KLEIN ISD
FUTURE READY

Keeping You Connected

# Employee Benefits Guide 2015-2016

KLEIN ISD

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*While information in this Benefit Booklet is believed to be correct at the time of printing, this information is for education and reference purposes only. This material is in summary form. The provisions in each plan are governed by the Summary Plan Description, or the Certificate of Coverage, or the Group/ Individual contract of that plan.*

# Table of Contents

# Welcome to Your 2015-2016 Annual Enrollment

## MANDATORY RE-ENROLLMENT FOR ALL EMPLOYEES!

Annual Enrollment begins July 23, 2015 and ends August 24, 2015 at midnight. Everyone must actively enroll or decline the medical coverage. All changes are effective September 1, 2015.

### THIS YEAR IS AN ACTIVE ANNUAL ENROLLMENT

Due to the Affordable Care Act (ACA), TRS is requiring that all employees MUST make an election to sign up or decline the TRS ActiveCare medical plans. Instructions for online enrollment can be found later in this booklet. **If an employee fails to go online and submit his/her medical election, any current medical plan election will be dropped and the employee/dependents will not be covered under any of the Klein ISD medical plan offerings for the 2015-2016 plan year.** *NOTE: If you currently do not have Medical coverage with TRS ActiveCare, you still must go online and actively decline coverage.*

All other current benefits will rollover and become active September 1st, unless you make a change during Annual Enrollment, with the exception of Flexible Spending Accounts (FSAs), which you must actively re-enroll each year. Please review and print your summary of benefits for your records. It is very important that you verify your beneficiary, address and contact numbers.

The ACA and TRS are now requiring social security numbers for any of your dependents. This is not a Klein ISD rule, but a federal law. Therefore, you must provide valid social security numbers for your dependents during Annual Enrollment.

### MEDICAL HIGHLIGHT CHANGES

- The same three medical plans are available: **TRS ActiveCare 1-HD**, **TRS ActiveCare 2**, and **TRS ActiveCare Select** (In-Network ONLY)
- No change in individual or family deductibles
- Out-of-pocket maximum changes:
  - **TRS ActiveCare 1-HD**:
    Individual – $6,350 to $6,450 / Family – $9,200 to $12,900
  - **TRS ActiveCare Select:**
    Individual – $6,350 to $6,600 / Family – $9,200 to $13,200
  - **TRS ActiveCare 2**:
    Individual – $6,000 to $6,600 / Family – $12,000 to $13,200

  *NOTE: All three plans: Out-of-pocket maximums include any deductibles, copayments and coinsurance from medical or from pharmacy.*
- Rate Changes: The District absorbs 70.75% of the overall annualized rate increase. Based on how the District provides funding, 58.58% of employees will see a decrease in rates, another 12.46% will see a maximum of $9.00 per month increase
- FSA Contributions: For all employees that have elected a TRS medical coverage the District will contribute $300.00 toward your elected medical Flexible Spending Account (or HSA) – coverage is effective September 1, 2015. Your own contributions must be elected each year.

### DENTAL HIGHLIGHT CHANGES

- Cigna is our new carrier for both the PPO and DHMO Dental plans
  - Rates will be very similar to last year
  - Benefits will be very similar to last year
  - Provider network is the best available; you must elect a DHMO dentist after you enroll – visit www.mycigna.com.

### THIS IS YOUR ONLY CHANCE TO MAKE CHANGES IN YOUR BENEFITS!!

Be sure to attend one of our Benefits Meeting to learn about all the changes ( http://www.kleinisd.net/default.aspx?name=hrbrm.enrollment2015 )

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## The Importance Of Health Insurance

Having health insurance is very important - even if you are in good health. No one can tell when they will have an accident or get sick. Having good health insurance provides you with an affordable way to get medical care when you need it.

The cost of basic care can quickly add up, but the cost of care for a major illness or injury can be devastating. Health insurance can help you prepare for the worst that could happen. **Now having health insurance is also the law. The Affordable Care Act requires that most people have health insurance.** If you don't have it, you may have to pay a penalty. If you think you can't afford it, you may be able to get help paying for it based on your household size and income.

