New Hire	Employee	Dependent(s)
Who is Eligible	• Regular, full-time employee • Working an average of 20 hours per week	• Regular, full-time employee • Working an average of 20 hours per week	• 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	• Enroll by the deadline given by Human Resources	• Enroll during OE or when you have a QLE	• 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	• First of month following or coincident with date of hire	• You must be actively at work on the plan effective date for new benefits to be effective • QLE: Ask Human Resources	• Based on OE or QLE effective dates

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.

See Important Limitations and Exclusions section.

Maximum Dependent Eligibility Age by Plan

TO AGE 26

Medical, Telemedicine, Dental, Vision, Life and AD&D, Cancer, Hospital Indemnity, and Critical Illness

Qualifying Life Events

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

Marriage

Divorce

Annulment

Birth

Adoption

Placement for adoption

Change in benefits eligibility

Death

Undergoing FMLA, COBRA event, judgment, or decree

Becoming eligible for Medicare, Medicaid, or TRICARE

Receiving a Qualified Medical Child Support Order

Gain or loss of benefits coverage

Change in employment status affecting benefits

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

Medical Coverage

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

Medical Provider:

BlueCross BlueShield of Texas

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

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

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

Find an In-Network Provider

Visit **www.bcbstx.com/trsactivecare**.
Call **866-355-5999**.

Watch and learn more!

TRS Region 10 Monthly Medical Rates

	TRS-ActiveCare Primary		TRS-ActiveCare Primary+		TRS-ActiveCare HD		TRS-ActiveCare 2	
12 Pay Rates – Professional and Paraprofessional								
Irving ISD contributes $506 per month	Total Premium	Employee Cost	Total Premium	Employee Cost	Total Premium	Employee Cost	Total Premium	Employee Cost
Employee Only	$556.00	**$50.00**	$653.00	**$147.00**	$570.00	**$64.00**	$1,013.00	**$507.00**
Employee and Spouse	$1,502.00	**$996.00**	$1,698.00	**$1,192.00**	$1,539.00	**$1,033.00**	$2,402.00	**$1,896.00**
Employee and Child(ren)	$946.00	**$440.00**	$1,111.00	**$605.00**	$969.00	**$463.00**	$1,507.00	**$1,001.00**
Employee and Family	$1,891.00	**$1,385.00**	$2,155.00	**$1,649.00**	$1,938.00	**$1,432.00**	$2,841.00	**$2,335.00**
24 Pay Rates – Facilities Services and Operations								
Irving ISD contributes $253 per pay period	Total Premium	Employee Cost	Total Premium	Employee Cost	Total Premium	Employee Cost	Total Premium	Employee Cost
Employee Only	$278.00	**$25.00**	$326.50	**$73.50**	$285.00	**$32.00**	$506.50	**$253.50**
Employee and Spouse	$751.00	**$498.00**	$849.00	**$596.00**	$769.50	**$516.50**	$1,201.00	**$948.00**
Employee and Child(ren)	$473.00	**$220.00**	$555.50	**$302.50**	$484.50	**$231.50**	$753.50	**$500.50**
Employee and Family	$945.50	**$692.50**	$1,077.50	**$824.50**	$969.00	**$716.00**	$1,420.50	**$1,167.50**
17 Pay Rates – Food Service and CAO's								
Irving ISD contributes $357.18 per pay period	Total Premium	Employee Cost	Total Premium	Employee Cost	Total Premium	Employee Cost	Total Premium	Employee Cost
Employee Only	$392.47	**$35.29**	$460.94	**$103.76**	$402.35	**$45.18**	$715.06	**$357.88**
Employee and Spouse	$1,060.24	**$703.06**	$1,198.59	**$841.41**	$1,086.35	**$729.18**	$1,695.53	**$1,338.35**
Employee and Child(ren)	$667.76	**$310.59**	$784.24	**$427.06**	$684.00	**$326.82**	$1,063.76	**$706.59**
Employee and Family	$1,334.82	**$977.65**	$1,521.18	**$1,164.00**	$1,368.00	**$1,010.82**	$2,005.41	**$1,648.24**

TRS ACTIVECARE
TEACHER RETIREMENT SYSTEM OF TEXAS

TRS-ActiveCare
PLAN HIGHLIGHTS 2025-26

TRS-ActiveCare
REGION 10

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%.
- **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.

765391.0225

2025-26 TRS-ActiveCare Plan Highlights Sept. 1, 2025 –

How to Calculate Your Monthly Premium

Total Monthly Premium
− Your Employer Contribution
= **Your Premium**

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

Wellness Benefits at No Extra Cost*

Being healthy is easy with:

- $0 preventive care
- 24/7 customer service
- One-on-one health coaches
- Weight loss programs
- Nutrition programs
- Ovia™ pregnancy support
- TRS Virtual Health
- Mental health benefits
- And much more!

**Available for all plans.*
See the benefits guide for more details.

Primary Plans & Mental Health

- Both Primary and Primary+ offer $0 virtual mental health visits with any in-network provider.

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

	TRS-ActiveCare Primary	TRS-
Plan Summary	• Lowest premium of all three 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	• Lower deductible t • Copays for many s • Higher premium • Statewide network • Primary Care Provi • Not compatible wit • No out-of-network

Monthly Premiums	Total Premium	Employer Contribution	Your Premium	Total Premium
Employee Only	$556			$653
Employee and Spouse	$1,502			$1,698
Employee and Children	$946			$1,111
Employee and Family	$1,891			$2,155

Plan Features		
Type of Coverage	In-Network Coverage Only	I
Individual/Family Deductible	$2,500/$5,000	
Coinsurance	You pay 30% after deductible	Yo
Individual/Family Maximum Out of Pocket	$8,050/$16,100	
Network	Statewide Network	
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	Yo
TRS Virtual Health-RediMD™	$0 per medical consultation	$
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 2 You pay
Non-preferred	You pay 50% after deductible	Yo
Specialty (31-Day Max)	$0 if SaveOnSP eligible; You pay 30% after deductible	$0 if SaveOnSI
Insulin Out-of-Pocket Costs	$25 copay for 31-day supply; $75 for 61-90 day supply	$25 copay for 3

Aug. 31, 2026

TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

Each includes a wide range of wellness benefits.

