



BUDA
HAYS COUNTY ESD #2
HAYS COUNTY ESD #8
FIRE & EMS



2026 – 2027
Benefits Enrollment Guide



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Important Items to Remember



NEW HIRE WAITING PERIOD

New employees are eligible for company insurance benefits on the **1st of the month following date of hire.**

TERMINATION OF BENEFITS

When your employment with the company is terminated, your benefits will stop at the end of the month.

ELIGIBLE EMPLOYEES & DEPENDENTS

To be eligible for company benefits, you must be a full time employee working an average of 30 hours per week during the year. Children under the age of 26 are eligible to be covered under the benefits. They will be terminated from the plan at the end of the month in which they turn age 26.

OPEN ENROLLMENT

You can make changes to your plans (enroll in coverage, waive coverage, add/drop dependents, etc.) during this time period each year. All changes made during this time period will take effect on the renewal date.

MAKING PLAN CHANGES DURING THE YEAR

If you've had a major life event (getting married, having a child, getting divorced, losing coverage, becoming eligible for Medicare, etc.) during the year, you're able to make coverage changes to your plan even though it's outside of the Open Enrollment window. Employees have a **30 day window from the date of your Qualifying Event** to make changes. If adding a newborn baby to your plan, the baby's social security number will not be available right away. Please submit the paperwork without it, and provide it once it's available.

Please note that dependents are not automatically added and that changes, both additions and terminations, typically take effect the 1st of the month following the event.

NEED A NEW ID CARD OR ANOTHER ID CARD FOR A DEPENDENT?

You can register for the insurance carrier's website where you can print out temporary ID cards and order new cards, or you can contact Christensen Group at (210) 512-0512 or SABenefits@christensengroup.com or visit your Human Resources Department.

HAVE QUESTIONS ABOUT AN INSURANCE CLAIM?

Please have copies of your Explanation of Benefits (EOB) along with a copy of your bill(s) ready and contact Christensen Group at (210) 512-0512 or SABenefits@christensengroup.com.

Employee Navigator Online Enrollment

A simple way to review, enroll, and manage your benefits online.



STEP 1 | ACCESS YOUR ACCOUNT

Visit www.employeenavigator.com/benefits

First-time users should select **Register as a new user**.

You'll need:

- First & Last Name
- Company Identifier: **BudaFD**
- Last 4 digits of SSN
- Date of Birth

STEP 2 | VERIFY YOUR INFORMATION

Review and confirm your:

- Address
- Phone Number
- Email Address

Add or update eligible dependents as needed.

STEP 3 | REVIEW & SELECT BENEFITS

Review available coverage options including:

- Medical
- Dental
- Vision
- Life Insurance
- Disability
- Voluntary Benefits

STEP 4 | CONFIRM YOUR ELECTIONS

Review your elections summary, submit enrollment, and save your confirmation statement.

Need Assistance?

Christensen Group Insurance

(210) 512-0512 SABenefits@christensengroup.com

Helpful Tip: Log in anytime throughout the year to update information, view benefits, or submit qualifying life events.

Health Insurance

Curative | PPO

DEDUCTIBLE	IN-NETWORK WITH BASELINE VISIT	IN-NETWORK WITHOUT BASELINE VISIT
Single	$0	$5,000
Family	$0	$10,000
COINSURANCE		
Member %	0% coinsurance	20% coinsurance
OUT OF POCKET MAXIMUM		
Single	$0 copay	$7,500
Family	$0 copay	$15,000
COMMONLY USED SERVICES		
Telemedicine	$0 copay	$0 copay
Primary Care Physician	$0 copay	$25 copay after ded
Specialist	$0 copay	$50 copay after ded
Urgent Care	$0 copay	20% coinsurance after ded
PREVENTIVE CARE		
Preventive Services	0% coinsurance	0% coinsurance
MAJOR MEDICAL EXPENSES		
Outpatient Surgery	0% coinsurance	20% coinsurance after ded
Inpatient Hospitalization / Surgery	0% coinsurance	20% coinsurance after ded
Diagnostic Labs & X-Rays	0% coinsurance	20% coinsurance after ded
Emergency Room	0% coinsurance	20% coinsurance after ded
PRESCRIPTION DRUGS		
Preferred	$0 copay	$50 copay after ded
Non-Preferred	$50 copay	$100 copay after ded
Specialty Preferred / Non-Preferred	$250 copay	25% coinsurance after ded
PLAN INFORMATION		
Plan Year	10/1/26 - 9/30/27	
Deductible Period	Calendar Year	
Policy #	A8000351	
Network Name	Curative	
Member Website	www.curative.com	

COST PER PAY PERIOD	
Employee Only	$0.00
Employee + Spouse	$213.38
Employee + Child(ren)	$157.44
Family	$403.96



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Plan Explanation

The plan details operate on a **Calendar Year**. Below is a list of services your plan includes and the amount **YOU** are responsible for paying.

*** Baseline Visits must be completed by each adult over age 18 on the medical plan within 120 Days of the plan anniversary date of October 1st.**

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Another year, another Baseline.

Complete your annual Baseline to continue with $0 care! If you completed your Baseline last year, enjoy $0 care and preferred prescriptions straight away!* If you missed last year's Baseline, you have a chance this time around to unlock your $0 perks.

Just remember to complete your Baseline **within 120 days of your plan renewal date to keep or get these benefits.** *As always, your Baseline is confidential and won't impact your premiums or coverage.*

1 Log into your Curative account

You likely already have access to the member portal at **health.curative.com**. Log-in with your credentials or check and sign-up for your annual Baseline with the options below!

2 Baseline onboarding

Learn about your plan's benefits and resources, any updates and changes, find $0 providers, sign up for telehealth, check medication coverage, and get connected to programs to reach your health goals. For renewals, your onboarding will be self-guided.

Self-guided onboarding

Complete your onboarding on your own by watching short videos and completing important tasks. Your Care Navigator will follow up with you after to answer any questions.



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3 Baseline clinical check-in

Schedule a Zoom virtual meeting with a Curative Clinician to discuss your medical history and any health questions. They'll help create a plan tailored to you. You can even get labs done before or after for a more complete picture of your health. Austin residents can also schedule in-person.

Clinical Check-ins can be scheduled after the Self-guided Onboarding.

Continue to enjoy $0 out-of-pocket costs!

Your Care Navigator will follow-up after the visit and you can always find their contact info on the Member Portal. For time-sensitive Curative benefit questions, you can call our **24/7 Member Services at 855-428-7284**.

Visit to learn more about the Baseline:
curative.com/baseline

Watch to learn more about your Baseline Onboarding options:
cur.tv/baseline-preview

Who has to complete the annual Baseline Visit?

All our members must complete an annual Baseline Visit.
If you've joined us within the last 8 months before your renewal, don't worry – you won't have to go through the Baseline again right away. We've got your back until the next plan renewal.