To help you better understand our 2015-2016 benefits program in more detail, Klein ISD is providing you this brief guide containing your 2015-2016 benefit options. **Please refer to plan documents for details, including important coverage exclusions and limitations.**

# Administration

# Eligibility

## TRS ActiveCare Medical Plans

To be eligible for TRS ActiveCare, you must be an active, contributing TRS member or a regular part-time or substitute employee working a minimum of 10 hours a week. All employees contributing to TRS are eligible for the District medical contribution if medical is elected. All non-TRS members including substitutes are responsible for the full medical premium. Retirees eligible for TRS-Care are NOT eligible for TRS ActiveCare. Spouses and children up to age 26 are eligible to be enrolled as dependents. Retirees that are rehired and working more than 20 hours per week are considered full-time, and therefore, eligible for all benefits, except TRS ActiveCare medical coverage.

Your eligible dependents include:

- Your legally married spouse (same sex or opposite sex), or with whom you have proof of Common Law marriage
- Your children up to the age of 26, regardless of student, marital status (medical only) or tax status, including stepchild(ren), adopted child(ren), child(ren) for whom you are the legal guardian, a grandchild who is your dependent for federal income tax purposes at the time of application
- Your child over age 26, if medically incapacitated – forms required, please consult the Human Resource Department.

## Important Notes on Eligibility

- Benefits for a dependent child will continue until the last day of the calendar month in which they turn 26
- If you are married to another employee, only one of you may cover any dependent children
- No one may be considered as a dependent of more than one employee.

## Section 125 Cafeteria Plan

The Internal Revenue Service (IRS) approved cafeteria plan allows you to pay premiums for the following benefits on a pre-tax basis:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Cancer Insurance
- Flexible Spending Account (FSA).

By choosing to use before-tax dollars, an employee can reduce federal income taxes by reducing taxable income by the amount of the insurance premiums paid.

# Qualifying Life Events


Generally, you may only change your benefit elections during the annual open enrollment period. However, you can change your benefit elections during the year if your experience a Qualifying Life Event. Qualifying Life Events include:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse or dependent child
- Adoption of/placement for adoption of your child
- Termination or commencement of your spouse's employment
- Involuntary loss of medical coverage
- Qualification by the Plan Administrator of a Medical Child Support Order
- Entitlement to Medicare or Medicaid
- Loss of COBRA coverage.

If you experience a Qualifying Life Event, you must notify Klein ISD and complete your benefit election form within 31 days of the effective date of change. Depending on the type of change, you may need to provide proof of the change. If you do not contact the Klein ISD Benefits Department and make your benefit election within 31 days, you will have to wait until the next annual enrollment period to make changes, unless you have another Qualifying Life Event.

## Once Benefits Are Elected

Once you have made your benefit elections, they will remain in effect until the end of the plan year (September 1 through August 31).

**PLEASE REMEMBER, IT'S YOUR RESPONSIBILITY TO BECOME EDUCATED ABOUT THE BENEFITS MADE AVAILABLE TO YOU AND TO TAKE AN ACTIVE ROLE IN YOUR OVERALL HEALTH CARE. BE SURE TO REVIEW ALL OPTIONS BEFORE MAKING YOUR FINAL ELECTIONS.**

# 2015-2016 Employee Monthly Rates

(Effective September 1, 2015)

| TRS ActiveCare Medical Plan Funding | Employee Rates Per Month | District* Contribution | TRS Total |
|---|---|---|---|
| **TRS ActiveCare 1 HD – Medical** | | | |
| EE Only | $30.00 | $311.00 | $341.00 |
| EE + Child(ren) | $231.00 | $384.00 | $615.00 |
| EE + Spouse | $388.00 | $526.00 | $914.00 |
| EE + Family | $633.00 | $598.00 | $1,213.00 |
| **TRS Select Aetna ACO – Medical** | | | |
| EE Only | $132.00 | $341.00 | $473.00 |
| EE + Child(ren) | $364.00 | $398.00 | $762.00 |
| EE + Spouse | $603.00 | $519.00 | $1,122.00 |
| EE + Family | $760.00 | $571.00 | $1,331.00 |
| **TRS ActiveCare 2 – Medical** | | | |
| EE Only | $246.00 | $368.00 | $614.00 |
| EE + Child(ren) | $584.00 | $408.00 | $992.00 |
| EE + Spouse | $929.00 | $549.00 | $1,478.00 |
| EE + Family | $982.00 | $539.00 | $1,521.00 |
| **The Scott & White HMO – Medical** | | | |
| The Scott & White HMO is available if you live in a zip code area they service.<br>If you are interested in the Scott & White HMO, call 800-321-7947 to confirm your eligibility, or visit them at: www.sw.org | | | |