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

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

n-Network Coverage Only	In-Network	Out-of-Network
$1,200/$2,400	$3,300/$6,600	$6,600/$13,200
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
Statewide Network	Nationwide Network	
Yes	No	

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

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

ible 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
P eligible; You pay 30% after deductible	You pay 20% after deductible
31-day supply; $75 for 61-90 day supply	You pay 25% after deductible

This plan is closed and not accepting new enrollees. If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan.

TRS-ActiveCare 2

- Closed to new enrollees
- Current enrollees can choose to stay in 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
Nationwide Network	
No	

$30 copay	You pay 40% after deductible
$70 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)
$0 if SaveOnSP eligible; You pay 30% after deductible ($200 min/$900 max)/ No 90-day supply of specialty medications
$25 copay for 31-day supply; $75 for 61-90 day supply

Compare Prices for Common Medical Services

REMEMBER: Call a Personal Health Guide 24/7 to help you find the best price for a medical service. Reach them at **1-866-355-5999**.

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/Indpendent Lab: You pay $0 Outpatient: You pay 30% after deductible	Office/Indpendent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	Office/Indpendent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 40% after deductible
High-Tech Radiology	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 Costs	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 Hospital Costs	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; performed by an ophthalmologist or optometrist)	You pay $70 copay	You pay $70 copay	You pay 30% after deductible	You pay 50% after deductible	You pay $70 copay	You pay 40% after deductible
Annual Hearing Exam (one per plan year)	$30 PCP copay $70 specialist copay	$15 PCP copay $70 specialist copay	You pay 30% after deductible	You pay 50% after deductible	$30 PCP copay $70 specialist copay	You pay 40% after deductible

***Pre-certification for genetic and specialty testing may apply. Contact a PHG at **1-866-355-5999** with questions.*

www.trs.texas.gov

Revised 05/30/25

Telemedicine

Your benefit coverage offers access to quality telemedicine services. Connect anytime day or night with a board-certified doctor via your mobile device or computer **for free**!

Telemedicine Provider:

RECURO HEALTH

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

When to Use Telemedicine

Use telemedicine for minor conditions such as:

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

Recuro Behavioral Health

Managing stress or life changes can be overwhelming but it's easier than ever to get help right in the comfort of your own home. Talk to a licensed counselor or psychiatrist by phone, secure video, or app from your home, office, or on the go! **Recuro** offers affordable, confidential online therapy for a variety of counseling needs.

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

Registration is Easy

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

Visit **www.recurohealth.com**.

Call **855-6RECURO**.

Download the **Recuro** app to your mobile device.

Watch and learn more!

Health Care Options

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

Health Care Provider		Symptoms	Average Cost	Average Wait
Non-Emergency Care				
 **TELEMEDICINE**	Access to care via phone, online video, or mobile app whether you are at home, work, or traveling; medications can be prescribed 24 hours a day, 7 days a week	• Allergies • Cough/cold/flu • Rash • Stomachache	$0	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.

Prescription Savings

Clever RX Benefits

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

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

- BIN **020529**
- PCN **CLEVR**
- Group ID **1085**
- Member ID **1807**

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

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

QUESTIONS?

For Clever RX, call **800-873-1195**.

Contact Clever RX

Visit **www.cleverrx.com**.
Call **800-873-1195**.

Preventive Care

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

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** to review what types of services are covered under preventive care.

Having a doctor who knows you and your medical history is a key part of preventive care.

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 cleanings and exams	Oral health risk assessment
Immunizations	Vision screening	Vision screening
Dental cleanings and exams		
Vision screening		

Frequently Asked Questions

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.

Benefits Assistance

We all have questions. Higginbotham Public Sector is available to help you with questions about:

Enrollment

Benefits Information

Claims and Billing

Eligibility Issues

833-900-1491

irvingisd@hps.higginbotham.net

COMPANY ID: 1807

Call or text with a bilingual representative Monday through Friday from 7:00 a.m. to 6:00 p.m. CT.
If you leave a message after 3:00 p.m. CT, your call or text will be returned the next business day.
You can also email your questions or requests at anytime.

Health Savings Account

The Health Savings Account (HSA) is a type of personal savings account that helps pay for current and future health costs and supplements retirement savings.

HSA Administrator:

EECU

An HSA is a type of personal savings account that is yours to keep. The money in your HSA grows tax-free and spends tax-free if used to pay for qualified medical expenses. Any unused funds roll over year after year.

Two Ways To Use Your HSA

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.

Triple Tax Savings

1. Tax-free contributions
2. Tax-free growth
3. Tax-free withdrawals

Watch and learn more!

Maximum HSA Contributions

- **2025: $4,300** Individual/ **$8,550** Family
- **2026: $4,400** Individual/ **$8,750** Family
- If age 55 or older, you can contribute an extra **$1,000**.

HSA Eligibility

Open and contribute to an HSA if you are:

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

Important HSA Information

- Have your doctor file your claims and use your HSA debit card to pay any balance due.
- Keep ALL reimbursement records and receipts for tax records.
- Only HSA accounts opened through our plan administrator are eligible for automatic payroll deductions.
- Get automatic payroll deductions by opening your HSA through our plan administrator.

HSA Contacts

- Visit **https://www.eecu.org**.
- Call **817-882-0800** for Customer Service.
- Call **800-333-9934** for a lost/stolen card.
- Download the mobile app.

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.

FSA Administrator:

Higginbotham™

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 an HSA.

TWO WAYS TO ACCESS YOUR FSA FUNDS

- Use your Higginbotham Benefits Debit Card to pay for qualified expenses, doctor visits, and prescription copays (Health Care FSA only).
- Pay out-of-pocket and submit your receipts for reimbursement:
  - Visit **https://flexservices.higginbotham.net**.
  - Email **flexclaims@higginbotham.net**.
  - Fax **866-419-3516**.