If you're under 18 when your plan kicks in, you can hold off on the Baseline until the next plan year.

If you were moved to the high-deductible plan, you won't be shifted to the $0 out-of-pocket plan until after your renewal date and once your Baseline within the first 120 days of the renewal year is completed.

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Members must complete a Baseline Visit within the first 120 days of the plan's start date to maintain $0 out-of-pocket costs for covered services with in-network providers and preferred prescriptions. EPO Value members must also use a Curative Pass for $0 covered care. See Summary Plan Description and Benefits Booklet for additional requirements for the Baseline Visit.

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Getting Help, Your Way

Our support is designed specifically for your plan, so you get accurate, personalized answers you can trust—plus seamless access to real people for more complex needs.

INSTANT CHAT

Curative AI

Our AI digital assistant understands your specific plan and can handle routine requests instantly—no waiting.

MEMBER PORTAL MOBILE APP

Ask Curative AI to:

- Find doctors and check coverage
- Refill prescriptions
- Check prior authorization status
- Submit reimbursement requests
- Schedule/cancel your Baseline Visit
- Order/replace your member ID or Curative Cash Card

CALL/TEXT ANYTIME

Member Services

Our AI digital assistant will start by helping you. If more support is needed, it will connect you directly to a live agent.

(855) 428-7284 *Available 24/7*

What to expect when you call:

1. Choose English or Spanish
2. Meet our digital assistant
3. Tell us why you're calling
4. Verify your info
5. Plan overview
6. Get help from our digital assistant or get connected with a live agent

PERSONALIZED CARE

Care Navigator

Reach your Care Navigator for personalized support—text for the fastest response, or email if you prefer.

Email: carenavigator@curative.com

Text: Find phone number in Member Portal

GENERAL SUPPORT

Email

For general questions or support, reach out anytime.

General: health@curative.com

Curative Pharmacy: pharmacy@curative.com

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Your Curative Cash Card helps you access $0 care*

curative cash card

The Curative Cash Card is designed to give members more convenient access to $0 care for specific eligible services. Using it only as intended helps avoid payment issues and supports a smoother $0 care experience for Curative members.

Step 1: Check the provider

- Complete one-time Cash Card activation in the Member Portal
- Search for your provider in the Curative Provider Search
- If the provider is labeled “Cash Card only”, plan to use your Cash Card
- For providers **not** labeled “Cash Card only”, plan to use your Member ID Card
- **Note:** You can use your Cash Card at any urgent care location, even if it’s not listed in the Provider Search

Step 2: Make sure it’s an eligible Cash Card service**

- **Eligible Services:** Office visits, urgent care, behavioral health, outpatient hospital services *(like imaging or infusions)*, inpatient hospital services *(like surgeries and medical monitoring)*
- **Planned Care:** For planned surgeries or procedures, contact Member Services as soon as possible to confirm next steps and whether a good faith estimate is needed
- **Ineligible Services:** Prescriptions, standalone labs, other non-covered benefits

Step 3: Tell the Front Desk

- Let the office know you’ll “pay the cash rate”
- When payment is requested, simply present your Cash Card
- If you run into any issues, contact Member Services right away at **855-428-7284**, available 24/7.

Step 4: Curative handles the rest

Eligible services are paid for by Curative***

Don’t see your go-to provider?

Nominate your provider at cur.tv/nominate or contact Member Services at **855-428-7284** or **health@curative.com**

Questions? Give Member Services a call at 855-428-7284 or health@curative.com

Learn more about Curative Cash Card at curative.com/cash-card

**Members must be 18 years and older to use the Curative Cash Card and complete their Baseline Visit in the first 120 days of their plan start date to maintain $0 out-of-pocket costs. Curative Cash Card Visa® Commercial Credit cards are issued by Celtic Bank. Additional Terms & Conditions can be found in your Member Portal Account at health.curative.com. This overview does not apply to EPO Value members. EPO Value members should follow the Curative Pass guidance in the Member Portal to confirm when to use their Cash Card.*

***For limitations of the Curative Cash Card, go to: curative.com/cash-card. The Curative Cash Card can be used only when Curative is your primary insurance. It counts as payment in full and does not work with other insurance.*

****All Cash Card payments are limited to eligible, covered services and are subject to plan rules. All transactions are reviewed for coverage, clinical guidelines, usual and customary review compliance, and may require prior authorization. Provider participation, payment methods, and acceptance of new patients may change at any time.*

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curative | H-E-B

The power of personalized nutrition.



Curative is making it easier for you to elevate your health with personalized nutrition plans brought to you by H-E-B Wellness Nutrition Services* in Texas. H-E-B dietitians are a covered benefit for members who complete a Baseline Visit within 120 days of plan activation.

Through Curative's partnership, H-E-B dietitians create personalized plans that take into account your budget, lifestyle, and specific health requirements. Not only will the team assist you with food selections, they'll also show you exact products that will make a difference in your nutrition plan.

H-E-B Dietitians see the supermarket as a classroom where they can share their knowledge about food and nutrition in ways that are convenient and hassle-free through better-for-you swaps. H-E-B Dietitians make product recommendations that are personalized for you and your journey.

Curative and H-E-B Wellness Nutrition Services believe in providing comprehensive support to help you achieve your nutrition goals while accommodating your preferences and unique circumstances. H-E-B dietitians specialize in the following conditions:

AUTOIMMUNE DISORDERS
Multiple Sclerosis
Celiac Disease
Rheumatoid Arthritis
Crohn's Disease
Ulcerative Colitis

BEHAVIORAL ISSUES
Alzheimer's
Dementia
Eating Disorders:
Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder

CARDIOVASCULAR HEALTH
Coronary Artery Disease
Heart Attack or Stroke
Hypertension

DEVELOPMENTAL DISABILITIES
Autism Spectrum Disorders
Down's Syndrome
Prader-Willi

DIABETES
Type 1
Type 2
Gestational
Pre-Diabetes

DYSPHAGIA

FOOD ALLERGIES & AVERSIONS
Food Allergies
Food Sensitivities
Food Intolerances
Food Aversions (picky eaters)

PULMONARY
COPD
Cystic Fibrosis

MUSCULOSKELETAL CONDITIONS
Arthritis
Gout
Rheumatoid Arthritis
Osteoporosis

GASTROINTESTINAL DISORDERS
Gastroparesis
GERD
Peptic Ulcers
Esophageal
Gastric Surgery
Irritable Bowel Syndrome
Colostomy Ileostomy
Diverticular Conditions
Liver Cirrhosis
Gallbladder
Pancreatitis

NEUROLOGICAL CONDITIONS
Epilepsy
Huntington's Disease
Parkinson's Disease

NUTRIENT DEFICIENCIES
Anemia
Other Nutritional Deficiencies

OBSTETRICS
Prenatal Nutrition
Breastfeeding
RENAL
Kidney Stones
Kidney Disease
Dialysis

ENDOCRINE DISORDERS
Hyperthyroidism
Hypothyroidism
Hashimoto's
Grave's Disease

TRANSPLANT
Transplant of Kidney

WEIGHT MANAGEMENT
Overweight
Obesity
Underweight; BMI < 18.5
Malnutrition
Unintentional Weight Loss
Bariatric Surgery

The program covers:

- Weight Management
- Diabetes Management
- Childhood and Family Nutrition
- Cancer Nutrition Support
- Food Allergy Support
- Digestive Support
- Sports Nutrition
- Cardiovascular Health

To **start your nutrition journey**:

1. Call **H-E-B Nutrition Services - (855)-803-9355** to book a **virtual or in-store visit**
2. Use **Curative insurance**
3. Meet with H-E-B dietician
4. **Discover** how to **shop** for your **health**

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A simple guide to prior authorizations.



