2026 EMPLOYEE BENEFITS GUIDE

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Office: 830.778.4100 | www.sfdr-cisd.org

HEALTH BENEFITS

Note: *This PDF is interactive, you may click in on the above navigation bar to jump to desired page throughout the guide. TOC page numbers listed below are also interactive.*

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Directory

For any questions or concerns you may have regarding your 2026 Employee Benefits, you can contact the following;

- For claims assistance, you can contact the insurance carrier. You will need your ID number or Social Security number, date of service and provider name.
- For additional assistance or questions, please contact one of our Benefits Advisors at the Benefits Service Center to learn more about your benefits.

Before you speak with a Benefit Advisor(s), please have the following information ready: dependents' names, birth dates, social security numbers, addresses, and phone numbers.

Benefits Service Center		
Monday - Friday: 8:00 am - 7:00 pm CST **Saturday:** 9:00 am - 3:00 pm CST	(855) 731-4452	
Benefit/Carrier	**Website**	**Phone**
Medical Blue Cross Blue Shield of Texas (BCBSTX)	www.bcbstx.com	PPO: 800-521-2227 HMO: 877-299-2377
Flexible Spendings Accounts Proficient Benefit Solutions	www.proficientbenefits.com	888-659-8151
Dental MetLife	www.metlife.com	800-942-0854
Vision Eyetopia	www.eyetopia.org	800-662-8264
Basic Term Life and AD&D **Voluntary Term Life** **Long-Term Disability** The Standard	www.standard.com www.standard.com www.standard.com/yourchoice	800-368-1135
Accident **Critical Illness** **Hospital Indemnity** Voya	presents.voya.com/ebrc/sanfelipe	877-236-7564
Cancer Guardian	www.guardianlife.com	888-482-7342
Universal Life Trustmark	www.trustmark.com	847-615-1500
Professional Enrollments Concepts (PEC) Benefits Enrollment Center	N/A	855-731-4452

Staff Member	**Email**	**Phone**
San Felipe Del Rio CISD Contact		
Rachel Garcia Employee Benefits Coordinator	Rachel.garcia@sfdr-cisd.org	830-778-4100
Brown & Brown/Alamo Insurance		
Lexy Young Account Manager	lexy.young@bbrown.com	210-524-7123

WELCOME
To Your Employee Benefits

Each year, we strive to offer comprehensive and competitive benefit plans to our employees. In the following pages, you will find a summary of our benefit plans for the **January 1, 2026 to December 31, 2026** Plan Year. Please read this Guidebook carefully as you prepare to make your elections for the upcoming Plan Year.

San Felipe Del Rio CISD will be utilizing Professional Enrollment Concepts' (PEC) services for our benefit communication and enrollment this year. PEC's Benefit Advisors will provide you with a detailed explanation of your entire benefit program. They will review your benefits with you on an individual, confidential basis. They will also be able to discuss any personal situations you may have that could potentially impact your benefit decision.

About this Benefits Guidebook

This Benefits Guidebook describes the highlights of San Felipe Del Rio CISD's benefits program in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents, and not the information in this Guidebook. If there is any discrepancy between the description of the program elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. You should be aware that any and all elements of **San Felipe Del Rio CISD's** benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules, or otherwise as decided by San Felipe Del Rio CISD.

WHAT'S NEW
THIS 2026 YEAR?

- **New contributions for FSA** - See page 11 for plan details.
- **Voya is new carrier for Accident effective January 1, 2026 -** See page 19 for plan details.
- **Voya is new carrier for Critical Illness effective January 1, 2026 -** See page 20 for plan details.
- **A new Hospital Indemnity plan through Voya will be offered effective January 1, 2026 -** See page 21 for plan details.

ELIGIBILITY

San Felipe Del Rio CISD encourages the health and financial well-being of its employees by providing access to quality and affordable healthcare. Eligible Full-Time employees have access to San Felipe Del Rio CISD's comprehensive Benefit Program. Please note that any time during the plan year, San Felipe Del Rio CISD may conduct audit requesting supporting documentation on all eligible dependents.

Please make sure to review this Benefit Guide in detail to learn more about these options.

Employee Eligibility

Full-Time employees who work a minimum of 20 hours per week and are at least 18 years of age are eligible to participate in the benefits program. The BCBS medical plan is effective as of your hire date and all other benefits will be effective first of the month followings your hire date. Once your enrollment is completed, you may not make any changes to your elections unless you have a Qualifying Life Event or your hours worked per week drop below the minimum.

Dependent Eligibility

If you apply for coverage, you may include your dependents. All employees must ensure that only family members who meet the following requirements are enrolled in the San Felipe Del Rio CISD insurance and health care benefit programs.

- Your spouse
- Your eligible children up to age 26 for medical, dental and vision coverage.
- Children" are defined as your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

Qualifying Life Events

If you experience a Qualifying Life Event (for instance: getting married or having a baby), please contact **Employee Benefits Support Services at ext 4020**; **proof of the Qualifying Life Event** must be submitted to **Employee Benefits Support Services within 31 days** in order **to change current benefit election**.

- A change in the number of dependents (birth, adoption, death, guardianship);
- A change in marital status (marriage, divorce, death, legal separation);
- A dependent's loss of eligibility (attainment of limiting age or change in student status);
- A change in associate's, spouse's, or dependents' work hours;
- A termination or commencement of employment of associate's spouse or eligible dependent with coverage;
- Other events as the administrator determines to be permitted or any other applicable guidelines issued by the Internal Revenue Service.

MEDICAL

Carrier *- Blue Cross Blue Shield of Texas*

The medical program, administered by Blue Cross Blue Shield of Texas, provides the framework for your health and well-being. To better meet the varying needs of our employees, San Felipe Del Rio CISD offers the following medical plans.

Benefits (per calendar year)	**HMO 1**	**HMO 2**	**PPO**
Deductible In-Network (Individual/Family) Out-of-Network (Individual/Family)	 $2,500/$5,000 N/A	 $1,200/$2,400 N/A	 $0/$0 $500/$1,500
Out-of-Pocket Maximum In-Network (Individual/Family) Out-of-Network (Individual/Family)	 $8,000/$16,000 N/A	 $6,900/$13,800 N/A	 $2,000/$6,000 $7,000/$21,000
Coinsurance (participant pays) In-Network Out-of-Network	 30% N/A	 20% N/A	 20% 40%
Primary Care Office Visit	$30 copay	$15 copay	$25 copay
Preventative Care	Covered at 100%	Covered at 100%	Covered at 100%
Specialist Office Visit	$70 copay	$70 copay	$40 copay
Urgent Care	$50 copay	$50 copay	$50 copay
Virtual Visits (MDLive)	$0 copay	$0 copay	$0 copay
Hospital Admission	30% after deductible	20% after deductible	$150 copay + 20% coinsurance
Hospital Services In-Patient	30% after deductible	20% after deductible	20% after deductible
Hospital Services Out-Patient	30% after deductible	20% after deductible	20% after deductible
Diagnostic Procedures (Bone Scan, CT Scan, MRI, PET Scan)	30% after deductible	20% after deductible	20% after deductible
Ground and Air Ambulance Services	30% after deductible	20% after deductible	20% after deductible
Mental Health Office Visit	$30 copay	$15 copay	$25 copay
Prescription Drugs **(at Participating Pharmacies)** Generic Preferred Name Brand Non-Preferred Name Brand Specialty 90-Day Mail Order	 $15 copay $60 copay $100 copay $200 copay 3x retails copay	 $15 copay $60 copay $100 copay $200 copay 3x retails copay	 $10 copay $35 copay $60 copay Covered at applicable Tier 1, 2, or 3 copay 3x retails copay

*All copays and coinsurances apply to the Medical Out-of-Pocket Maximum for all plans.
**Effective January 1, 2026 the district's contribution for health coverage per employee per month is $519.57.