IMPORTANT RULES

- You cannot change your election during the year unless you experience a Qualifying Life Event.
- Funds allocated to the Health Care FSA/Dependent Care FSA must be used during the plan year or are forfeited. Irving ISD does offer a 75-day grace period.
- Benefit elections roll annually; changes must be made during Open Enrollment.

Watch and learn more!

Health Care FSA Debit Card

The Higginbotham Health Care FSA debit card gives you immediate access to your Health Care FSA funds. You do not need to file a claim when you make a purchase with your debit card. **You can only use this debit card for qualified Health Care FSA expenses. Claims must be submitted for Dependent Care FSA expenses.**

> **NOTE**
>
> You may file claims incurred during the plan year for another 90 days.

Higginbotham Portal and App

The Higginbotham Portal and app provide information and resources to help you manage your FSAs to:

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

To register for an online portal account, visit **https://flexservices.higginbotham.net**, then click *Get Started* and follow the instructions.

Once your registration is complete, you can then download the **Higginbotham FSA app**. Use the same username and password for both your portal account and app. The app makes it easy to manage your account and file claims.

QUESTIONS?

- Call **866-419-3519**.
- Email **flexclaims@higginbotham.net**.

Higginbotham Flex Mobile App

Download the Higginbotham app to easily access your Health Care FSA information.

- View your account balance
- View debit card activity
- File a claim and upload receipts
- Set up notifications

Register on the Higginbotham Portal first to access the mobile app, and use the same username and password for both.

Dependent Care FSA

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

DEPENDENT CARE FSA GUIDELINES

- Overnight camps are not eligible for reimbursement (only day camps can be considered).
- If your child turns 13 midyear, you may only request reimbursement for the part of the year when the child is under age 13.
- You may request reimbursement for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.
- Dependent Care FSA funds require claims submission; the debit card may not be utilized. Claims are not reimbursed until funds are available in the account, and after services are rendered. Claims submitted prior to occurrence date will be denied and need to be resubmitted once incurred.
- Dependent Care FSA enrollees may not also claim the childcare tax credit when filing federal taxes. You can only do one or the other.

Annual Maximum FSA Contributions

2025	Health Care FSA	Dependent Care FSA
Maximum	$3,300	$5,000 if filing jointly or head of household and $2,500 if married filing separately.
Carryover	No carryover – use it or lose it	No carryover – use it or lose it

FSA Store

Access **www.fsastore.com** for thousands of FSA-eligible products and services that you can buy with your FSA debit card.

Qualified HSA and FSA Expenses

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

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

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

HSA and FSA Comparison

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

	Health Savings Account	Flexible Spending Account
Internal Revenue Code	Section 223	Section 125
Description	An HSA is an actual bank account in your name that allows you to save and pay for unreimbursed qualified medical expenses tax-free.	An FSA allows you to pay out-of-pocket expenses tax-free for: • copays, deductibles, and certain services not covered by medical plan • qualifying dependent care
Employer Eligibility	A qualified High Deductible Health Plan	All employers
Contribution Source	You and/or your employer	You and/or your employer
Account Owner	Individual	Employer
Underlying Insurance Requirement	High Deductible Health Plan	None
2025 Insurance Plan Minimum Deductible	• $1,650 single • $3,300 family	N/A
Maximum Contribution	• $4,300 single • $8,550 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...

18 HSA

19 FSA

Dental Coverage

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

Dental Provider:

Cigna

Networks:

Total Cigna DPPO
Cigna Dental Care DHMO

You have a choice of **three** plans:

- **High DPPO Plan**
- **Low MAC DPPO Plan**
- **DHMO Plan**

Find an In-Network Provider

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

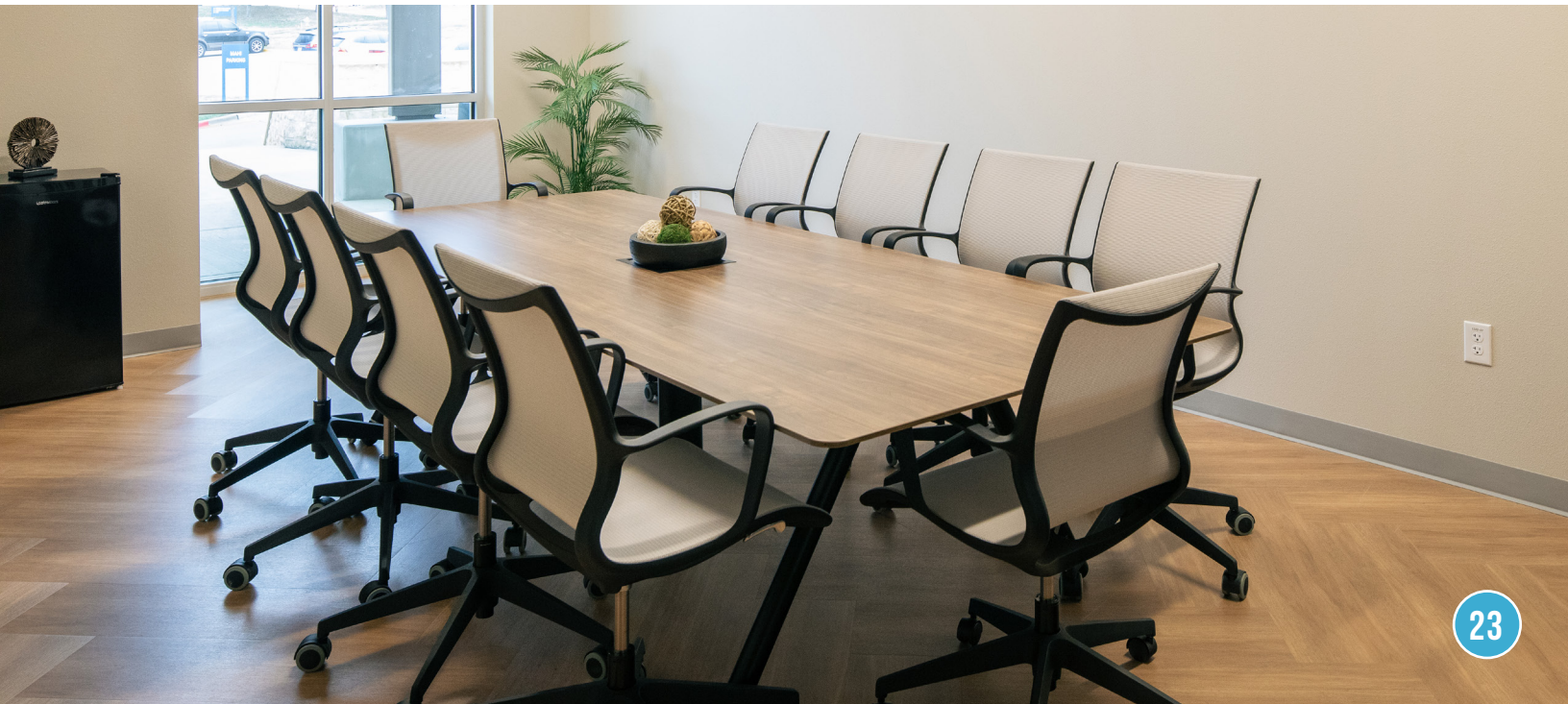
Watch and learn more!