At Curative, we are dedicated to ensuring you receive the best, safest, and most cost-effective healthcare. Through prior authorization, our medical experts evaluate treatments for safety and effectiveness, supporting your well-being while controlling costs. By utilizing our trusted network, ensuring continuity of care, and preventing unnecessary claims, we strive to provide comprehensive and organized healthcare for our valued members.

When it's required:

- Medical necessity
- Benefits restrictions
- Hospital-based services
- Elective procedures
- Therapy services

This list is not exhaustive. For more information call member services.

Uninterrupted care

Prior authorization helps us plan your care so you get the right support and we don't miss anything. During your transition to our health plan, preserving continuity of care is vital for a seamless healthcare experience.

Pregnancy: If you are 24 weeks or beyond, you cannot be required to use in-network providers. In cases of high risk, this period might be less than 24 weeks, but it will be subject to review.

Life-threatening illness (e.g., Oncology): If you are undergoing treatment for a life-threatening illness, our plan ensures that you won't be required to change providers for a set period, allowing you to utilize out-of-network services without disruption.

How it works:

1. When your healthcare provider recommends a service or treatment that requires prior authorization, they will submit a request to us.
2. Our team of medical experts will review the request based on (1) benefits coverage and (2) established guidelines and medical necessity.
3. If approved, you can proceed with the recommended treatment knowing that it meets evidence-based care protocols for quality and cost-effectiveness.
4. In cases where a request is denied, we will provide an explanation, and you and your provider can explore alternative options.

Common reasons for denial include:

- Lack of Medical Necessity
- Not a covered benefit
- In the Experimental/Investigational phase

How to appeal:

Request appeal by calling Member Services or email **medicalmanagement@curative.com**. A doctor needs to provide supporting documentation. Once we receive an appeal, we will respond with an Appeal Authorization Letter.

Questions?

If you have any questions or need assistance withthe prior authorization process please contact Member Services at **855-428-7284.**

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curative telehealth

Curative Telehealth: Fast, seamless virtual care.



Get the care you need, anytime, anywhere.

Curative Telehealth provides 24/7 nationwide virtual care, connecting you with a licensed provider in less than an hour. Whether by phone or video, get fast, hassle-free care—directly through your Curative Member Portal.*

Fast, easy access
See a provider **in less than an hour,** anytime, from home, work, or on the go.

Seamless experience
Access directly through your Curative Member Portal without the hassle of extra apps or logins.

Nationwide coverage
Available **in all 50 states**, so you always have a consistent virtual care option.

Online or phone
Select **video or phone** visits based on your needs and comfort level.

Guided symptom intake
Answer a few quick questions to get connected with the right care provider.

Getting started with Curative Telehealth is easy

1. **Log in or call**
   Start a visit through your Curative member portal or by phone.
   health.curative.com/curative-telehealth
2. **Answer a few questions**
   Our system will match you with the right provider.
3. **See a provider fast**
   Get care via **video or phone,** with visits starting **in less than an hour.**

For more info, go to curative.com/telehealth

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*For EPO Value, no Curative Pass is required for Curative Telehealth.

Flexible Spending & Dependent Care Accounts

WHAT IS AN FSA AND DCA?

A **Flexible Spending Account (FSA)** is an employersponsored spending account that allows employees to set aside pre-tax earnings to pay for eligible health care or dependent care expenses.

A **Dependent Care Account (DCA)**, is a pre-tax benefit that allows employees to set aside money from their paycheck to pay for eligible childcare or adult dependent care expenses so they can work.

WHAT ARE FSA ELIGIBLE EXPENSES?

FSA: Eligible Expenses under the FSA are called Qualified Medical Expenses (QME). These are defined in IRS Publication 502. Examples of qualified medical expenses are Deductibles, Office Visits, Prescription Drugs, Hospital bills, Dental charges, Lenses & Frames, etc.

HOW DO I USE THEM?

You contribute to the FSA and DCA through pre-tax payroll deductions. Ameriflex will provide you with a debit card, or you may have to submit claim forms or receipts along with itemized bills from your provider to obtain reimbursement.

WHEN CAN I ENROLL FOR AN FSA AND DCA?

Since the contributions are made via pre-tax payroll deductions you may only enroll at open enrollment or when you have a mid-year qualifying event.

WHEN CAN I ACCESS THE FUNDS?

Since this is an employer owned account, you have access to all funds from the 1st day of the plan year for your FSA. The DCA funds are deposited as they are taken out of your paycheck.

MEMBER WEBSITE / CUSTOMER SERVICE

www.myameriflex.com

(888) 868-3539

ARE THERE ANY CONTRIBUTION LIMITS?

FSA: For 2026, the IRS has set the maximum employee contribution limit for health Flexible Spending Account at $3,400.

DCA: For the 2026 tax year, the contribution limit is $7,500 per household for single individuals and married couples filing jointly, or $3,750 if you are married and filing separately.

*** 2027 Contribution Limits will be communicated once they are published by the IRS.**

WHAT ARE DCA ELIGIBLE EXPENSES?

Eligible dependent care expenses generally include daycare, preschool, before and after school care, summer day camps, and adult day care services for a qualifying child under age 13 or a dependent adult who cannot care for themselves, as long as the care enables you and your spouse to work or look for work.

DO I HAVE TO SAVE RECEIPTS FOR MY EXPENSES?

Yes, you should always save your FSA receipts because you may be required to submit documentation to verify that your expenses were eligible under IRS rules.

DO I HAVE TO USE ALL FUNDS BEFORE THE END OF THE YEAR?

For the FSA Only, Employees can rollover $680 in unused funds to the next plan year. Any amount over the $680 will be forfeited at the end of the year. All unused DCA funds are forfeited at the end of the year.

WHAT TAX BENEFITS ARE THERE?

You are able to pay for QME's through pre-tax FSA contributions.