Medical Plan Monthly Deductions			
Coverage Tier	**HMO 1**	**HMO 2**	**PPO**
Employee	$0.00	$70.50	$277.95
Employee + Spouse	$623.48	$778.59	$1,234.97
Employee + Child(ren)	$415.65	$542.56	$915.95
Family	$1,039.13	$1,250.64	$1,872.98

BlueCross BlueShield of Texas

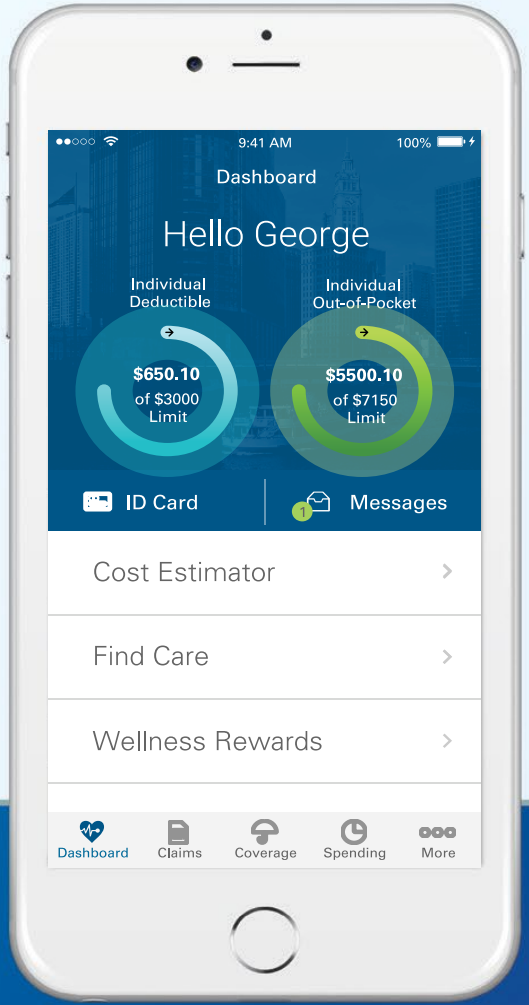
The BCBSTX App!

TEXAS

Stay connected with Blue Cross and Blue Shield of Texas (BCBSTX) and access important health benefit information wherever you are.

- Find an in-network doctor, hospital or urgent care facility
- Access your claims, coverage and deductible information
- View and email your member ID card
- Log in securely with your fingerprint
- Access Health Care Accounts and Health Savings Accounts
- Download and share your Explanation of Benefits*
- Get Push Notifications and access to Message Center*

Available in Spanish



Text** BCBSTXAPP to 33633 to get the app.

* Currently only available on iPhone®. iPhone is a registered trademark of Apple Inc.

** Message and data rates may apply. Terms and conditions and privacy policy at bcbstx.com/mobile/text-messaging.

Download on the App Store

GET IT ON Google play

bcbstx.com/mobile

BlueCross BlueShield of Texas

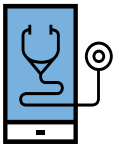
It's now easier to find a provider and manage health care expenses.

Provider Finder from Blue Cross and Blue Shield of Texas (BCBSTX) is a fast, easy-to-use tool that improves members' experience when they're looking for in-network health care providers. Plus, it can help them manage their out-of-pocket costs.

The updated Provider Finder platform has undergone intensive testing. The result is a better experience that will help members be smarter consumers of health care.

By going to **bcbstx.com**, members can login or create an account on Blue Access for Members℠ (BAM℠) and use Provider Finder to:

- Find in-network providers, clinics, hospitals and pharmacies.
- Search by specialty, ZIP code, language spoken, gender and more.
- See clinical certifications and recognitions.
- Compare quality awards for doctors, hospitals and more.
- Read or add reviews for providers.
- Estimate the out-of-pocket costs for more than 1,700 health care procedures, treatments and tests.*
- Find cost savings opportunities using the Medication Finder tool.



Go Mobile with BCBSTX

Even on the go members can manage their ID cards and stay on top claims activity, coverage information and prescription refill reminders. It's easy: Log into or create a BAM account at **bcbstx.com** or text BCBSTX to 33633** to download our mobile app.

* Not all plans provide this information.

** Message and data rates may apply. Terms and conditions and privacy policy are available at bcbstx.com/mobile/text-messaging.

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BlueCross BlueShield of Texas

Your Virtual Medicine Cabinet Is Here

Save On Prescriptions With Just A few Clicks

MyBlueRxTX is a personalized pharmacy app for Blue Cross and Blue Shield of Texas (BCBSTX) members. We're making it easy to understand and manage prescription drugs and out-of-pocket costs for yourself and your family.

How it works

This app puts your prescription drug information in your hands with features that allow you to:

- Compare drug costs at different pharmacies
- Find available lower-cost drug options
- Manage prescription drug care for your family*
- Access information about your prescription drugs, including medication details, claims history, coverage, pre-approvals and refills
- Get reminders when it's time to refill your prescription
- Search for and contact in-network pharmacies

Scan a QR code to download the free app.
Use your Blue Access for Members℠ login, or create a new account to get started.

MyBlueRxTX (iOS)
Download on the App Store

MyBlueRxTX (Android)
GET IT ON Google Play

* Who are listed as dependents on your BCBSTX plan. Adult children (age 18-26) and other dependents can download the app and create their own account.

Not all features are available for all plans

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BlueCross BlueShield of Texas

A home delivery (mail order) pharmacy service you can trust.

Express Scripts® Pharmacy delivers your long-term (or maintenance) medicines right where you want them. No driving to the pharmacy. No waiting in line for your prescriptions to be filled.

Savings and Convenience

- Express Scripts® Pharmacy delivers up to a 90-day supply of long-term medicines.[1]
- Prescriptions are delivered to the address of your choice, within the U.S., with free standard shipping.
- You can order from the comfort of your home — through your mobile device, online or over the phone. Your doctor can fax, call or send your prescription electronically to Express Scripts® Pharmacy.
- Tamper-evident, unmarked packaging protects your privacy.