DPPO Plan

Two levels of benefits are available with the DPPO plans: 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, due to balance billing.

DHMO Plan

If you enroll in the DHMO plan, you will be assigned your initial Primay Care Dentist (PCD) based upon zip code. You may change your PCD by contacting **Cigna**. With a DHMO, you get unlimited dental services, pay fixed copays, have no deductibles, and have no claim forms to file. NOTE: there is no coverage for services provided without a referral from your PCD or from out-of-network providers (except in a true emergency).



Dental Coverage

Dental Benefits Summary

	High DPPO Plan[1]		Low MAC DPPO Plan[2]		DHMO Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Network	Total Cigna DPPO		Total Cigna DPPO		Cigna Dental Care DHMO
Calendar Year Deductible • Individual • Family	$50 $150	$50 $150	$50 $150	$50 $150	Charges are fixed and not subject to annual maximums or deductibles under the DHMO plan.
Policy Year Benefit Maximum Per individual	$1,500		$750		
	You Pay		**You Pay**		**You Pay**
Class I: Diagnostic & Preventive Exams, cleanings, X-rays, fluoride treatments, sealants, space maintainers	$0	$0	$0	$0	$5 - $75
Class II: Basic Restorative Fillings, minor oral surgery, emergency care to relieve pain	20%[3]	20%[3]	30%[3]	30%[3]	Payment based on schedule
Class III: Major Restorative Crowns, dentures, bridges, periodontics, endodontics	50%[3]	50%[3]	50%[3]	50%[3]	Payment based on schedule
Class IV: Orthodontia Child(ren) to age 19 Lifetime Maximum	50% $1,000	50% $1,000	50% $1,000	50% $1,000	Payment based on schedule
Class IX: Implants Policy Year Maximum	50% 3 implants; $3000	50% 3 implants; $3000	Not covered	Not covered	Payment based on schedule
Employee Monthly Premiums					
Employee	$37.46		$25.70		$16.04
Employee & Spouse	$64.12		$44.07		$32.08
Employee & Child(ren)	$89.23		$61.31		$41.07
Employee & Family	$125.57		$86.27		$45.09

[1] For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 90th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.

[2] For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Allowable Charge. **The dentist may balance bill up to their usual fees.**

[3] The amount you will pay after your deductible has been met.

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.

Vision Provider:
SuperiorVision® by VersantHealth®

Network:
Superior Vision

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

Vision Benefits Summary

	Vision Plan	
	In-Network You Pay	**Out-of-Network Reimbursement**
Copays		
• Exam	$10	
• Materials	$15	
• Contact lens fitting	$25	
Exam	$0	Up to $42
Lenses		
• Single vision	$0	Up to $32
• Bifocal	$0	Up to $46
• Trifocal	$0	Up to $61
• Progressives	See plan for details	Up to $61
• Polycarbonate for eye dependent children	$0	Not covered
• Factory scratch coat	$0	Not covered
Frames	20% off balance over $140 allowance	Up to $68
Contacts		
In lieu of frames and lenses		
• Fitting and evaluation	Covered in full	Not covered
• Conventional contacts	20% off balance over $140 allowance	Up to $100
• Disposable contacts	10% off balance over $140 allowance	Up to $100
Employee Monthly Premiums		
Employee	$7.98	
Employee & Spouse	$15.76	
Employee & Child(ren)	$15.44	
Employee & Family	$23.50	

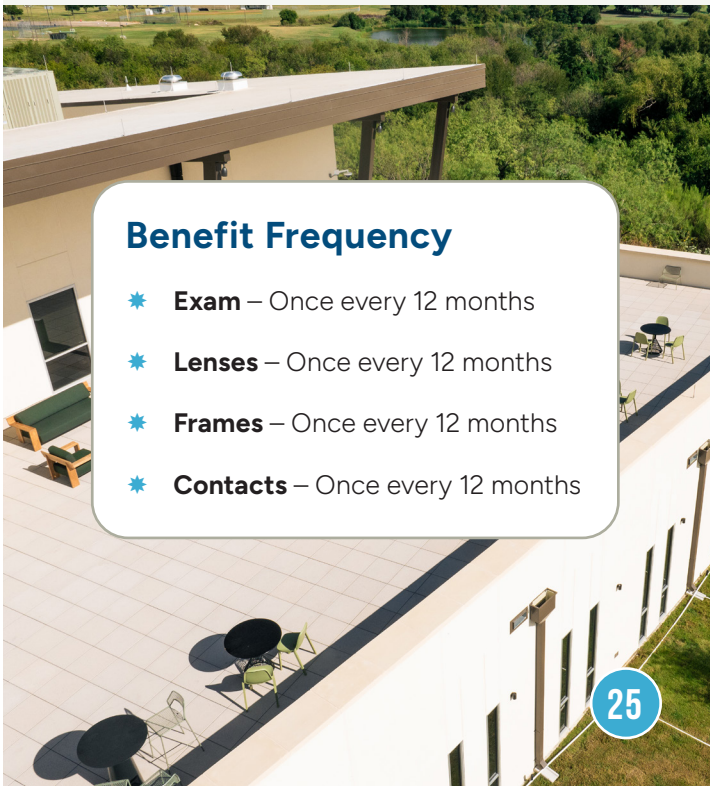
Find an In-Network Provider

Visit **www.superiorvision.com**.
Call **800-507-3800**.
Group #**30980**.
Download the **Superior Vision app**.