Dental Insurance

Standard | PPO

DEDUCTIBLE	COVERAGE
Single	$50
Family	$150
MAXIMUM THE CARRIER WILL PAY	
Annual Maximum	$1,500
FREQUENCIES	
Cleanings	2 per benefit period
Exams	2 per benefit period
DENTAL COVERAGE	
Cleanings, Exams, X-Rays, Fluoride (under age 18), Space Maintainers	0%
Sealants, Fillings, Oral Surgery, Endodontics (root canal), Periodontics (gum disease), Simple Extractions, General Anesthesia	20%
Crowns, Bridges, Dentures, Inlays, Onlays, Implants	50%
Orthodontia	Not Covered
Max Keeper Benefit	Benefits for Preventive procedures are not deducted from the plan participant's annual maximum benefit. This saves the entire annual maximum for the Basic and Major procedures.
Orthodontia Maximum Age	Dependents are covered up to age 26
OUT OF NETWORK COVERAGE	
	Contracted Fee Schedule. Reimbursement is based on a pre-determined fee schedule rather than the dentist's actual charges, leaving the member responsible for any difference between the fee allowance and the dentist's billed amount.
PLAN INFORMATION	
Plan Year	10/1/26 - 9/30/27
Policy #	172395
Network Type	Dental PPO

COST PER PAY PERIOD	
Employee Only	$0.00
Employee + Spouse	$7.84
Employee + Child(ren)	$8.43
Family	$16.15

Plan Explanation

The plan details operate on a **Calendar Year**. This is a list of services covered by your plan and the amount **YOU** are responsible for paying.

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Vision Insurance

Standard | VSP



Plan Explanation

Vision insurance helps cover the cost of routine eye exams, prescription glasses, and contact lenses, with benefits typically including copays, allowances, and discounts on vision care services and materials.

Lens options - (ex. UV protection, coatings, anti-scratch, blue screen, tint, etc.) and are not included in the lens copay and will be subject to additional cost.

Laser Vision Correction (LASIK) - There are discounts available through in-network laser vision correction providers.

VISION COVERAGE	IN-NETWORK (VSP)	OUT-OF-NETWORK
Eye Exam	$10	Up to $45
Single Vision Lenses	$25	Up to $30
Lined Bi-Focal / Tri-Focal Lenses	$25	Up to $50 / $65
Lenticular Lenses	$25	Up to $100
Contact Lenses Allowance (Conventional & Disposable)	$130	Up to $105
Fitting & Evaluation	Up to $60 copay	Not covered
Retail Frame Allowance	$130	Up to $70
FREQUENCIES		
Exams (Date of Service)	Once every 12 months	
Lenses (Date of Service)	Once every 12 months (Contact lenses in lieu of frames and spectacle lenses)	
Frames (Date of Service)	Once every 24 months	
OUT OF NETWORK		
	While you will receive a partial reimbursement when you go out of network, the out of network provider may not file the claim.	
PLAN INFORMATION		
Plan Year	10/1/26 - 9/30/27	
Policy #	172395	

PREMIUM PER EMPLOYEE PAYCHECK	
Employee Only	$0.00
Employee + Spouse	$1.56
Employee + Child(ren)	$1.18
Family	$2.74

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Basic Life/AD&D Insurance

Standard



Plan Explanation

Buda Fire Department pays 100% of the premium for the Basic Life and Accidental Death & Dismemberment (AD&D) insurance.

Basic Life Insurance provides a lump-sum benefit to designated beneficiaries in the event of an employee's death, helping provide financial protection and support for loved ones.

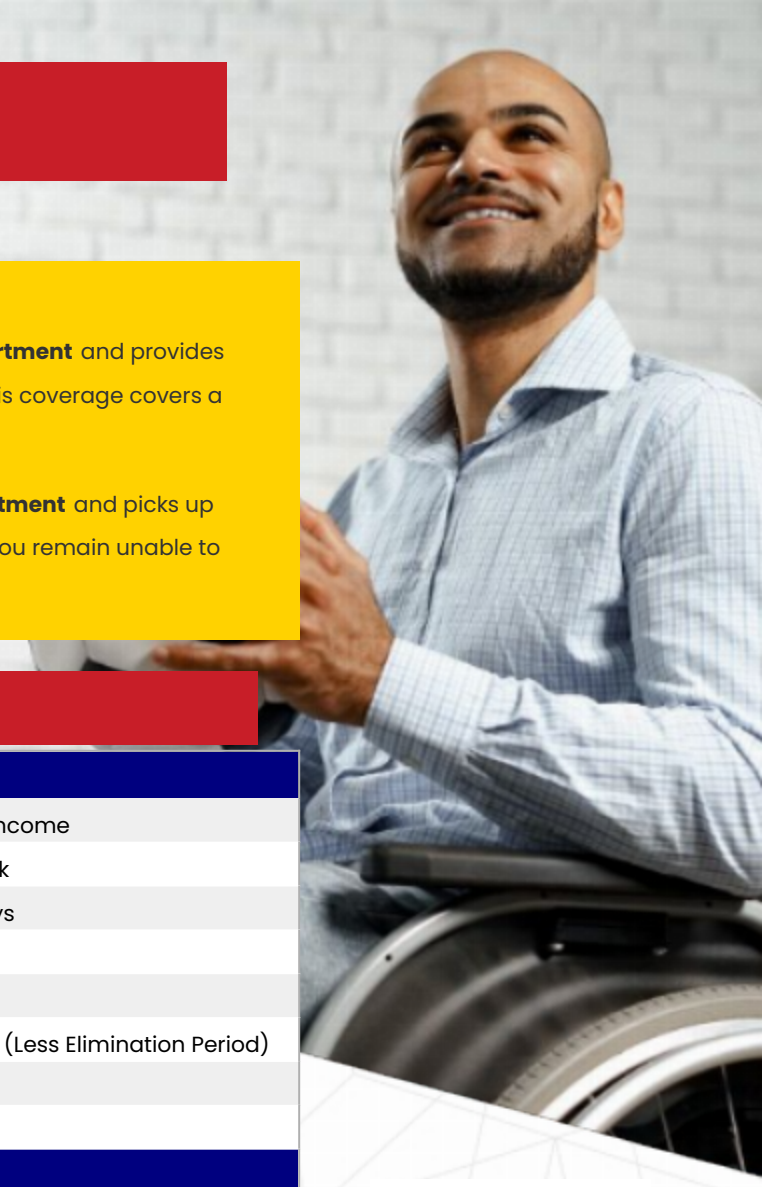
BASIC LIFE/AD&D	
Basic Life Amount	3 times your annual earnings to a maximum of $500,000
Basic AD&D Amount	3 times your annual earnings to a maximum of $500,000
Age Reduction Schedule	Coverage reduced by 35% at age 65, 50% at age 70, and 65% at age 75.
Line of Duty Benefit	Provides public safety officers and additional $50,000 benefit when suffering a loss in a line of duty accident. Public safety officers include police officers, firefighters, correction officers, judicial officers and officially recognized or designated firefighters meeting the definition of a public safety officer.
PLAN INFORMATION	
Plan Year	10/1/26 - 9/30/27
Policy #	172395

TheStandard®

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Disability Insurance



Plan Explanation

Short-Term disability (STD) premium is 100% paid for by Buda Fire Department and provides income to you if you're unable to work due to a covered illness or injury. This coverage covers a percentage of your salary for a limited period while you recover.