Support and Service

- You can receive notices by phone, email or text — your choice — when your orders are placed and shipped. You will be contacted, if needed, to complete your order. To select your notice preference, register online at **express-scripts.com/rx** or call **833-715-0942**.
- 24/7 access to a team of knowledgeable pharmacists and support staff.
- Choose to receive refill reminder notices by phone or email.
- Multiple pharmacy locations are located across the U.S., for fast processing and dispensing.

5

Medicines may take up to 5 business days to deliver after Express Scripts® Pharmacy receives and verifies your order.

Getting Started with Express Scripts® Pharmacy Mail Order

Online and Mobile

You have more than one option to fill or refill a prescription online or from a mobile device:

- Visit **express-scripts.com/rx.** Follow the instructions to register and create a profile. See your active prescriptions and/or send your refill order.
- Log in to **myprime.com** and follow the links to Express Scripts® Pharmacy.

Over the Phone

Call **833-715-0942**, 24/7, to refill, transfer a current prescription or get started with mail order. Please have your member ID card, prescription information and your doctor's contact information ready.

Through the Mail

To send a prescription order through the mail, visit **bcbstx.com** and log in to Blue Access for Members℠ (BAM℠). Complete the mail order form. Mail your prescription, completed order form and payment to Express Scripts® Pharmacy.

Talk to Your Doctor

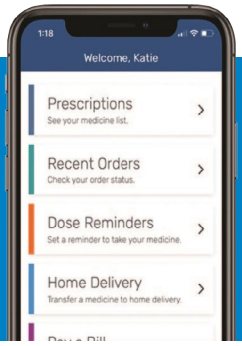
Ask your doctor for a prescription for up to a 90-day supply of each of your long-term medicines.[1] You can ask your doctor to send your prescription electronically to Express Scripts® Pharmacy, call **888-327-9791** for faxing instructions or call the pharmacy at **833-715-0942**. If you need to start your medicine right away, request a prescription for up to a one-month supply you can fill at a local retail pharmacy.

Refills Are Easy

Refill dates are shown on each prescription label. You can choose to have Express Scripts® Pharmacy remind you by phone or email when a refill is due. Choose the reminder option that best suits you.

Questions?

Visit **bcbstx.com**. Or call the phone number listed on your member ID card.



Use the mobile app to manage your prescriptions

- Refill prescriptions
- Track your order
- Make payments
- Set reminders to take medicines and more

1. Prescriptions of up to a 90-day supply, or the most amount allowed by the benefit plan.

Express Scripts® Pharmacy is a pharmacy that is contracted to provide mail pharmacy services to members of Texas. The relationship between Express Scripts® Pharmacy and Blue Cross and Blue Shield of Texas is that of independent contractors. Express Scripts® Pharmacy is a trademark of Express Scripts Strategic Development, Inc.

Prime Therapeutics LLC is a pharmacy benefit management company, contracted by BCBSTX to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics LLC. MyPrime.com is an online resource offered by Prime Therapeutics, LLC.

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Save with a FSA

PROFICIENT™ BENEFIT SOLUTIONS

What if you could save 30% on your healthcare expenses?

Health FSA

No matter what health plan option you choose, chances are you and your family will incur out-of-pocket costs this plan year – in the form of deductibles, copays, coinsurance, etc. Health FSA dollars can be used to pay for these expenses for you, your spouse and children (up to the age of 26). You can choose to contribute up to the maximum of $3,400 per plan year and it is all tax-sheltered dollars. The best part is – up to $680 rolls over to the new plan year if you don't use it. And because the Health FSA is pre-funded, your entire annual election is available for use on the first day of your plan year.

Helpful Tips:

- **Know your coverage.** Every health plan will have out-of-pocket costs in the form of deductibles, copays, and coinsurance.
- **Consider your budget and financial goals.** Ensure your contributions fit into your overall personal finances. Ask yourself how many office visits, prescriptions, specialists, labs, and other procedures you or your family is likely to need.
- **Factor in major purchases.** Look up average costs for any major planned treatments or procedures.
- **Look back at prior years.** Your prior year spending may give you a hint as to how much you are likely to spend this year.

It's time to make those decisions again:

- Regardless of which health insurance plan you choose, you are likely to incur out-of-pocket costs. An FSA allows you to stretch your healthcare dollars an average of 30% by using pre-tax funds.
- Put the 'right' amount of money into your account. Consider your financial goals, your likely spending needs, and your budget constraints.

Dependent Care FSA

The most you can set aside is $ 7,500 single or married and filing jointly or $3,750 if married and filing separately. The person whose expenses you are claiming must be

- your qualifying child under the age of 13, who shares the same residence with you; or
- your spouse or qualifying child or qualifying relative who is physically or mentally unable to care for him/herself who shares the same residence with you and has income less than the Federal exemption amount.

You must make a new election each year!

210-659-8100 • ask@proficientbenefits.com • www.proficientbenefits.com

PROFICIENT™
BENEFIT SOLUTIONS

Manage your account on-the-go!

PROFICIENT™
connect

Register Today!

Visit www.proficientbenefits.com
Click on *Login*
Select *Proficient Connect*
Click on *Register*

- **Step One**- Complete the registration form
  - Choose a username & password
  - Enter your demographic information
  - Use Employer ID: SASSFDR when prompted for Registration ID
  - Your Employee ID is your SSN without dashes or spaces
- **Step Two**- Select 4 security questions
- **Step Three**- Confirm email address
- **Step Four**- Review and confirm registration information and security questions. *You may want to print your security questions for future reference.*

Features

- **A single digital experience** – optimal viewing experience across all browsers and devices, including touchscreens
- **Personalized content** – resources and messages are tailored to your individual preferences and account settings
- **Full account details at your fingertips** – intuitive online access to plan details, account balances, and transaction history (including prior years)
- **Self-service convenience** – check balances, submit claims and receipt documentation, pay bills, manage investments, and more
- **Comprehensive decision support tools** – educational and interactive tools to help you make critical spending and saving decisions throughout the plan year
- **Communication when you need it** – manage your preferences, with access to more than 25 alerts to keep you connected to your account
- **Value-add services and offers** – to help you get the most value from your healthcare dollars

The Proficient Connect mobile app provides ultimate convenience and 24/7 access directly from your tablet or mobile device.

Register Today!

Download and open the Proficient Connect app

Click on *Register*

- **Step One**- Complete the registration form
  - Select a username
  - Create and confirm password
  - Use Employer ID: SASSFDR when prompted for Registration ID
  - Your Employee ID is your SSN without dashes or spaces
- **Step Two**- Select 4 security questions
- **Step Three**- Confirm email address
- **Step Four**- Review and confirm registration information and security questions.

Note: If your device uses touch or face recognition access technology , you can choose to enable them to access Proficient Connect Mobile(Touch ID and Face ID for Apple devices, or Fingerprint Access for Android devices). These options can be changed and disabled at any time via the 'Settings' screen.