Watch and learn more!

ID Cards

If you need a vision ID card, you can get one by calling Superior Vision Customer Service, registering for an account, or downloading the app.



Benefit Frequency

- **Exam** – Once every 12 months
- **Lenses** – Once every 12 months
- **Frames** – Once every 12 months
- **Contacts** – Once every 12 months

Life and AD&D Insurance

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

Life and AD&D Provider: NEW YORK LIFE

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).

Basic Term Life

Basic Term Life insurance is provided at no cost to you. **You are automatically covered at $12,000 for this benefit.**

Designating a Beneficiary

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

Watch and learn more!

Life and AD&D Insurance

Voluntary Group Term Life

If you need more coverage than Basic Term Life and AD&D, you may buy Term Life for yourself and your dependent(s). If you leave the district, you may be able to take your insurance with you. New Hires may be eligible for Guaranteed Issue coverage; that means no health questions. A minimum election of $10,000 reserves the Guaranteed Issue for future enrollments. If you decline Voluntary Life insurance when first eligible and wish to elect at a later date, Evidence of Insurability (EOI) – proof of good health – may be required before coverage is approved.

Voluntary Accidental Death & Dismemberment

Accidental Death & Dismemberment is separate from your Basic and Voluntary Life Insurance coverage. AD&D is a very inexpensive form of life insurance that can give you additional protection in the event of an accidental death or dismemberment. The full amount of AD&D coverage you select is called the Full Amount and is equal to the benefit payable for the loss of life. Benefits for other losses — such as loss of sight, speech, or hearing; coma; or paralysis — are payable as a predetermined percentage of the full amount.

> Please contact the Irving ISD Benefits office at **972-600-5431** for assistance in filing a life claim.

Voluntary Term Life Insurance	
Employee	• Increments of $10,000 up to 5 times basic annual earnings not to exceed $500,000 • New Hire Guaranteed Issue $250,000 • Open Enrollment Guaranteed Issue $250,000
Spouse	• Increments of $5,000 up to 100% of employee amount, not to exceed $250,000 • New Hire Guaranteed Issue $50,000 • Open Enrollment Guaranteed Issue $50,000
Child(ren)	• Birth to six months – $500 • Six months to age 26 – $5,000 or $10,000 • Guaranteed Issue $10,000

Voluntary Term Life Monthly Rates		
Age	**Employee Rate per $10,000**	**Spouse Rate per $5,000**
<30	$0.400	$0.200
30-34	$0.550	$0.280
35-39	$0.600	$0.300
40-44	$1.000	$0.500
45-49	$1.600	$0.800
Child(ren) Rate per $5,000		
To age 26	$1.250	

Voluntary AD&D Insurance	
Employee	• Increments of $10,000, not to exceed $500,000.
Spouse	• Up to 100% of employee amount to a maximum of $300,000 (if no dependent children).
Child(ren)	• Up to 10% of employee amount to a maximum of $30,000 (if no spouse).

Voluntary AD&D Rates per $10,000	
Employee	$0.17
Employee & Spouse	$0.25
Employee & Child(ren)	$0.28
Employee & Family	$0.32

Supplemental Coverage Highlights

- **Portable** – keep your supplemental coverage if you leave your current employer.
- **Convertible** – convert your group term life insurance benefits to an individual whole life policy if your coverage ends.
- **Reduction of Benefit** – Employee benefit amount reductions begin at 65. Spouse voluntary life ends at 70.

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

Individual Life Insurance

Help protect your family with the Family Protection Plan Group Level Term Life Insurance to age 121.

Individual Life Insurance Provider:

5 STAR LIFE INSURANCE

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 26 years old). The coverage lasts until age 121 for all insured if premiums are paid, so no matter what the future brings, your family is protected.

	Individual Life Insurance
Employee	• New Hire Guaranteed Issue $150,000 • Open Enrollment Guaranteed Issue $150,000
Spouse	• New Hire Guaranteed Issue $50,000 • Open Enrollment Guaranteed Issue $50,000
Child(ren)	• Guaranteed Issue $10,000

Individual Life Insurance Highlights

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 allows 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.

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 in-facility care, home health care professionals, home modifications, and 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 nonguaranteed 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.

Educator Disability Insurance

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

Educator Disability Provider: NEW YORK LIFE

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

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

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

Disability Rates

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

Watch and learn more!

File a Disability Claim

- Visit **www.newyorklife.com**.
- Call **800-362-4462**.
- Group #**SLH10016**

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

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

1

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

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

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

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

2

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

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

Educator Disability FAQ

What is disability insurance?

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

Does this plan have pre-existing condition limitations?

Yes. Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures), during the three months just prior to the most recent effective date of insurance. Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance. However, the first eight weeks of disability will be waived from the Pre-existing Condition Limitation clause.

How long do benefits last?

Once you qualify for benefits under this plan, you continue to receive them until you no longer qualify for benefits, or you reach the maximum benefit period allowed based upon age and type of disability. Benefits may be reduced by other sources. Consult plan documents for details.

How do I file a claim?

Call **New York Life** at **800-362-4462** to file a claim using Group **#SLH10016**.

Hospital Indemnity Insurance

The Hospital Indemnity plans help you with the high cost of medical care by paying you a cash benefit when you have an inpatient hospital stay.