**SPLIT/POOLED PREMIUMS: THE DISTRICT CONTRIBUTION WILL BE AT THE "EMPLOYEE ONLY" LEVEL PER ELIGIBLE EMPLOYEE FOR THE PLAN ELECTED.*

THE TRS ACTIVECARE MEDICAL PLAN IS ADMINISTERED BY AETNA. A SEPARATE ENROLLMENT GUIDE IS AVAILABLE. FOR ADDITIONAL INFORMATION OR TO FIND A PROVIDER, VISIT THE TRS ACTIVECARE WEBSITE AT WWW.TRSACTIVECAREAETNA.COM OR FROM A LINK ON THE KLEINET OR KLEINISD.NET.

PART-TIME AND SUBSTITUTE EMPLOYEES ARE ELIGIBLE TO ENROLL IN A TRS-ACTIVECARE MEDICAL PLAN; HOWEVER, PART-TIME AND SUBSTITUTE EMPLOYEES ARE NOT ELIGIBLE FOR THE DISTRICT CONTRIBUTION AND WILL BE REQUIRED TO PAY THE ENTIRE PREMIUM SET BY TRS. PART-TIME AND SUBSTITUTE EMPLOYEES ARE NOT ELIGIBLE TO PARTICIPATE IN ANY OTHER BENEFITS DESCRIBED IN THIS BOOKLET, EXCEPT THE INDIVIDUAL RETIREMENT PLANS, 403B AND 457B.

RETIREES THAT ARE REHIRED AND WORKING MORE THAN 20 HOURS PER WEEK ARE CONSIDERED FULL-TIME, AND THEREFORE, ELIGIBLE FOR ALL BENEFITS, EXCEPT TRS ACTIVECARE MEDICAL COVERAGE.

# Employee Monthly Rates (Cont'd)


(Effective September 1, 2015)

| Dental Plans | |
|---|---|
| **Cigna DHMO – Dental** | |
| EE Only | $11.38 |
| EE + Child(ren) | $23.72 |
| EE + Spouse | $20.20 |
| EE + Family | $34.68 |
| **Cigna DPPO – Dental** | |
| EE Only | $30.16 |
| EE + Child(ren) | $73.52 |
| EE + Spouse | $59.20 |
| EE + Family | $102.14 |
| **Vision Plan** | |
| **Vision Services Plan (VSP) – Vision** | |
| EE Only | $6.32 |
| EE + Child(ren) | $10.14 |
| EE + Spouse | $9.04 |
| EE + Family | $17.18 |

NOTE: Rates will be deducted equally between two pay checks each month. Rates reflect a monthly cost for employees receiving 24 pay checks a year; employees who receive 20 to 21 pay checks will pay an additional amount beginning September 1, 2015, to pay for the summer.

All other benefits refer to other sections in this booklet or online at:
http://www.mybenefitshub.com/kleinisd or http://www.kleinisd.net/ - Departments – Benefits

## ID Cards

- **Medical** – Only if you make a change will you receive a new ID card
- If you change your Medical, or elect it for the first time, you will receive a new Medical ID card from Aetna
- Changes in Medical, or a new enrollee, will also receive a pharmacy ID card from CVS – CareMark.
- **Dental** - Effective September 1, 2015, Cigna will be our Dental carrier for both the DHMO and PPO dental plans. DHMO participants will receive new ID cards at their homes. PPO participants will receive their ID card in September or they can print their new ID cards online.
- **Vision** – VSP – No Card Issued.
- **Flexible Spending Account** – My Benny Card administered thorough Boon Chapman (see expiration date on card) you keep the same card, your new contribution and District's contribution is loaded on the existing card the first week of September. KEEP YOUR CURRENT CARD.
- **Mailing Address and Telephone Numbers** – On file with Klein ISD. If you need to make a correction, go online at KNET or www.kleinisd.net to the employee access center.