Features

Ask Emma – the industry's first voice-activated intelligent assistant that provides answers to questions you may have about your benefit account

Access accounts – check balances, view transaction history, and more

Manage claims – submit new claims, upload receipts, and check claims status

Eligibility Scanner – check the eligibility of an item

Access cards – manage card details, access your PIN, and initiate card replacement for lost or stolen cards

Receive alerts – view important account messages

Update your profile – update personal information, including your email and mobile phone

PO Box 380678, San Antonio TX 78268 • 210-659-8100 • ask@proficientbenefits.com • www.proficientbenefits.com

DENTAL

Carrier *- MetLife*

MetLife gives you the freedom to choose whether you would like to visit a participating dentist or an out-of-network dentist. There are considerable cost savings when using a dentist who is in network. The following is a brief summary of the major plan provisions.

Dependent Age Limits: To age 26 | **Waiting Periods:** None

Benefit	Low Plan 1k	Mid Plan 3k	High Plan 5k
Deductible (aggregate) Period Waived for	**$50 Individual / $150 Family** Calendar Year Preventive	**$50 Individual / $150 Family** Calendar Year Preventive	**$50 Individual / $150 Family** Calendar Year Preventive
Annual Maximum (applies to A, B, C services)	$1,000 per person	$3,000 per person	$5,000 per person
Reimbursement	Negotiated Fee Schedule	Negotiated Fee Schedule	Negotiated Fee Schedule
Type A - Preventative Services Oral Examinations (once/6 months) Cleanings (once/6 months) Sealants (to age 15, 1/ molar in lifetime) Bitewing X-Rays (to age 19, twice/1 year) X-Rays Fluoride (to age 15, once/1 year) Space Maintainers (to age 15, 1/ lifetime) Lab & Other Tests	100%	100%	100%
Type B - Basic Services Amalgam Fillings (1 replacement/surface in 24 months) Oral Surgery (simple extractions) Surgical Extractions Periodontics Non Surgical (once/quadrant, 24 months) General Anesthesia Recementations (once/12 months) Harmful Habits Appliances	80%	80%	80%
Type C - Major Services Crown Buildups/Post Core (1/tooth in 5 calendar years) Implants (1/tooth in 5 calendar years) Bridges & Dentures (1 in 5 calendar years) Crown, Denture, and Bridge Repair (once/12 months) Crowns, Inlays, Onlays (1 replacement/tooth in 5 calendar years) Periodontal Surgery (once/quadrant, 36 months)	50%	50%	50%
Endodontics/Periodontics	50%	80%	80%
***Orthodontia Maximum**	$1,000 per person	$1,500 per person	$2,000 per person

*Orthodontia is covered at 50%, it's a lifetime maximum, and adults and children (to age 26) are eligible for Ortho benefits for all plans.

Dental Plan Monthly Deductions			
Coverage Tier	**Low Plan 1k**	**Mid Plan 3k**	**High Plan 5k**
Employee Only	$28.15	$31.05	$38.81
Employee + Spouse	$57.84	$63.80	$79.75
Employee + Child(ren)	$65.52	$72.26	$90.33
Family	$95.56	$105.40	$131.75

MetLife

www.metlife.com/mybenefits

How to Register on MyBenefits

MyBenefits provides you with a personalized, integrated and secure view of your MetLife-delivered benefits. You can take advantage of a number of self-service capabilities as well as a wealth of easy to access information. MetLife is able to deliver services that empower you to manage your benefits. As a first time user, you will need to register on MyBenefits. To register, follow the steps outlined below.

Registration Process for MyBenefits

Provide Your Group Name

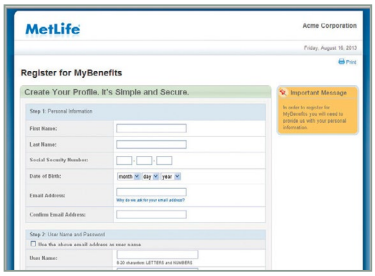
Access MyBenefits at www.metlife.com/mybenefits and enter your group name and click **'Submit.'**

The Login Screen

On the Home Page, you can access general information. To begin accessing personal plan information, click on **'Register Now'** and perform the one-time registration process. Going forward, you will be able to log-in directly.

Step 1: Enter Personal Information

Enter your first and last name, identifying data and e-mail address.



Step 2: Create a User Name and Password

Then you will need to create a unique user name and password for future access to MyBenefits.

The User Name and Password requirements may vary by company setup. General setup includes a User Name between 8-20 characters, containing at least one letter and one number, and a password between 6-20 characters, containing at least one letter and one number.

Step 3: Security Verification Questions

Now, you will need to choose and answer three identity verification questions to be utilized in the event you forget your password.

Step 4: Terms of Use

Finally, you will be asked to read and agree to the website's Terms of Use.

Step 5: Process Complete

Now you will be brought to the "Thank You" page.

Lastly, a confirmation of your registration will be sent to the email address you provided during registration.

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166
www.metlife.com

VISION

Carrier *- Eyetopia*

Eyetopia is pleased to present to you two vision benefits designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health.

Dependent Age Limits: To age 26 | **Waiting Periods:** None

Benefit	Vision Plan - 120/145 (once every calendar year)	Vision Plan - 180/300H (once every calendar year)
Benefit One[2] (choose either one of the following 2 options every 12 months) Refractive Exam- One refraction or one Routine Vision Exam Medical co-pays or any material or service of an equal or lesser value	$10 copay[1] $45 allowance	$5 copay[1] $65 allowance
Benefit Two (choose only one of the following Vision Correction Options) Eyetopia Vision Care Provides you with three (3) options for correcting your vision		
Lenses and/or frame [3] Single Vision[4] Bifocal[4] Trifocal[4]	 $20 copay[1] $20 copay[1] $20 copay[1]	 copay not applicable copay not applicable copay not applicable
Frames The member may select any frame on display, allowance will be applied toward the frame selected. The member pays any amount exceeding the allowance.	$120 allowance	$180 allowance
Contact Lenses Elective [6] Medically Necessary[7]	$145 allowance after $20 co-pay to be applied toward lenses, fitting fee, and any other charges $145 evaluation allowance and $400 contact lens allowance	$300 allowance to be applied towards lenses, fitting fee, and any other charges $250 evaluation allowance and $400 contact lens allowance
Refractive Surgery Option[7] (You may select refractive surgery instead of spectacles or contact lenses during each plan period) LASIK, ASA, ICL or RLE	In-Network: $350 per eye allowance Out-of-Network: $75 per eye allowance	In-Network: $500 per eye allowance Out-of-Network: $150 per eye allowance

Vision Plan Monthly Deductions		
Coverage Tier	Vision Plan - 120/145	Vision Plan - 180/300H
Employee Only	$8.00	$20.00
Employee + One	$15.00	$39.00
Family	$22.00	$54.00

1 The co-pay must be paid to the Participating Provider at the time of service.
2 When Health Insurance Carriers offer an annual wellness eye exam it creates an overlap in benefits for Eyetopia Members. If this occurs, the Member may choose another option under Benefit One as described, a $10.00 co-pay is still required to exercise these other options.
3 Special Lens Materials and Non-covered Items: Transition, ultra light, premium PALs, rush service, service agreements, other special lens materials, oversize, other extras and any items not specifically mentioned above may be substituted provided the Member pays any amount exceeding the price of the covered benefit and the Participating Provider's usual and customary fees for the upgrade at the time of service.
4 Standard Progressive Lenses are defined as any brand offered by the Participating Provider with up to a $120.00 retail value.
5 If the contact lens exam or "fitting" is performed and the patient decides against getting contact lenses, the patient is responsible for the cost of the contact lens fitting fee.
6 If the contact lens evaluation, fitting or dispensing service is performed and the Member decides to use their benefit toward an alternative vision correction option, the Member must pay the cost of the contact lens evaluation, fitting or dispensing service before another vision correction benefit option can be used.
7 The Participating Provider must pre-authorize medical necessity.
8 This allowance can be applied toward the contact lens fitting fee and all other charges including follow-up visits and contact lenses.