Hospital Indemnity Insurance Provider:

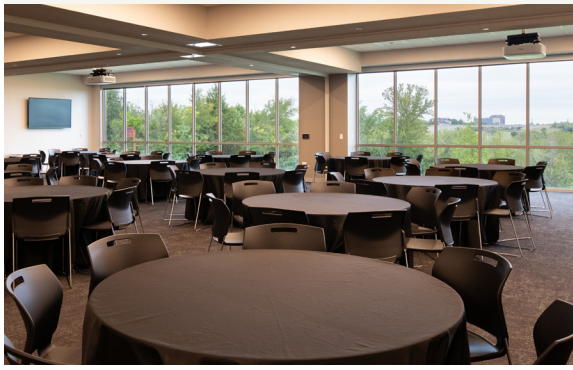
Cigna

Unlike traditional insurance which pays a benefit to the hospital or doctor, these plans pay 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!

File a Claim

- Email **hospitalcare@cigna.com**.
- Call **800-754-3207**.
- Group #**HC960777**



Hospital Indemnity Benefits Summary

	Plan 1	Plan 2
Hospital Admission *(no elimination period)* Limited to 1 day, 1 benefit(s) every 365 days.	$1,250	$2,500
Hospital Chronic Condition Admission *(no elimination period)* Limited to 1 day, 1 benefit(s) every 365 days.	$50	$50
Hospital Stay *(no elimination period)* Limited to 30 days, 1 benefit(s) every 365 days.	$100	$200
Hospital Intensive Care Unit (ICU) Stay *(no elimination period)* Limited to 30 days, 1 benefit(s) every 365 days.	$200	$400
Hospital Observation Stay *(24-hour elimination period)* Limited to 72 hours.	$100 per 24-hour period	$200 per 24-hour period
Newborn Nursery Care Stay Limited to 30 days, 1 benefit per newborn child. This benefit is payable to the employee even if child coverage is not elected.	$100	$200
Employee Monthly Contributions		
Employee **Employee and Spouse** **Employee and Child(ren)** **Employee and Family**	$17.42 $30.88 $28.58 $42.04	$34.38 $61.02 $56.54 $83.18

Critical Illness Insurance

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

Critical Illness Provider: NEW YORK LIFE

Watch and learn more!

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

Critical Illness Insurance Benefits Summary

Critical Illness Insurance Plan

Employee – $10,000, $20,000 or $30,000 | **Spouse** – 100% of employee amount | **Children** – 50% of employee amount

Covered Conditions

Vascular		Other Specified		Neurological	
Heart Attack, Stroke, Sudden Cardiac Arrest	100%	Major Organ Failure, End-Stage Renal Disease, Coma, Paralysis, Blindness, Loss of Hearing or Speech	100%	Advanced Stage Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease	25%
Coronary Artery Disease	50%				

Cancer		Recurrence Benefit		Wellness Benefit	
Invasive Cancer	100%	Heart Attack, Stroke, Coma, Major Organ Failure, Invasive Cancer	100%	Health Screening/ Wellness Benefit	$50 per covered individual
Carcinoma in Situ	25%	Coronary Artery Disease	50%		
Skin Cancer	2.5%	Carcinoma in Situ	25%		
		Recurrence Period	90 days & 180 days for cancer		

Employee* and Spouse Monthly Rates per $1,000 of Coverage

Age	Rate	Age	Rate	Age	Rate
<20	$0.19	**40-44**	$0.47	**65-69**	$4.05
20-24	$0.19	**45-49**	$1.15	**70-74**	$4.05
25-29	$0.26	**50-54**	$1.15	**75-79**	$6.58
30-34	$0.26	**55-59**	$2.27	**80-84**	$6.58
35-39	$0.47	**60-64**	$2.27	**85+**	$8.08

* Child(ren) are included in the employee rate at 50% of employee benefit amount.

Cancer Insurance

Treatment for cancer is often lengthy and expensive. While your health insurance helps pay the medical expenses for cancer treatment, it does not cover the cost of non-medical expenses, such as out-of-town treatments, special diets, daily living, and household upkeep. In addition to these non-medical expenses, you are responsible for paying your health plan deductibles and/or coinsurance. Cancer insurance helps pay for these direct and indirect treatment costs so you can focus on your health.

Cancer Insurance Provider:

CHUBB®

Watch and learn more!

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.

Cash benefits for every step of the way. Choose the right level of coverage during the enrollment period to better protect your family. The following is a **sample** of the benefits provided. See the plan document for full details, including pre-existing condition limitations and continuity of coverage.

Cancer Insurance Benefits Summary

	Low Plan	High Plan
First cancer benefit (one per person, per calendar year)	$100	$100
Diagnosis of cancer	$5,000 – employee or spouse	$10,000 – employee or spouse
Hospital confinement	$300 per day, 31 days maximum; additional days $200	$300 per day, 31 days maximum; additional days $600
Hospital confinement ICU	$600 per day, 31 days maximum; additional days $600	$600 per day, 31 days maximum; additional days $600
Radiation therapy, chemotherapy, immunotherapy	$6,000 maximum per person, per year	$12,000 maximum per person, per year
Medical Imaging Benefit	$500, two per year	$500, two per year
Heart Attack or Stroke Benefit	$5,000 $2,500 recurrence benefit	$10,000 $5,000 recurrence benefit
Cancer Treatment Benefits Bone marrow transplant Stem cell transplant	Lifetime maximum: 2 transplants per benefit First transplant: $3,000; additional: 50% First transplant: $300; additional: 50%	Lifetime maximum: 2 transplants per benefit First transplant: $6,000; additional: 50% First transplant: $600; additional: 50%
Surgical Treatment Benefits Surgery Skin cancer surgery, two per year	 Up to $4,125 $100	 Up to $4,125 $100
Specialty Care Benefits Family member transportation Family member lodging Home health care	 $100 per trip, 12 trip maximum $100 per day, 100 days maximum $100 per day, 30 days maximum	 $100 per trip, 12 trip maximum $100 per day, 100 days maximum $300 per day, 30 days maximum
Employee Monthly Contributions		
Employee **Employee + 1** **Employee + Family**	$13.64 $19.68 $24.76	$22.28 $38.32 $48.60