# Medical TRS — Aetna

| BENEFIT | TRS ACTIVECARE 1 HD (IN- / OUT-OF-NETWORK) | TRS SELECT AETNA (IN-NETWORK ONLY) | TRS ACTIVE CARE 2 (IN- / OUT-OF-NETWORK) |
|---|---|---|---|
| **Annual Deductible** | | | |
| • Single | $2,500 | $1,200 | $1,000 |
| • Family | $5,000 | $3,600 | $3,000 |
| **Out-of-Pocket Maximum** | | | |
| • Single | $6,450 | $6,600 | $6,600 |
| • Family | $12,900 | $13,200 | $13,200 |
| Coinsurance (Plan Pays/You Pay) | 80% / 20% | 80% / 20% | 80% / 20% |
| **Office Visit Copay** | 20% after deductible | $30/PCP<br>$60/Specialist | $30/PCP<br>$50/Specialist |
| **Diagnostic Lab** | 20% after deductible | Covered 100%/No deductible; if performed at Quest facility; 20% after deductible | Covered 100%/No deductible; if performed at Quest facility; 20% after deductible |
| **Preventive Care** | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Inpatient Hospitalization** | 20% after deductible | $150 copay per day, plus 20% after deductible ($750 max. copay per admission) | $150 copay per day, plus 20% after deductible ($750 max. copay per admission; $2,250 max. per cal. yr.) |
| **Outpatient Hospitalization** | 20% after deductible | $150 copay per visit plus 20% after deductible | $150 copay per visit plus 20% after deductible |
| **Teledoc® Physician Services** | $40 consultation fee | Plan pays 100% | Plan pays 100% |
| **Emergency Room** | 20% after deductible | $150 copay plus 20% after deductible (copay waived if admitted) | $150 copay plus 20% after deductible (copay waived if admitted) |
| **High-Tech Radiology** (CT scan, MRI, nuclear medicine) | 20% after deductible | $100 copay plus 20% after deductible | $100 copay plus 20% after deductible |
| **Prescription Drug** Drug Deductible (per plan year) | Subject to plan year deductible | $0 for generic drugs; $200 per person brand-name drugs | $0 for generic drugs; $200 per person brand-name drugs |
| **Retail Short Term.** (31 days) | 20% after deductible | | |
| • Generic | | $25 | $25 |
| • Preferred Brand | | $40* | $40* |
| • Non-Preferred Brand | | 50% coinsurance | $65* |
| **Retail Maintenance.** (31 days) | 20% after deductible | | |
| • Generic | | $25 | $25 |
| • Preferred Brand | | $50*** | $105* |
| • Non-Preferred Brand | | 50% coinsurance | $80* |
| **Mail Order & Retail-*Plus*** (90 days) | 20% after deductible | | |
| • Generic | | $45 | $45 |
| • Preferred Brand | | $105* | $105* |
| • Non-Preferred Brand | | 50% coinsurance | $180* |
| **Speciality Drugs** | 20% after deductible | 20% after deductible | $200 per fill (31 day supply)<br>$450 per fill (90 day supply) |

** If the patient obtains a brand-name drug when a generic equivalent is available, the patient will be responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug.*

**For a detailed medical summary of benefits, for all TRS medical plans, please refer to your summary plan documents.**

# Dental — Cigna (New Carrier)


**CIGNA PPO PLAN**: The Cigna Dental PPO plan allows you to visit any dentist, nationwide. Although you may go to any dentist under this plan, employees are encouraged to use dentists in the Cigna Dental PPO Network. If the dentist you choose participates in the CIGNA Dental PPO network, your payment will be based on negotiated fees and your out-of-pocket cost will generally be lower than with a non-participating dentist. However, whether or not your dentist is in the CIGNA Network, your benefit percentages will be the same. Dentists in the CIGNA Dental network can be found on-line by going to www.myCigna.com. Employees who opt for the DPPO are welcome to go online to print their dental ID cards. DPPO participants will receive a non-peronsalized dental ID card in September.

**CIGNA DHMO Plan**: Under this plan, you must choose a primary care dentist from the CIGNA DHMO – Houston, TX network. A list of participating DHMO primary care dentists can be found at www.myCigna.com. Under plan name, click on Dental and select DHMO-Houston, Texas. Your primary care dentist coordinates all of your dental care and must obtain authorization for you or your covered dependent to be able to see a specialist, such as an oral surgeon or orthodontist. Your primary care dentist or any dentist who has been authorized to provide treatment will handle all claim submissions. All enrolled employees will receive a dental ID card from CIGNA Dental DHMO mailed to their home. You must select a plan Dentist or one will be assigned to you that is close to your home.