LIFE AND AD&D

Carrier *- The Standard*

BASIC TERM LIFE AND AD&D

The company provides you with a **maximum amount of $10,000** of Basic Life and Accidental Death and Dismemberment (AD&D) Insurance coverage through The Standard. San Felipe Del Rio CISD provides a guaranteed issue amount of Basic Life insurance at ***no cost to you during your employment***. Please ***call*** the Benefits Service Center ***to designate or update beneficiary information***.

The AD&D insurance provides a monetary benefit to an employee or beneficiary when the employee experiences certain bodily injuries or death resulting from a covered accident while insured. The company provides a guaranteed issue amount equal to the basic life insurance amount.

Benefits Payable	
	Employee Benefits
Age Reduction	To 50% at age 70

VOLUNTARY TERM LIFE AND AD&D

In addition to the company paid life insurance, you have the opportunity to elect additional life insurance through The Standard. AD&D amount will reflect the Voluntary Life insurance amount.

Benefits	Voluntary Term Life and AD&D
Employee Benefit Benefit Amount Guarantee Age Reduction Employee Maximum Benefit	 Each year at annual enrollment the employee can increase in increments of $10k with no EOI not to exceed GI of $200,000. Up to $200,000 To 50% at age 70 $500,000
Spouse Benefit Benefit Amount Guarantee Age Reduction Spouse Maximum Benefit	 Each year at annual enrollment the employee can increase in increments of $5k with no EOI not to exceed GI of $50,000. Up to $50,000 To 50% at age 70 $250,000, cannot exceed 100% of the Employee additional life coverage.
Child Benefit Benefit Amount Guarantee Age Reduction	 For eligible children 14 days to 26 years you may choose to purchase benefits of $5,000 or $10,000 to $10,000 Up to $10,000 N/A

Please speak to a licensed Benefit Advisor(s) for personalized rates.

UNIVERSAL LIFE

Carrier *- Trustmark*

Trustmark's fully-portable Universal Life solutions address differing employee needs for permanent life insurance and peace of mind for a lifetime. These are available for employees and their spouses and their children in face amounts from $5,000 up to $300,000. The options include the industry's most comprehensive Living Benefits package.

Benefits	Universal Life Plan
Universal Life Events®	LifeEvents pays a higher death benefit during the working years when expenses are high and families need maximum protection. At age 70, when financial needs are typically lower, the death benefit reduces to one third. However, higher Living Benefits do not reduce — they continue through retirement to match the greater need for Long Term Care (LTC).
Spouse/Domestic Partner	Inflation-fighting options for employees and spouses. Guaranteed increases to both living and death benefits without underwriting. Employees and spouses through age 60: additional premium of $1 per week on each of the first 10 anniversaries.
Terminal Illness Benefit	Accelerates 75% of death benefit amount when life expectancy is 24 months or less, as compared with 50% and 6- or 12-month life expectancies commonly seen in the industry.
Accelerated Death Benefit for Critical Care (Built-in)	Designed to accelerate Death Benefit at 4% per month for up to 25 months to pay for long-term care in an assisted living or long-term care facility, or home health care and/or adult day care.

Please speak to a licensed Benefit Advisor(s) for personalized rates.

ACCIDENT

New Carrier! *Voya*

You do everything you can to keep your family safe, but accidents do happen. It's comforting to know you have help to manage the medical costs associated with accidental injuries, both on and off the job. Voya's Accident insurance pays a scheduled cash benefit upon diagnosis of covered accident injuries. The Accident policy will pay a ***$100 wellness benefit*** once per calendar year, per person.

Benefit	Accident Plans	
	Low Plan	High Plan
Accidental Death Benefit Employee Spouse Children	 $100,000 $50,000 $25,000	 $200,000 $100,000 $50,000
Ambulance: Ground **Ambulance: Air**	$600 $2,500	$700 $3,000
Lacerations	Up to $750	Up to $960
Second and Third Degree Burns	Up to $20,000	Up to $22,000
Skin Grafts	50% of burn benefit	50% of burn benefit
Concussion	$450	$550
Dislocation	Up to $10,000	Up to $14,000
Emergency Dental Work (crown/extraction)	$400/$125	$480/$180
Eye Injury (remove of foreign object/surgery)	$110/$400	$120/$420
Fractures	Up to $12,000	Up to $16,000
Tendon, Ligament, Rotator Cuff	Up to $2,000	Up to $2,800
Surgery	Up to $3,000	Up to $4,000
Urgent Care Facility Treatment	$325	$425
Emergency Room Treatment	$325	$425
Hospital Admission	$3,000	$4,000
Hospital Confinement (per day up to 365)	$400	$500
Critical Care CCU Admission	$3,000	$4,000
Critical Care Confinement (per day up to 30 days)	$500	$700

Accident Plan Monthly Deductions		
Coverage Tier	Low Plan	High Plan
Employee Only	$17.63	$24.18
Employee + Spouse	$33.18	$46.28
Employee + Child(ren)	$36.10	$50.65
Family	$44.89	$63.45

CRITICAL ILLNESS

New Carrier! *Voya*

You have responsibilities - to yourself and to your family. Critical Illness Insurance protects you and your family in the event of a serious illness or other medical condition with coverage that is portable (meaning you can take it with you if you leave!) Payments are made directly to the employee and can be applied to claims, household bills, or other expenses as needed. The Critical Illness policy will pay a ***$50 wellness benefit*** once per calendar year, per person.

Benefit	Critical Illness Plan
Coverage Amounts	
Employee (Guaranteed Issue - $30,000) Spouse (Guaranteed Issue - $15,000) Child (All child amounts are guaranteed)	$10,000, $20,000 or $30,000 $5,000, $10,000 or $15,000 25% of employee amount
Benefit	
Heart Attack (cardiac arrest is not a heart attack) Stroke Sudden Cardiac Arrest* Major Organ Transplant (includes Major Organ Failure & End Stage Renal (Kidney) Failure)** Severe Burns	100%
Coronary Artery Bypass	50%
Parkinson's Disease Alzheimer's Disease Huntington's Disease Muscular Dystrophy	100%

* Cardiac arrest is not a heart attack.