Employee Assistance Program

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

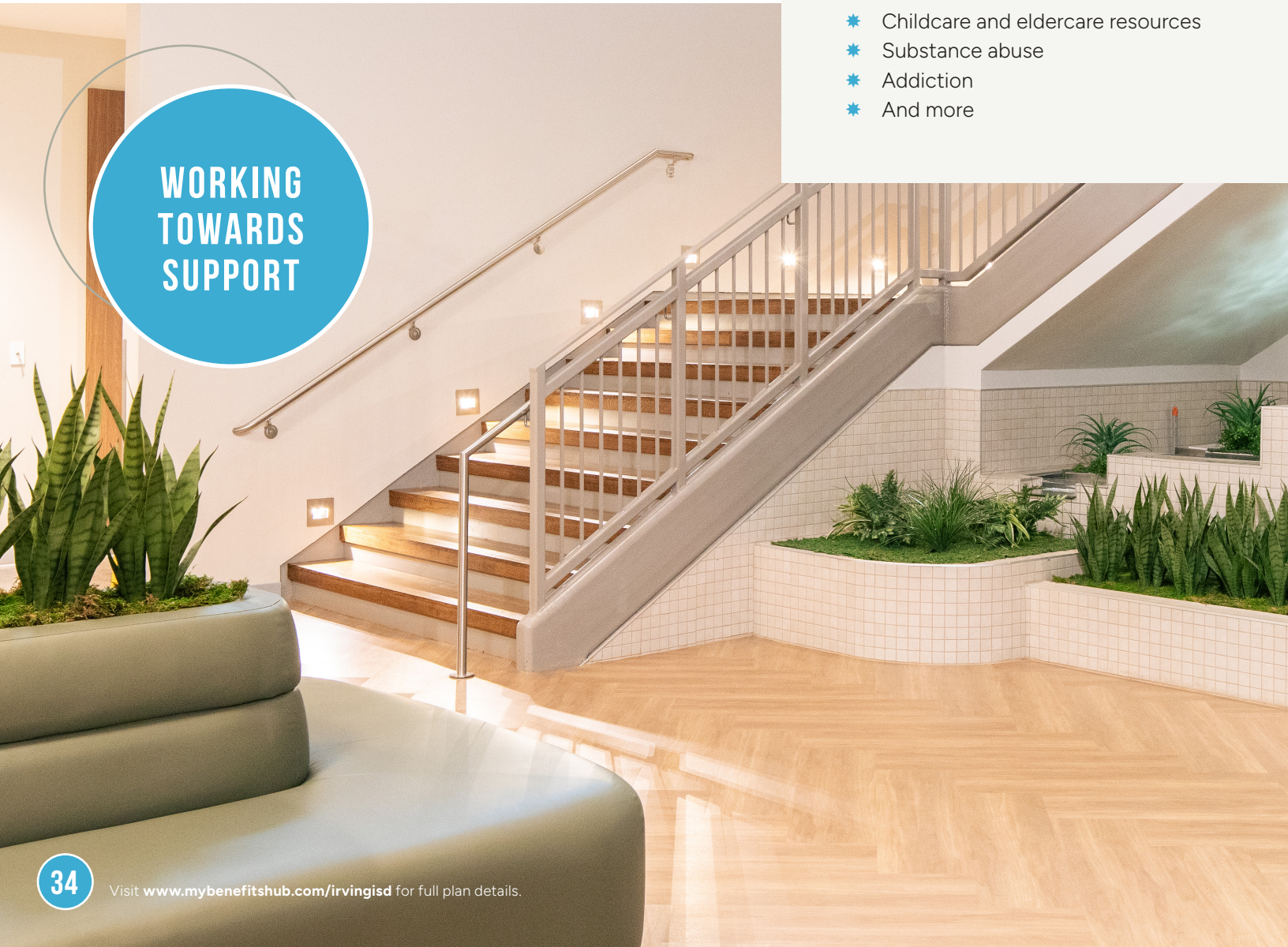
Employee Assistance Program Provider: NEW YORK LIFE

Get 24/7 Support

Visit **www.guidanceresources.com**.
Call **800-344-9752**.
Web ID **#NYLGBS**.

Get confidential counseling and support services from licensed professionals at little or no cost to help with:

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



Catastrophic Leave Bank

The purpose of the Catastrophic Leave Bank is to provide income replacement for members that experience a catastrophic illness/injury that forces that member to exhaust all leave time earned and lose compensation from the District.

How does the Catastrophic Leave Bank work?

An eligible employee may join the Catastrophic Leave Bank by donating three days of accrued or anticipated local sick leave. These days will be subtracted from the member's local sick leave record and become the property of the **Irving ISD Catastrophic Leave Bank**. These days cannot be returned.

A few things to keep in mind:

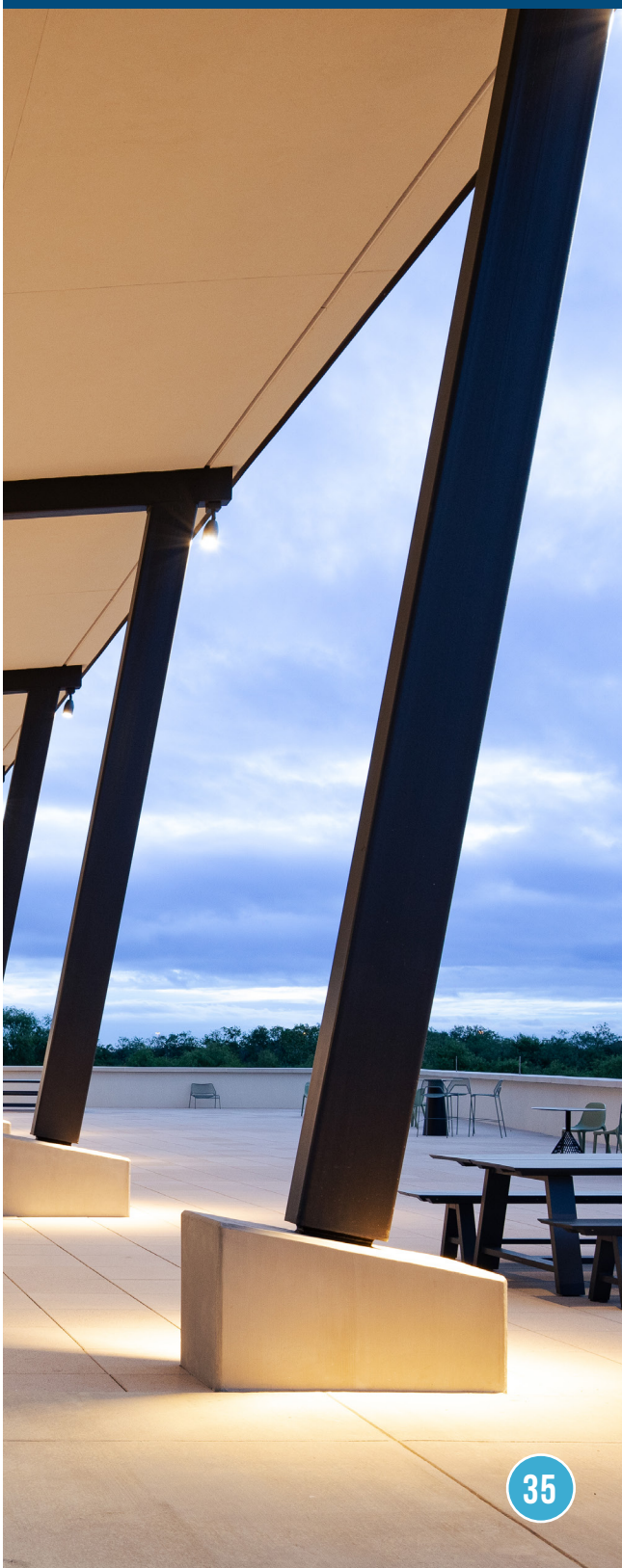
- Catastrophic Leave Bank is for your own catastrophic serious health condition only.
- To request Catastrophic Leave Bank days, you must be absent a minimum of seven consecutive days due to your catastrophic illness/injury.
- Receiving days from the bank depends upon meeting Catastrophic Leave Bank guidelines.
- Catastrophic Leave Bank days that are granted are only for absences from working days and not for holidays, vacation days, or other such days for which you are not paid.

Further Information

For details on the Catastrophic Leave Bank guidelines for membership and usage, please contact **hr-benefitsandleaves@irvingisd.org**.

For More Information

Email **hr-benefitsandleaves@irvingisd.org**.



Retirement Plans

When you consistently save money throughout your career, it lays a secure foundation for your retirement years.

Retirement Providers:

nbs national benefit services

TCG TRUSTED CAPITAL GROUP

To Enroll or Get More Details

NBS
Visit **www.nbsbenefits.com**.
Call **855-399-0335**.

TCG Administrators
Visit **http://tcgservices.com**.
Call **512-600-5200**.

We offer two plans to help with your retirement goals:

- A **403(b)** plan is a U.S. tax-advantaged retirement savings plan available for public education organizations.
- A **457(b)** plan is a tax-deferred compensation plan provided for employees of certain tax-exempt, governmental organizations, or public education institutions.

Maximum Contributions

	2025	2026
Annual Maximum	$23,500	$24,500
CATCH-UP		
Ages 50-59 & 64+	$7,500	$8,000
Ages 60-63	$11,250	$11,250

Plan Comparison

403(b)	457(b)
What is a 403(b)? A 403(b) plan is a retirement plan for certain employees of public schools, tax-exempt organizations, and ministers. Contributions are made under a Salary Reduction Agreement (SRA) with your employer. This agreement allows your employer to withhold money from your paycheck to be contributed directly into a 403(b) account for your benefit. Usually, you do not pay income tax on these contributions until you withdraw them from the account. You have 35+ companies to choose from with a variety of investment types available (fixed annuity, fixed index annuity, variable annuity, investment advisory services, or mutual funds).	**What is a 457(b)?** The 457(b) plan is a type of deferred-compensation retirement plan that is available for governmental employers. The employer provides the plan and the employee defers compensation into it on a pre-tax basis. For the most part, the plan operates similarly to a 401(k) or 403(b) plan. The key difference is that there is no penalty for withdrawal before the age of 59½ (but subject to income tax). Irving ISD has selected one company to provide our employees with the 457(b) plan. **TCG Administrators** offers several investment options. Visit the website for a list of fees of service plan providers.
How to Enroll	
• **Step 1:** Set up your 403(b) account with an approved vendor • **Step 2:** Complete the Salary Reduction Agreement with **NBS** There is an additional tax penalty on any funds withdrawn prior to retirement age.	• Complete the Salary Reduction Agreement with **TCG Administrators** There is no penalty for early withdrawal (upon separation of service).

You may enroll in a 403(b) and/or 457(b) **anytime during the year**!

Glossary of Terms

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

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

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

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

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

Employer Contribution – The amount your employer contributes to the cost of your benefits.

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

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

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

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

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

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

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

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

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

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

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

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

SSNRA – Social Security Normal Retirement Age.

Important Legal Notices

Women's Health and Cancer Rights Act of 1998

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

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

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

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

Special Enrollment Rights

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

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

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

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

Marriage, Birth or Adoption

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

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Irving ISD
Benefits Department
2621 W. Airport Freeway
Irving, TX 75062
972-600-5211

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 Irving ISD and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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 Irving ISD at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your

Important Legal Notices

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

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

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

Contact the Human Resources Department at **972-600-5211**.

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

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

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

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

September 1, 2025
Irving ISD
Benefits Department
2621 W. Airport Freeway
Irving, TX 75062
972-600-5211

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

Irving ISD's 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.

Important Legal Notices

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.

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.

Important Legal Notices

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.

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.

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.

Important Legal Notices

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:

Irving ISD
Benefits Department
2621 W. Airport Freeway
Irving, TX 75062
972-600-5211

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

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

To see if any other States have added a premium assistance program since **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 Irving ISD group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the Irving ISD plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan Contact Information

Irving ISD
Benefits Department
2621 W. Airport Freeway
Irving, TX 75062
972-600-5211

Important Legal Notices

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

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

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

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

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

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

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

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This brochure highlights the main features of the Irving ISD employee benefits program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Irving ISD reserves the right to change or discontinue its employee benefits plans at anytime.