**Contact customer service at 1.800.244.6224** to change dentists or to request additional dental ID cards. Please refer to the benefits HUB for a schedule of benefits, limitations and exclusions.

| PLAN BENEFITS | DHMO<br>IN-NETWORK (ONLY) |
|---|---|
| Deductible (Single/Family) | N/A |
| Individual Annual Maximum | N/A |
| Sample of Covered Procedures | Copay Schedule |
| Adult cleaning (two per calendar year each at $0) (additional cleanings available at $55 each) | $0 |
| Child cleaning (two per calendar year each at $0) (additional cleanings available at $45 each) | $0 |
| Periodic oral evaluation | $0 |
| Comprehensive oral evaluation | $0 |
| Topical fluoride (two per calendar year each at $0) (additional topical fluoride available at $15 each) | $0 |
| X-rays – (bitewings) 2 films / X-rays panoramic film | $0 |
| Sealant – per tooth | $12 |
| Amalgam filling (silver colored) – 2 surfaces | $0 |
| Composite filling (tooth–colored) – 1 surface, Anterior | $0 |
| Molar root canal (excluding final restoration) | $305 |
| Comprehensive orthodontics – child (up to 19th birthday) – Banding | $485 |
| Periodontal (gum) scaling & root planing – 1 quadrant | $50 |
| Periodontal (gum) maintenance | $40 |
| Removal/extraction of erupted tooth | $6 |
| Removal/extraction of impacted tooth | $100 |
| Crown – porcelain fused to high noble metal | $270 |
| Implant supported retainer for porcelain fused to metal fixed partial denture | $740 |

| PLAN BENEFITS | DPPO<br>IN-NETWORK (Out-of-Network benefits are available) |
|---|---|
| Deductible (Single/Family) | $50/$150 |
| Individual Annual Maximum + Wellness Incentive* | Year 1: $1,250<br>Year 2: $1,400<br>Year 3: $1,550<br>Year 4: $1,700 |
| Class I: Preventive & Diagnostic Care | Cigna Coinsurance |
| Oral Evaluations | 80% |
| X-rays | 80% |
| Cleanings | 80% |
| Class II: Basic Restorative Care | Cigna Coinsurance |
| Fillings | 80% |
| Emergency Care to Relieve Pain | 80% |
| Root Canal Therapy/Endodontics | 80% |
| Asthetics | 80% |
| Oral Surgery - Simple Extractions | 80% |
| Class III: Major Restorative Care | Cigna Coinsurance |
| Crowns | 80% |
| Surgical Extractions of Impacted Teeth | 50% |
| Dentures & Repairs, Relines, Rebases and Adjustments | 50% |
| Bridges | 50% |
| Inlay/Onlays | 50% |
| Class IV: Orthodontics (Dependent Child(ren) to age 19) | Cigna Coinsurance |
| Coinsurance Level | 50% |
| Lifetime Maximum | $1,000 |
| Orthodontics | |

*Wellness Incentive: When you or your family members receive any preventive care in one plan year, the annual dollar maximum will increase in the following plan year. When you or your family members remain enrolled in the plan and continue to receive preventive care, the annual dollar maximum will increase in the following plan year, until it reaches the level maximum of $1,700 per member.

**For a detailed dental summary of benefits, for both the DHMO and DPPO, please refer to your summary plan documents.**
Finding a network dentist is easy and there are several ways to choose your network general dentist: Find a dentist at Cigna.com. Cigna's online dental directory is updated weekly: Call 1.800.Cigna24 (1.800.244.6224) to speak with a customer service representative. A Cigna representative can send you a customized dental directory listing via email.

# *Vision — VSP*

Klein ISD understands the importance of good vision care. Vision Service Plan doctors take the time to get to know you and your eyes. Through a WellVision Exam®, our doctors look for more than just vision problems. They can detect signs of serious health conditions like diabetes, high blood pressure, and high cholesterol too. VSP doctors are located nearby and most offer weekend and evening appointments.

Plus, all of our doctors offer eye wear choices you'll love. Before selecting your eye wear, ask your doctor what is fully covered by your VSP plan. The following chart summarizes the main benefits of your plan.

**Those eligible for coverage include**: Employees eligible and those contributing to TRS and full-time retirees, spouses and dependent children up to age 26. By contract, the deduction for vision will be pre-tax. Benefits include copays for an annual exam and materials (i.e. contacts or lens/frames). The frame benefit is a bi-annual benefit; one new set of frames every 24 months. **No ID cards are necessary**.