** Major organ transplant means the irreversible failure of the insured's heart, lung, pancreas, entire kidney or liver, or any combination thereof, determined by a doctor specialized in care of the involved organ.

Critical Illness Plan Monthly Deductions - Employee							
		<30	30-39	40-49	50-59	60-69	70+
Non-Tobacco	Rate per $1,000	$0.18	$0.30	$0.51	$0.91	$1.49	$3.20
Tobacco	Rate per $1,000	$0.19	$0.41	$0.81	$1.44	$2.46	$5.29

Critical Illness Plan Monthly Deductions - Spouse							
		<30	30-39	40-49	50-59	60-69	70+
Non-Tobacco	Rate per $1,000	$0.18	$0.30	$0.51	$0.91	$1.49	$3.20
Tobacco	Rate per $1,000	$0.19	$0.41	$0.81	$1.44	$2.46	$5.29

Critical Illness Plan Monthly Deductions - Child	
Rate	**Amount**
$0.48	$2,500
$0.95	$5,000
$1.43	$7,500

HOSPITAL INDEMNITY NOTICE

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

HOSPITAL INDEMNITY

New Plan! *Voya*

Voya's Hospital Indemnity plan can complement your health insurance to help you pay for the costs associated with a hospital stay. It can also provide funds that can be used to help pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, copays, and deductibles.

This plan also allows you to continue coverage in the event that your employment ends or when the policy is terminated and not being replaced.

Benefit	Hospital Indemnity Plans	
	Low Plan	High Plan
Hospital Admission	$1,000	$2,000
Critical Care Unit Admission	$1,000	$2,000
Rehabilitation Inpatient Facility Admission	$1,000	$2,000
Hospital Confinement (per day, up to 30 days per confinement)	$100	$200
Critical Care Unit Confinement (per day, up to 30 days per confinement)	$200	$400
Rehabilitation Inpatient Facility Confinement (per day, up to 30 days per confinement)	$100	$200
Newborn Benefits **If no child coverage inforce:** **Flat One-time Benefit Amount**	$300	$300
If child coverage is elected within 30 days of Qualifying Life Event (QLE):	**Voluntary:** All covered children will receive the same coverage as the employee.	**Voluntary:** All covered children will receive the same coverage as the employee.

Hospital Indemnity Plan Monthly Deductions		
Coverage Tier	Low Plan	High Plan
Employee Only	$14.79	$29.12
Employee + Spouse	$29.57	$58.26
Employee + Child(ren)	$31.78	$62.63
Family	$46.56	$91.77

CANCER INSURANCE

Carrier *- Guardian*

While most people can appreciate the importance of having health and disability insurance, the costs of cancer can go well beyond what they cover. Cancer insurance is an affordable way to provide additional funds to help cover out-of pocket expenses.

The average out-of-pocket cost for patients with cancer is estimated to be $1,200 a month. Copays and deductibles, out-of-network and experimental treatments, home health care needs, and travel are just some of the costs a person could face if they are diagnosed with cancer. And that's on top of everyday bills such as groceries, utilities, car payments and others they need to keep up with. Cancer insurance is an affordable way for you to address rising medical costs while strengthening your employee benefit package.

Benefit	Cancer Plans	
	Advantage Plan	Premier Plan
Initial Diagnosis Benefit Employee Spouse Child	 $1,500 $1,500 $1,500	 $1,500 $1,500 $1,500
Benefit Waiting Period	30 days	30 days
Cancer Screening	$50; $50 follow-up screening	$50; $50 follow-up screening
Radiation Therapy or Chemotherapy	Up to $15,000	Up to $20,000
Pre-Existing Condition Limitation	3 months prior/ 6 months treatment free/ 12 months exclusion period	
Air Ambulance (limit 2 trips per confinement)	$1,500 per trip	$2,000 per trip
Ambulance (limit 2 trips per hospital confinement)	$200 per trip	$250 per trip
Anesthesia	25% of surgery benefit	
Anti-Nausea	$50/day up to $150 per month	$50/day up to $250 per month
Attending Physician (limit 75 visits)	$25/day while hospital confined	
Blood/Plasma/Platelets (per year)	$100/day up to $5,000	$200/day up to $10,000
Bone Marrow/Stem Cell	Bone Marrow: $7,500 Stem Cell: $1,500 50% benefit for 2nd transplant $1,000 benefit if a donor	Bone Marrow: $10,000 Stem Cell: $2,500 50% benefit for 2nd transplant $1,500 benefit if a donor
Experimental Treatment	$100/day up to $1,000/month	$200/day up to $2,400/month
Extended Care Facility/Skilled Nursing Care	$100/day up to 90 days per year	$150/day up to 90 days per year
Hospital Confinement	$300/day first 30 days $600/day for 31st day thereafter	$400/day first 30 days $800/day for 31st day thereafter
ICU Confinement	$400/day for first 30 days; $600/day for 31st day thereafter per confinement	$600/day for first 30 days; $800/day for 31st day thereafter per confinement
Skin Cancer	Biopsy Only: $100 Reconstructive Surgery: $250 Excision of a skin cancer: $375 Excision of a skin cancer with flap or graft: $600	

Cancer Plan Monthly Deductions		
Coverage Tier	Advantage Plan	Premier Plan
Employee Only	$23.81	$28.55
Employee + Spouse	$44.89	$53.72
Employee + Child(ren)	$26.60	$31.61
Family	$47.68	$56.78

LONG-TERM DISABILITY

***Carrier** - The Standard*

We understand the unique needs of those who work in education, and we have Long-Term Disability insurance to meet those requirements. The Standard's Long-Term Disability insurance can replace a portion of your salary if you become ill or injured and can't work. It can help you cover your expenses and protect your finances at a time when you're not getting a paycheck and have extra medical bills.

The Standard's Long-Term Disability Insurance provides income replacement benefits for you and your family in the unfortunate event you are unable to work due to injury or illness.

Highlights	Long-Term Disability Plan
Employee Benefit	You may purchase a benefit in multiples of $100 units, starting at a minimum of $200, up to $7,500.
Benefit Waiting Period	0 Days - Accidental injury/7 Days - Other disabilities* 14 Days - Accidental injury/Other disabilities* 30 Days - Accidental injury/Other disabilities* 60 Days - Accidental injury/Other disabilities 90 Days - Accidental injury/Other disabilities 180 Days - Accidental injury/Other disabilities
Maximum Monthly Benefit	The lesser of $7,500 or 66 2/3% of your pre-disability earnings rounded to the nearest $100.
Maximum Benefit Period	If you become disabled before age 62, LTD benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years 6 months, whichever is longer. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins.

Please speak to a licensed Benefits Advisor(s) for personalized rates.

* If you are hospital confined for at least 4 hours during the benefit waiting period, the following will apply; the remainder of your benefit waiting period will be waived, LTD benefits will become payable on the first day you are hospital confined, and your maximum benefit period will begin on the date your LTD benefits are payable.