Long-Term disability (LTD) premium is 100% paid for by Buda Fire Department and picks up where short-Term disability ends, providing a portion of your paycheck if you remain unable to work due to a covered illness or injury for an extended period.

Standard | Short-Term Disability

SHORT-TERM DISABILITY	
% of Income Replacement	66.66% of Weekly Income
Maximum Benefit	$2,000 / Week
Elimination Period (Injury/Illness)	7 days / 7 days
Benefit Duration	180 Days
Pre-Existing Condition Limitation	None
Maternity Benefit	6 Weeks Natural / 8 Weeks C-Section (Less Elimination Period)
Guaranteed Issue	Full Amount
Taxation of Benefit	Taxable
PLAN INFORMATION	
Plan Year	10/1/26 - 9/30/27
Policy #	172395

Standard | Long-Term Disability

LONG-TERM DISABILITY	
% of Income Replacement	66.66% of Monthly Income
Maximum Benefit	$5,000 / Month
Elimination Period	180 Days
Benefit Duration	Up to Social Security Normal Retirement Age
Own Occupation Period	24 Months
Pre-Existing Condition Limitation	3 Months Prior / 12 Months Insured
Guaranteed Insurability	Full Amount
Taxation of Benefit	Taxable
PLAN INFORMATION	
Plan Year	10/1/26 - 9/30/27
Policy #	172395

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Accident Insurance

Manhattan Life



Plan Explanation

Accident Insurance is offered as a **voluntary employee paid benefit** and provides a lump-sum cash benefit if you experience a covered accidental injury, such as a fracture, dislocation, laceration, or emergency room visit. Benefits are paid directly to you and can be used for medical expenses, deductibles, or everyday costs while you recover.

INJURY	SCHEDULED BENEFIT
Ambulance Ground / Air	$300 / $1,000
Burn - 3rd degree	Up to $10,000
Coma	$20,000
Concussion	$200
Dislocations	Up to $3,600
Doctor Follow-Up Visits	$100/visit up to 2 visits per accident
Emergency Room Treatment	$200
Eye Injury	Up to $300
Fractures	Up to $6,000
Hospital Admission / Confinement	$1,500 / $300 per day
Hospital ICU Admission / Confinement	$1,500 / $600 per day
Laceration	Up to $200
Surgery	$400
Urgent Care Visit	$200
X-Ray	Up to $150
Emergency Dental Work	Up to $300
Wellness Benefit	$100 per person, per year
Accidental Death & Dismemberment	$75,000
PLAN INFORMATION	
Plan Year	10/1/26 - 9/30/27
Policy #	891925

COST PER PAY PERIOD	
Employee Only	$10.60
Employee + Spouse	$18.00
Employee + Child(ren)	$22.31
Family	$29.83

ManhattanLife

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Critical Illness Insurance

Manhattan Life



CRITICAL ILLNESS BENEFIT	
Employee Maximum Benefit	$30,000
Spouse Maximum Benefit	$15,000
Children Benefits	$5,000
Pre-Existing Condition Clause	12 months prior / 12 months insured
ILLNESS	**% OF SCHEDULE BENEFIT**
Invasive Cancer, Heart Attack, Stroke, Organ Failure, Kidney Failure, Coma, Loss of Hearing, Loss of Sight, Loss of Speech, Permanent Paralysis (2 limbs), Severe Burns	100% lump sum benefit
Coronary Heart Disease, Non-Invasive Cancer	25% lump sum benefit
Ruptured Brain Aneurysm, Transient Ischemic Attack	10% lump sum benefit
PLAN INFORMATION	
Plan Year	10/1/26 - 9/30/27
Policy #	891925

COST PER PAY PERIOD

AGE BANDS	COST PER $5,000		COST PER $5,000	
	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILDREN	FAMILY
18 - 29	$1.65	$2.48	$1.65	$2.48
30 - 39	$3.59	$5.39	$3.59	$5.39
40 - 49	$8.60	$12.90	$8.60	$12.90
50 - 59	$16.83	$25.24	$16.83	$25.24
60 - 64	$25.92	$38.88	$25.92	$38.88
65 - 69	$32.40	$48.60	$32.40	$48.60

ManhattanLife™

Plan Explanation

Critical Illness Insurance is offered as a **voluntary employee paid benefit** and provides a lumpsum cash benefit upon diagnosis of a covered serious condition such as heart attack, stroke, or cancer. The benefit is paid directly to you and can be used for medical expenses, treatment costs, travel, or everyday living expenses during recovery.

Hospital Indemnity Insurance

Manhattan Life



Plan Explanation

Hospital Indemnity Insurance is offered as a **voluntary employee paid benefit** and provides a cash benefit if you are admitted to the hospital for a covered illness or injury. Benefits are paid directly to you and can help cover deductibles, coinsurance, or everyday expenses during a hospital stay.

HOSPITAL INDEMNITY BENEFIT	
Hospital Admission	$1,500 per admission, limited to 1 admission per calendar year. Confinement is a minimum of 18 hours.
Hospital Confinement	$200 per day, limited to 30 days.
ICU Confinement	$200 per day, limited to 15 days.
Pre-Existing Condition Limitation	12 month prior / 12 months insured
Maternity Waiting Period	300 Days
PLAN INFORMATION	
Plan Year	10/1/26 - 9/30/27
Policy #	891925

COST PER PAY PERIOD	
Employee Only	$10.49
Employee + Spouse	$29.42
Employee + Child(ren)	$23.34
Family	$42.27

ManhattanLife™

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

MASA Medical Transport Solutions

MASA Access |



Plan Explanation

MASA Access Medical Transport is offered as a **voluntary employee paid benefit**.

MASA Access provides financial protection against unexpected out-of-pocket costs associated with emergency medical transportation, including ground ambulances, air ambulances, and medically necessary hospital-to-hospital transfers. Even with health insurance, ambulance services can result in significant expenses due to deductibles, coinsurance, or out-of-network charges.

MASA helps bridge these coverage gaps by covering eligible transportation expenses, giving you and your family added financial protection and peace of mind during a medical emergency.