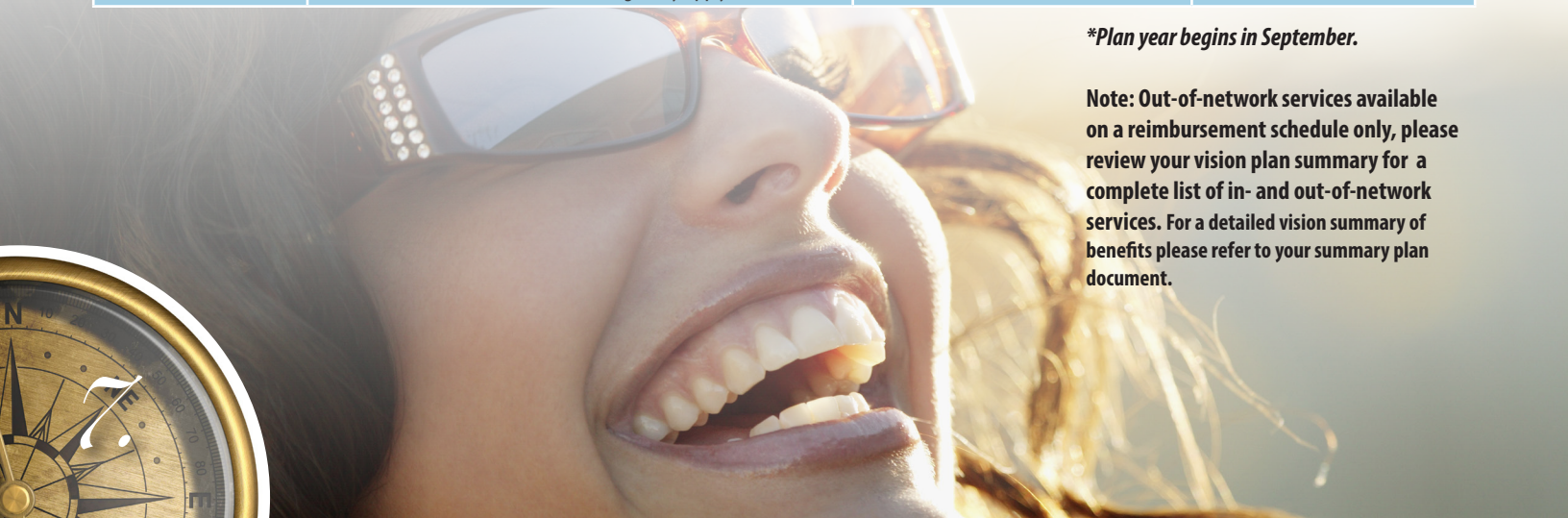
For more information visit the VSP website at www.vsp.com

- Member Services **800.877.7195** (Monday- Friday 7 am - 10 pm, Saturday 8 am - 7 pm Central Time) / Hearing Impaired: **800.428.4833**

| BENEFIT | DESCRIPTION | COPAY (IN-NETWORK)* | FREQUENCY |
|---|---|---|---|
| WellVision Exam | • Focuses on your eyes and overall wellness | $15 | Every plan year* |
| Prescription Glasses | • Single vision, lined bifocal, and lined trifocal lenses<br>• Polycarbonate lenses for dependent children | $30 | See Frames & Lenses |
| Frame | • $150 allowance (a wide selection of frames)<br>• $170 allowance for featured<br>• 20% off amount over your allowance | Included in Prescription Glasses | Every other plan year |
| Lenses | • Single vision, lined bifocal, and lined trifocal lenses<br>• Polycarbonate lenses for dependent children | Included in Prescription Glasses | Every plan year |
| Lens Enhancements | • Scratch-resistant coating<br>• Standard progressive lenses<br>• Premium progressive lenses<br>• Custom progressive lenses<br>• Average savings of 20-25% on other lens enhancements | Up to $60 | Every plan year |
| Contacts (in lieu of glasses) | • $150 allowance for contacts; copay does not apply<br>• Contact lens exam (fitting and evaluation) | Up to $60 | Every plan year |
| Diabetic Eyecare Plus Program | • Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. | $20 | As needed |

***Plan year begins in September.***

**Note: Out-of-network services available on a reimbursement schedule only, please review your vision plan summary for a complete list of in- and out-of-network services. For a detailed vision summary of benefits please refer to your summary plan document.**



# Flexible Spending Accounts (FSAs)

The Flexible Spending program is administered by **Boon-Chapman (800.252.9653 - Select Option 5)**. Persons eligible to enroll in the Flexible Spending Accounts (FSAs) are employees eligible and contributing to the TRS and retirees that are considered full-time. There are two types of accounts available: **Flex Spending Account** and **Dependent Care Spending Account**. **Important Note: Flexible Spending Accounts must be re-elected each year**.