Definition of Disability: During the first 24 months, Standard will define disability as follows:

You are unable to perform the material and substantial duties of your regular occupation due to sickness or injury; you have a 20% or more loss of indexed monthly earnings due to the same sickness or injury; and, during the elimination period, you are unable to perform any of the material and substantial duties of your regular occupation.

After benefits have been paid for 24 months, you are disabled when Standard determines that, due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

Why is LTD coverage so valuable?

- It's flexible. You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.
- It's affordable. Your cost is based on your age when you buy the insurance and will not increase when you move into the next age band.
- It's convenient. Your premiums are automatically deducted from your paycheck.

Emotional wellbeing and work-life balance resources to keep you at your best

SupportLinc offers expert guidance to help you and your family address and resolve everyday issues

In-the-moment support
Reach a licensed clinician by phone 24/7/365 for immediate assistance

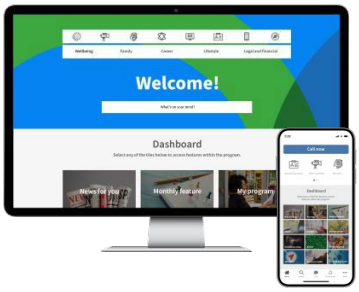
Financial expertise
Consultation and planning with a financial counselor

Legal consultation
By phone or in-person with a local attorney

Short-term counseling
Access up to **five (5) no-cost counseling sessions,** in-person or via video, to resolve stress, depression, anxiety, work-related pressures, relationship issues or substance abuse

Convenience resources
Referrals for child and elder care, home repair, housing needs, education, pet care and so much more

Confidentiality
Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law



Your web portal and mobile app
- The one-stop shop for program services, information and more
- Discover on-demand training to boost wellbeing and life balance
- Find search engines, financial calculators and career resources
- Explore thousands of articles, tip sheets, self-assessments and videos

Convenient, on-the-go support
- **Textcoach®**
  Personalized coaching with a licensed counselor on mobile or desktop
- **Animo**
  Self-guided resources to improve focus, wellbeing and emotional fitness
- **Virtual Support Connect**
  Moderated group support sessions on an anonymous, chat-based platform

Start with Navigator
Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator survey. You'll immediately receive personalized guidance to access support and resources.

supportlinc

Download the mobile app today!

1-888-881-5462

supportlinc.com:
sfdrcisd

HEALTH INSURANCE TERMS

In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, health plans, and health care providers.

- **Benefits -** The amount of money payable by an insurance company to a claimant under the insurance policy.
- **Claim -** A request by an individual (or his /her provider) for the insurance company to pay for services obtained.
- **Co-insurance -** The money that an individual is required to pay for services, after deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20% of the charges while the health plan pays 80%.
- **Co-payment -** An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered.
- **Deductible -** A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual or contract year basis.
- **Exclusions and Limitations -** Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).
- **Flexible Spending Account (FSA) -** An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.
- **High Deductible Health Plan (HDHP) -** A health plan that meets the requirements of being considered an HDHP. There are NO copayments on an HDHP. All medical and prescription drug expenses are applied towards the calendar year deductible first, then once a member has satisfied his/her deductible, the coinsurance will apply.
- **In-Network -** Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.
- **Medically Necessary -** A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.
- **Out-of-Network -** Typically refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.
- **Maximum Out-of-Pocket Maximum -** The total amount paid each year by the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that calendar year.
- **Pre-Existing Condition -** Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.
- **Preferred Provider Organizations (PPO) -** A type of managed care plan in which doctors and hospitals agree to provide discounted rates to plan members. Patients are typically reimbursed 80-100% for treatment received withing the network, versus 50-70% outside the network.
- **Primary Care Physician (PCP) -** A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP services as a gatekeeper for an individual's care, referring him or her to specialists and admitting him or her to hospitals when needed.
- **Reasonable and Customary Charges -** The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges then are the responsibility of the patient.
- **Explanation of Benefits (EOB)-** A summary of claims processed which will be provided to you after a claim is processed for you or for a dependent. This statement outlines year-to-date deductible and out-of-pocket amounts met during the year. This statement will be mailed unless it is turned off on the website.

FREQUENTLY ASKED Q&A

This document outlines important annual, required legal notices for San Felipe Del Rio CISD. If you have any questions about these notices, contact the Human Resources at **830-778-4100**.

GENERAL

If I am already enrolled and not making any changes, do I have to complete the Open Enrollment process?

Yes. It is important that you review any rate or plan changes to your current plan.

If I want to decline coverage, must I still complete the Open enrollment process?

Yes. It is important that Human Resources has a record of your decision. Please keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a special qualifying event such as a marriage, divorce, birth or adoption of a child, or loss of other coverage.

Can I enroll my spouse or dependent on one plan and myself on another?

No. All covered dependents, including spouse, must be on the same plan as the employee.

Can I drop or change plans during the plan year?

Changes can only be made if there has been a qualifying event or personal life change. Examples include marriage, divorce, birth of a child, or change in employment status.

What is the difference between a calendar year and a contract year?

A plan on a calendar year runs from January 1–December 31. Items like deductible, maximum out-of-pocket expense, etc. will reset every January 1. All Individual and Family plans are on a calendar year. A plan on a contract year (also called benefit year) runs for any 12-month period within the year. Items like deductible, maximum out-of-pocket expense, etc. will reset at the plan's renewal date. For example, ABC Company renews on July 1 every year. Your deductible would start July 1 and end on June 30. The deductible would reset every July 1 for ABC Company members.

What happens if I sign up for insurance but find later on in the year that I cannot afford the premiums?

If the reason for your change in affordability is due to a life-changing event such as the loss of a job, death of a spouse, or birth of a child, you would be eligible for special enrollment within 60 days of the event. If you do not enroll during this period, you will not be assured a health plan will cover you either through the Health Insurance Marketplace or in the private market. If you do not pay your premium, you could lose coverage and will not be able to enroll again until the next open enrollment period.

Benefit payments

For benefits received in the Network, you are responsible only for your co-payment, deductible and coinsurance amounts. Your provider will file the claim.

MEDICAL

Should I notify my pharmacy and physician of my benefits plan with Blue Cross Blue Shield of Texas (BCBSTX)?

Yes. On your next visit to the pharmacy or doctor, simply present your BCBSTX ID card. This will allow the provider to correctly bill UMR for the services you have received. It's important to inform your physician of the requirement to utilize an BCBSTX facility as a medical plan participant.