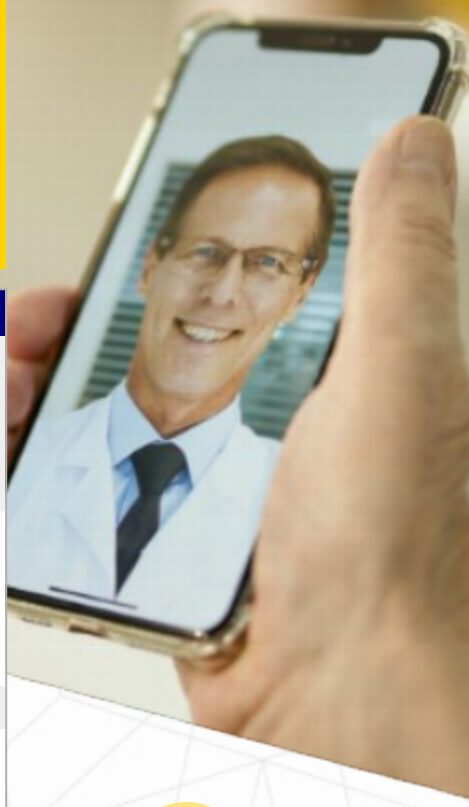
*** Rates shown are covering the Employee, Spouse, and Dependents up to Age 26.**

MASA ACCESS	
Emergent Plus Plan	Emergency Ground/Air Coverage in the United States and Canada.
Platinum Plan	Worldwide Coverage
Additional Plan Details	Please see Carrier Information Page for additional plan information by scanning the QR Code.
PLAN INFORMATION	
Plan Year	10/1/26 - 9/30/27
Policy #	B2BBFD
Member Website	www.masaaccess.com

COST PER PAY PERIOD	
Emergent Plus	$6.46
Platinum	$18.00

Employee Assistance Program

Alliance Work Partners | EAP



Plan Explanation

Alliance Work Partners Employee Assistance Program (EAP) is a 100% confidential and no cost. This plan is an employer-sponsored benefit that provides employees and their household members with access to short-term counseling, mental health support, and resources for personal or work-related challenges. Services often include help with stress, anxiety, family issues, financial concerns, legal questions, and referrals for ongoing care when needed.

BENEFITS PROVIDED	
Eligible Members	Employees, Retirees, Household members, regardless of age or relationship, residing in employee's home, including significant other and their children, Children and Grand-children age 26 and under residing in the US or Puerto Rico.
Services Provided	Confidential counseling, telephonic and video counseling, Legal and Financial services, Grief and Trauma support, EAP website, resources and referrals for everyday needs, access to global community, suicide and crisis lifeline,
Number of Visits	6 Face to Face in-person visits per incident
SafeRide Program	SafeRide is available to employees and family members for reimbursement up to $50.00 for a cab or rideshare distance of up to 50 miles one-way to the employee or family member's place of residence, should the employee or family member be impaired and consequently, unable to drive responsibly.
WorkLife Services	Academic Services, Adoption, Career resources, Health & Wellness, Legal, Parenting, Relocation, Elder Care, Financial, Grief and Loss, Hotlines, Nutrition, Pet Care, Retirement, Support Groups, Veteran's Services, Volunteer Options
PLAN INFORMATION	
Phone Number	(800) 343-3822
Website	www.awpnow
Registration Code / ID	AWP-BFD-6341