Flexible Spending Accounts work like a savings account—each pay period a pre-tax payroll deduction is deposited to your Healthcare and/or Dependent Care Spending Account. When you need money to cover an eligible healthcare expense, you make a pre-tax "withdrawal" by using your debit care or completing a claim form and providing proper documentation such as pharmacy receipts, detailed bills or explanation of benefit (EOB).

Keep your Benny card, only newly enrolled employees in the Healthcare FSA plan will receive a debit card. The Benny card may be used at the time of service to pay for your Healthcare FSA eligible expenses. It is important that you retain all receipts as supporting documentation for your healthcare purchases made with your debit card. Remember!... Up to $500 of the unused balance will roll over to the next plan year. Any unused funds over $500 after the plan year end will be forfeited.

**IMPORTANT: YOU MUST BE ENROLLED IN A MEDICAL PLAN SEPTEMBER 1st TO BE ELIGIBLE FOR THE DISTRICT CONTRIBUTION TO THE MEDICAL FLEXIBLE SPENDING ACCOUNT.**

| HEALTHCARE SPENDING ACCOUNT | DEPENDENT CARE SPENDING ACCOUNT |
|---|---|
| • Maximum annual contribution: $2,550 (PLEASE NOTE: Employees may only contribution $2,250 because of the district contribution of $300.)<br>• Used for most medical, dental, and vision care expenses that are not covered under the plans (like co-payments, deductibles, eyeglasses, and certain over-the-counter expenses) | • $5,000 annual tax year maximum (per tax filing household)<br>• Used for Dependent Care or Elder Care expenses (i.e. daycare, after school programs, or elder care programs) so you and your spouse can work or attend school on a full-time basis |

***IMPORTANT NOTE: Make FSA election based on your effective date through the end of December.***

## Healthcare Flexible Spending Account Expenses

Below is a partial list of qualified approved expenses.

- Alcoholism Treatment
- Allergy Medicine/Shots
- Ambulance Charges
- Acupuncture
- Bandages
- Birth Control/Condoms
- Blood Pressure Devices
- Chiropractor
- Copayments / Coinsurance
- Contact Lenses/Solution
- Crutches
- Deductibles
- Dental Expenses
- Doctor Fees
- Drug Addiction Treatment
- Emergency Room Visits
- Eyeglasses
- Fertility Treatments
- Health Care Equipment
- Hearing Aid Devices
- Hospital Expenses
- Insulin
- Laboratory Fees
- Nursing Home Care
- Optometrist
- Orthodontia
- Oxygen
- Pain Medicine
- Physical Exams
- Prescriptions Drugs
- Psychologist Fees
- Psychotherapy
- Smoking Cessation
- Special Tests
- Sterilization
- Therapy
- Transplants
- Vision Care
- X-Ray

## Frequently Asked Questions

1. **How does contributing to an FSA reduce my taxes?** FSA contributions are deducted from your pay check before taxes are calculated. This means you do not pay federal income taxes or social security taxes on the portion of your pay check you contribute to the FSA.
2. **If there's unused money in my FSA at the end of the plan year, do I get to keep it?** A change to the IRS rule will now allow a roll over of up to $500.00 in the 2015-2016 plan year. If you do not use all the money in your FSA for expenses incurred during the plan year, up to $500.00 of the unused balance will roll over to the next plan year.
3. **Can I request FSA reimbursement for services I received before the plan year begins if I am not billed until after the plan year starts?** No. According to the IRS guidelines, a qualified expense is "incurred' at the time the service is provided, not when you are billed or when you actually pay for this service. Therefore, you can only file claims for eligible expenses incurred during the same plan year.
4. **Where can I find a list of eligible expenses for reimbursement?** The Summary Plan Description in its entirety can be found on the KLEINET under Departments - Human Resources - Benefits.
5. **If I participate in the FSA Plan, will I receive a debit/credit card to pay for expenses eligible for reimbursement?** Yes. If you are participating for the first time, you will receive a card from Boon-Chapman which can be used quickly and conveniently to pay for eligible expenses.