LEGAL NOTICES

Important Notices

1/1/26

San Felipe Del Rio Consolidated Independent School District

Mailing Address 315 Griner Street
Del Rio, TX 78842

Contact Name Rachel Garcia

Contact Title Employee Benefits Support Services Coordinator

Contact Email: rachel.garcia@sfdr-cisd.org

Contact Phone: 830-778-4100

LEGAL NOTICES

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)
** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

LEGAL NOTICES

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this to the person listed under the "Plan Contact Information, at the end of this notice, along with supporting documentation of the qualified life event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

LEGAL NOTICES

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

San Felipe Del Rio Consolidated Independent School District
ATTN: Rachel Garcia
315 Griner Street
Del Rio, TX, 78842
rachel.garcia@sfdr-cisd.org
830-778-4100

LEGAL NOTICES

Notice of Special Enrollment Rights

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

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to 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 request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 request enrollment within 30 days after the marriage, birth, or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 30 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact the plan administrator (see cover page for contact information).

Newborns' and Mothers' Health Protection Act

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

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

Mental Health Parity & Addiction Act

The Mental Health Parity and Addiction Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (see cover page for contact information).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: 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; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema.

LEGAL NOTICES

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact your plan administrator (see cover page for contact information).

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

For additional information, contact your plan administrator (see cover page for contact information).

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra/main.htm

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http;//www.dol.gov/vets
An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

LEGAL NOTICES

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Rachel Garcia at 830-778-4100 or rachel.garcia@sfdr-cisd.org.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area

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PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name **San Felipe Del Rio Consolidated Independent School District**		**4. Employer Identification Number (EIN)** **741694073**
5. Employer address **315 Griner Street**		**6. Employer phone number** **830-778-4100**
7. City **Del Rio**	**8. State** **TX**	**9. Zip Code** **78842**
10. Who can we contact about health coverage at this job? Rachel Garcia		
11. Phone number (if different from above)	**12. Email address** **rachel.garcia@sfdr-cisd.org**	

Here is some basic information about health coverage offered by this employer:

· As your employer, we offer a health plan to:

- ☐ All employees. Eligible employees are: [fill in eligibility rules if applicable]
- ☑ Some employees. Eligible employees are: [full-time, working 20 hours/week or more]

· With respect to dependents:

- ☑ We do offer coverage. Eligible dependents are: [your legal spouse, regardless of gender, and your natural, step or adopted children until the end of the month in which they reach age 26]
- ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends this coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

LEGAL NOTICES

Your Information. Your Rights. Our Responsibilities.

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: 1/1/26

Privacy Officer: Rachel Garcia
Title: Employee Benefits Support Services Coordinator
Email: **rachel.garcia@sfdr-cisd.org**
Phone: 830-778-4100

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

LEGAL NOTICES

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
- In these cases we *never* share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
- *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide

LEGAL NOTICES

whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- *Example: We use health information about you to develop better services for you.*

Pay for your health services
- We can use and disclose your health information as we pay for your health services.
- *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan
- We may disclose your health information to your health plan sponsor for plan administration.
- *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

- How else can we use or share your health information?
- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

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

Do research
- We can use or share your information for health research.

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

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

LEGAL NOTICES

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 30 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

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COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

LEGAL NOTICES

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

LEGAL NOTICES

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

LEGAL NOTICES

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
Option 4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid.1-877-267-2323, Menu

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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OMB Control Number 1210-0137 (expires 1/31/2026)

SAN FELIPE DEL RIO CONSOLIDATED SCHOOL DISTRICT

2025-2026 ACADEMIC CALENDAR

July

4 Independence Day
(28-31) New Teacher Orientation

August

1 New Teacher Orientation
(4-7 Staff Development
8 Teacher Work Day
11 First Day of School/ Begin 1st Six Weeks

September

1 Labor Day / Holiday
19 End 1st Six Weeks
22 RTI Data Planning / No Classes
23 Begin 2nd Six Weeks

October

13 Indigenous People's Day / Holiday
31 End 2nd Six Weeks

November

3 RTI Data Planning / No Classes
4 Begin 3rd Six Weeks
11 Veteran's Day - Holiday
(24-28) Thanksgiving Break

December

(2-12) STAAR Testing
19 End 3rd Six Weeks
(22-31) Winter Break

January

(1-2) Winter Break
5 Teacher Work Day
6 RTI Data Planning/No Classess
7 Begin 4th Six Weeks
19 MLK Day / Holiday

February

13 RTI Data Planning / No Classes
16 President's Day
16 Make-Up Day / If Applicable
20 End of 4th Six Weeks
23 RTI Data Planning / No Classes
24 Start of 5th Six Weeks

March

(9-13) Spring Break

April

(3-6) Easter / Holiday
6 Make-Up Day / If Applicable
10 End of 5th Six Weeks
(7-30) STAAR Testing
13 Start of 6th Six Weeks

May

(1) STAAR Testing
22 Last Day for Seniors
25 Memorial Day / Holiday
28 End 6th Six Weeks/Last Day Of School
29 Graduation
29 Teacher Work Day

June

(16-26) STAAR Testing

July

3 Observance of Independence Day

July 2025

S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	~~28~~	~~29~~	~~30~~	~~31~~		

August 2025

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24	25	26	27	28	29	30
31						

September 2025

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November 2025

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30						

December 2025

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28	29	30	31			

January 2026

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18	19	20	21	22	23	24
25	26	27	28	29	30	31

February 2026

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22	23	<<24	25	26	27	28

March 2026

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15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

April 2026

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12	<<13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

May 2026

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10	11	12	13	14	15	16
17	18	19	20	21	^22^	23
24	25	26	27	28 >>	~~29~~	30
31						

June 2026

S	M	T	W	TH	F	S
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14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

July 2026

S	M	T	W	TH	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Legend

- New Teacher Orientation
- First/Last Day of School
- STAAR Testing
- « » Beginning/End of Six Weeks
- RTI Data Planning/PD / **No Classes**
- Student/Staff Holiday
- + + Make Up Day
- G Graduation
- ^ ^ Last day for Seniors
- Teacher Work Day
- Staff Development

INSTRUCTIONAL DAYS		TEACHER WORKING DAYS	
1st Six Weeks	29	1st Six Weeks	34
2nd Six Weeks	28	2nd Six Weeks	29
3rd Six Weeks	28	3rd Six Weeks	29
4th Six Weeks	30	4th Six Weeks	33
5th Six Weeks	27	5th Six Weeks	28
6th Six Weeks	33	6th Six Weeks	34
TOTAL	175 Days	TOTAL	187 Days
SENIORS	172 Days		

	Instructional Mins.	Waiver Mins.	Total Mins.:	Excess Mins.:	Instructional Day:	Total Instructional Mins.
Cardwell	76125	0	76125	525	7:50AM-3:05PM	435
Elementary:	76125	0	76125	525	7:50AM-3:05PM	435
SFMMS/DRMS:	76125	0	76125	525	8:15AM-3:30PM	435
DRHS/DRFS/ECHS/ Blended:	77875	0	77875	2275	8:10AM-3:35PM	445
Seniors:	76540	0	76540	940	8:10AM-3:35PM	445

NOTES

NOTES

2026 EMPLOYEE BENEFITS GUIDE

SPC Bldg.
315 Griner St. Del Rio, Texas 78840
Office: 830.778.4100 | www.sfdr-cisd.org

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