BROKER & HUMAN RESOURCES

Christensen Group Insurance

Service Team

SABenefits@christensengroup.com

(210) 512-0512

Buda Fire Department

Debra Hogan

DHogan@budafire.org

(512) 758-6979



CARRIER CONTACTS

Policy # A8000351

(855) 428-7284

www.curative.com

Policy # 172395

Dental: (888) 937-4783 Vision: (800) 877- 7195

Life: (800) 628-8600 Disability: (800) 368-2859

www.standard.com

Policy # 891925

(855) 448-6982

www.manhattanlife.com

Policy # B2BBFD

(800) 643-9023

www.masaaccess.com/member

Policy # AMFHC2800

(888) 868-3539

www.myameriflex.com

Registration Code: AWP-BFD-6341

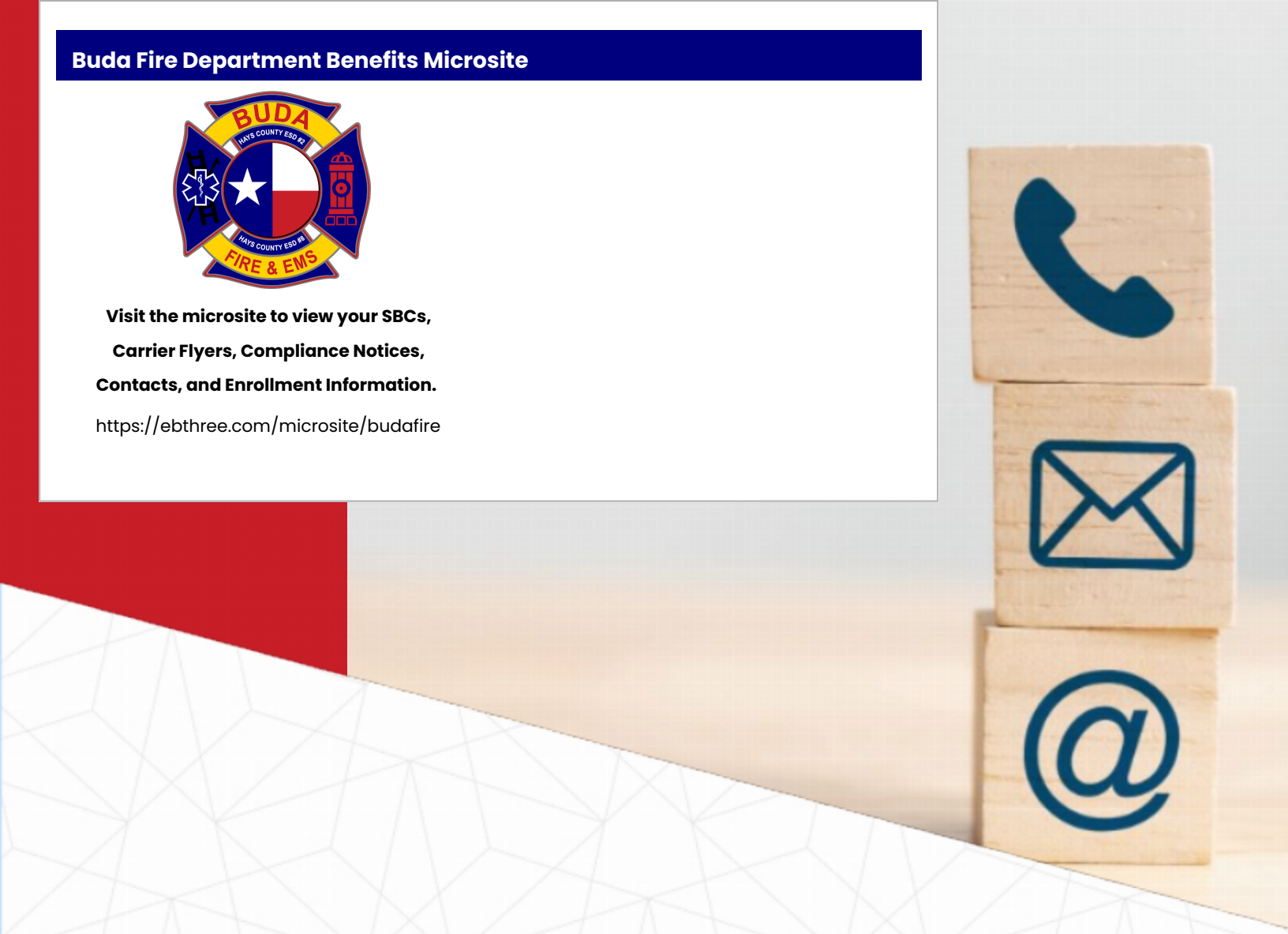
(800) 343-3822

www.awpnow.com

Buda Fire Department Benefits Microsite

Visit the microsite to view your SBCs, Carrier Flyers, Compliance Notices, Contacts, and Enrollment Information.

https://ebthree.com/microsite/budafire



Premium Assistance Under Medicaid and the

Children's Health Insurance Program (CHIP)

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

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

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

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

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

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: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
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	ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	IOWA – Medicaid and CHIP (Hawki)
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	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
KANSAS – Medicaid	KENTUCKY – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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
LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	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
MASSACHUSETTS – Medicaid and CHIP	MINNESOTA – Medicaid
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	MONTANA – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	NEVADA – Medicaid
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	NEW JERSEY – Medicaid and CHIP
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	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ 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)
NEW YORK – Medicaid	NORTH CAROLINA – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	PENNSYLVANIA – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	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)
RHODE ISLAND – Medicaid and CHIP	SOUTH CAROLINA – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	TEXAS – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	VERMONT– Medicaid
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/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
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, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
https://www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
https://www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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 the collection of information if the collection does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 5/31/2029)

Special Enrollment Notice

If you are declining enrollment 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).

In addition, if you have a new dependent as a result of 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, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Debra Hogan, Human Resource Director, (512) 758-6976, dhogan@budafire.org.

Patient Protection Model Disclosure

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

Curative generally ALLOWS the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Debra Hogan, Human Resource Director, (512) 758-6976, dhogan@budafire.org.

For plans and issuers that require or allow for the designation of a primary care provider for a child, add: For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add: You do not need prior authorization from Curative or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Debra Hogan, Human Resource Director, (512) 758-6976, dhogan@budafire.org

Newborn's Act Disclosure

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

WHCRA Enrollment Notice

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). 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.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: Group health plans or health insurance companies may impose deductibles or coinsurance requirements on mastectomies and post-mastectomy treatment, but no more than those established for other benefits. In other words, the deductible for post-mastectomy reconstructive surgery should be similar to the deductible for any similar procedure covered by the plan..

If you would like more information on WHCRA benefits, call your plan administrator (512) 758-6976

WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (512) 758-6976 for more information.

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

RETIREE COVERAGE ONLY:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Buda Fire Department, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Retiree coverage only: Commencement of a proceeding in bankruptcy with respect to the employer; or
- 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 notice to: Buda Fire Department.

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.

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, 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.

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.

* https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

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

Debra Hogan, Human Resource Director, (512) 758-6976, dhogan@budafire.org

Health Insurance Marketplace Coverage Options and Your Health Coverage

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 9.96% 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 9.96% of the employee's household income.

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.

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 your employer via the information provided below.

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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1. Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2024.
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.

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 Buda Fire Department		4. Employer identification Number (EIN) 743010903
5. Employer Address 209 FM 2770		6. Employer Phone Number (512) 758-6976
7. City Buda	8. State Texas	9. Zip Code 78610
10. Who can we contact about employee health coverage at this job? Debra Hogan, Human Resources Director, (512) 758-6976, dhogan@budafire.org		
11. Phone number (If different from above) (512) 758-6976		12. Email address dhogan@budafire.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:

☐ Some Employees, Eligible employees are:

• With respect to dependents:

☑ We do offer coverage, Eligible dependents are:

☐ 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 your 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ **Yes** (Go to question 15) ☐ **No** (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often ? ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often ? ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Quarterly ☐ Yearly

*An employer-sponsored 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.

Important Notice from Buda Fire Department About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Buda Fire Department and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Buda Fire Department has determined that the prescription drug coverage offered by the Curative is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.
However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Buda Fire Department coverage WILL be affected. .
If you do decide to join a Medicare drug plan and drop your current Buda Fire Department coverage, be aware that you and your dependents WILL be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Buda Fire Department and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Buda Fire Department changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call1-877-486-2048.

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

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

Date: 10/01/2026

Name of Entity/Sender: Buda Fire Department

Contact: Debra Hogan, Human Resource Director, (512) 758-6976, dhogan@budafire.org -- Position/Office: Human Resources Director

Phone Number: (512) 758-6976

Address: 209 FM 2770, Buda, Texas,

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

EMPLOYEE RIGHTS

PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT

The **Families First Coronavirus Response Act (FFCRA or Act)** requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

PAID LEAVE ENTITLEMENTS

Generally, employers covered under the Act must provide employees:

Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid sick leave based on the higher of their regular rate of pay, or the applicable state or Federal minimum wage, paid at:

- 100% for qualifying reasons #1-3 below, up to $511 daily and $5,110 total;
- 2/3 for qualifying reasons #4 and 6 below, up to $200 daily and $2,000 total; and
- Up to 12 weeks of paid sick leave and expanded family and medical leave paid at 2/3 for qualifying reason #5 below for up to $200 daily and $12,000 total.

A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

ELIGIBLE EMPLOYEES

In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons (see below). Employees who have been employed for at least 30 days prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below.

QUALIFYING REASONS FOR LEAVE RELATED TO COVID-19

An employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to **telework**, because the employee:

1. is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
2. has been advised by a health care provider to self-quarantine related to COVID-19;
3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis;
4. is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or
5. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
6. is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

ENFORCEMENT

The U.S. Department of Labor's Wage and Hour Division (WHD) has the authority to investigate and enforce compliance with the FFCRA. Employers may not discharge, discipline, or otherwise discriminate against any employee who lawfully takes paid sick leave or expanded family and medical leave under the FFCRA, files a complaint, or institutes a proceeding under or related to this Act. Employers in violation of the provisions of the FFCRA will be subject to penalties and enforcement by WHD.

For additional information or to file a complaint:
1-866-487-9243
TTY: 1-877-889-5627
dol.gov/agencies/whd

The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information.

Builds on HIPAA's protections. GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Before the Affordable Care Act, HIPAA prevented a plan or issuer from imposing a preexisting condition exclusion based solely on genetic information. Under the Affordable Care Act, plans are prohibited from excluding coverage or benefits due to any preexisting condition. HIPAA continues to prohibit discrimination in eligibility, benefits, or premiums based on a health factor (including genetic information).

Additional underwriting protections. GINA provides that group health plans cannot adjust premiums or contribution amounts for a plan, or a group of similarly situated individuals under the plan, based on genetic information of one or more individuals in the group. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.)

Prohibits requiring genetic testing. GINA generally prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. A plan or issuer may request the results of a genetic test to determine payment of a claim for benefits, but only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer under certain conditions to request (but not require) that a participant or beneficiary undergo a genetic test.

Restricts collection of genetic information. GINA prohibits plans from collecting genetic information (including family medical history) from an individual prior to or in connection with enrollment in the plan, or at any time for underwriting purposes. Thus, under GINA, plans and issuers are generally prohibited from offering rewards in return for the provision of genetic information, including family medical history information collected as part of a Health Risk Assessment (HRA).

GINA includes an exception for incidental collection of genetic information, provided the information is not used for underwriting purposes. However, the GINA regulations make clear that the incidental collection exception is not available if it is reasonable for the plan or issuer to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided.

Other protections. GINA also contains individual insurance market provisions, administered by the Department of Health and Human Services' Centers for Medicare & Medicaid Services, privacy and confidentiality provisions, administered by the Department of Health and Human Services' Office for Civil Rights, and employment-related provisions, administered by the Equal Employment Opportunity Commission (EEOC).

For more information, see the Frequently Asked Questions Regarding the Genetic Information Nondiscrimination Act on the EBSA Website.

Michelle's Law Notice

Note: Pursuant to Michelle’s Law, you are being provided with the following notice because the Buda Fire Department group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of Buda Fire Department group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the Buda Fire Department 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 Buda Fire Department group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

- The Buda Fire Department group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and
- .

To obtain additional information, please contact: Debra Hogan, Human Resources Director, (512) 758-6976, dhogan@budafire.org.

Buda Fire Department

209 FM 2770, Buda, Texas, 78610
https://budafire.org
(512) 758-6976, dhogan@budafire.org

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.**

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

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 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

Special Notes: We never sell or market your personal information

Greater limits on disclosures: We will never share any substance abuse treatment records without your written permission.

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

How We Handle Substance Use Disorder (SUD) Records
In addition to the general privacy protections described in this Notice, specific federal laws and regulations (42 CFR Part 2) apply to records regarding your identity, diagnosis, prognosis, or treatment for substance use disorders ("SUD Records") when received from a federally funded "Part 2" SUD program.

- Use and Disclosure of SUD Records: If we receive SUD Records from a Part 2 program, we will use and disclose those records only for purposes of treatment, payment, and health care operations, or as otherwise permitted by law. We may share this information within our health system to ensure you receive coordinated care, provided that the disclosure is consistent with your authorization or applicable federal regulations.
- Legal and Administrative Protections: We are strictly prohibited from using or disclosing your SUD Records for the purpose of initiating or substantiating any criminal charges against you or to conduct any investigation of you. Furthermore, your SUD Records will not be used or disclosed for legal, administrative, or legislative proceedings (such as civil, criminal, or administrative trials or hearings) without your express written consent or a specific court order that meets the requirements of 42 CFR Part 2.
- Fundraising Communications: We may use certain information to contact you for fundraising efforts to benefit our organization. However, if we intend to use any information derived from your SUD Records for these purposes, you have the absolute right to elect not to receive these communications. You may opt out of receiving fundraising materials at any time by contacting our Privacy Officer.

Global Consent for Future Use and Disclosure

You have the right to provide a single, "global" written consent that allows us to use and disclose your SUD Records for all future treatment, payment, and health care operations (TPO) purposes.

- Efficiency of Care: If you provide this global consent, we may share your SUD information with other health care providers, health plans, and business associates involved in your care without needing to obtain a new signature from you for each individual disclosure.
- Your Right to Revoke: You have the absolute right to revoke this consent at any time. Your revocation must be in writing. Please note that revoking your consent will not affect any actions we took or disclosures we made before we received your written request.
- Redisclosure: Information disclosed based on this global consent may be redisclosed by the recipient as permitted by HIPAA (for treatment, payment, or operations), but it generally cannot be used for legal or criminal proceedings against you without a separate, specific authorization.

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.

Effective Date of this notice: 10-01-2026

OHCA notice:

Privacy Official: Buda Fire Department, dhogan@budafire.org, (512) 758-6976

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that your employer receives advance written or verbal notice of your service;
- you have five years or less of cumulative service in the uniformed services while with that particular employer;
- you return to work or apply for reemployment in a timely manner after conclusion of service; and
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

HEALTH INSURANCE PROTECTION

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- are a past or present member of the uniformed service;
- have applied for membership in the uniformed service; or
- are obligated to serve in the uniformed service,

then an employer may not deny you:

- initial employment;
- reemployment;
- retention in employment;
- promotion; or
- any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

ENFORCEMENT

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at https://www.dol.gov/agencies/vets/. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: https://www.dol.gov/agencies/vets/programs/userra/poster Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

ESGR
1-800-336-4590

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

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

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

When balance billing isn't allowed, you also have these protections:

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

If you think you've been wrongly billed, contact . The federal phone number for information and complaints is: 1-800-985-3059

Visit: www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Visit: for more information about your rights under state laws.

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time.** When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must:**

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection.

You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must:**

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing:**

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process.**

WAGE AND HOUR DIVISION

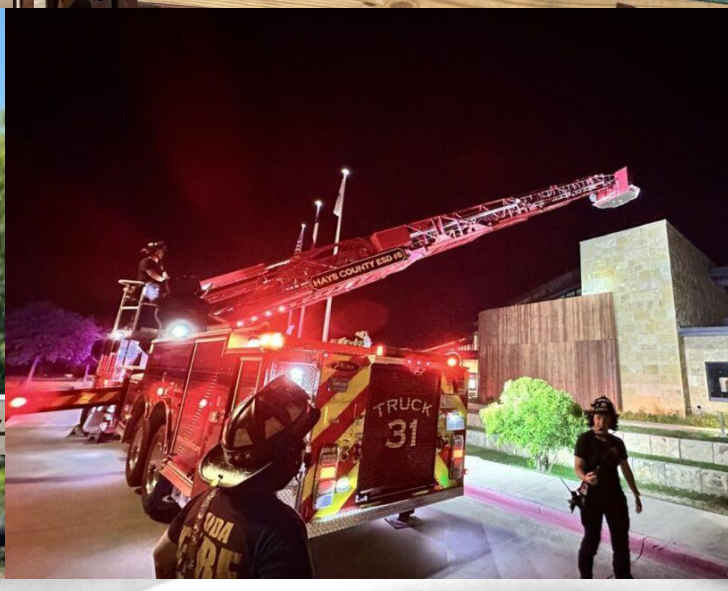
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