As of January 1, 2011, over-the-counter (OTC) medicines are paid from the Flexible Spending Account (FSA) only if a physician provides a prescription for the medication; debit cards cannot be used. To receive reimbursement from the FSA account for an over-the-counter medication, you must submit an FSA claim form, the prescription for the OTC medication from the physician and the receipt.

# Healthy Living Wellness Program

**KLEINWELL** is a wellness program designed to help Klein employees lower their risk of disease and improve their overall health. Kleinwell is available to all Klein employees whether insured through the district medical plan or not. The four primary goals of Kleinwell are:

- Help employees identify individual health risks and provide ways for improvement
- Provide motivation and support to lead employees to make healthy choices
- Control health care costs through disease prevention, and
- Improve and prolong lives of Klein employees.

The Kleinwell committee is composed of ten Klein employees representing different departments and campuses throughout the district. Their primary responsibility is planning and implementing group and individual activities to help employees adopt healthier behaviors. In addition, each campus has a Wellness Ambassador who will keep employees informed of upcoming Kleinwell activities and the cash incentives and probes.

The Kleinwell challenges/activities are designed to encourage employees to exercise more, eat healthier and improve their overall health and well-being. Below are some of the challenges/activities that have been held in the past year.

**Commit to Kleinwell Program Challenge**

- Walktober Challenge
- Flu Shot Program
- Maintain Don't Gain Holiday Challenge
- Kleinwell Sponsored Seminars
- Tips on increasing your Energy By 300%
- Dining Lean in Houston
- Spring Health Screening Challenge
- Health Risk Assessment Challenge
- Dental Check-up
- Smoking Cessation Program
- Physician Check-up.

There is nothing more important than your health! Because Klein ISD cares about the health of their employees, we encourage all employees to participate in the Kleinwell program. **For up-to-date information on the Kleinwell program, go to the KNET under Departments/Human Resources/Benefits and click on the KLEINWELL website.**


# Supplemental Term Life Insurance

You may elect additional term life insurance for you and your family, which includes an additional equal volume of AD&PL. Coverage is available in increments of $10,000. New hires may elect up to $300,000 or 5 times their annual employee compensation with Guarantee Issue (GI). Maximum coverage is $500,000 or 7 times salary (maximum coverage requires medical underwriting). Elections for spouses and children may not exceed the amount elected by the employee. New hires may elect up to $30,000 for their spouse without having to complete Evidence of Insurability (EOI).

During Annual Enrollment, a currently covered employee or an employee spouse's coverage may be increased by $10,000.00 without EOI up to the guaranteed limits. (Guaranteed limits – Employee: 5 times salary or $300,000/Spouse: $30,000)

**PLEASE NOTE: SUPPLEMENT TERM LIFE NOTICE: IF YOU ARE MARRIED TO A KLEIN EMPLOYEE YOU MAY NOT ELECT ADDITIONAL SPOUSE SUPPLEMENT TERM LIFE COVERAGE ON YOUR SPOUSE. ONLY ONE EMPLOYEE MAY PURCHASE ADDITIONAL SUPPLEMENT TERM COVERAGE ON YOUR CHILD(REN).**

## Age/Rate Information For Employee Term Life

| EMPLOYEE AGE / RATES | | | | | |
|---|---|---|---|---|---|
| START AGE | END AGE | MEMBER'S GENDER | MINIMUM COVERAGE | MAXIMUM COVERAGE | RATE PER $1,000 |
| 18 | 29 | BOTH | $10,000.00 | $500,000.00 | $0.047 |
| 30 | 34 | BOTH | $10,000.00 | $500,000.00 | $0.057 |
| 35 | 39 | BOTH | $10,000.00 | $500,000.00 | $0.066 |
| 40 | 44 | BOTH | $10,000.00 | $500,000.00 | $0.085 |
| 45 | 49 | BOTH | $10,000.00 | $500,000.00 | $0.123 |
| 50 | 54 | BOTH | $10,000.00 | $500,000.00 | $0.179 |
| 55 | 59 | BOTH | $10,000.00 | $500,000.00 | $0.255 |
| 60 | 64 | BOTH | $10,000.00 | $500,000.00 | $0.312 |
| 65 | 69 | BOTH | $10,000.00 | $500,000.00 | $0.444 |
| 70 | 74 | BOTH | $10,000.00 | $500,000.00 | $0.916 |
| 75 | 120 | BOTH | $10,000.00 | $500,000.00 | $1.888 |

**Cost Calculation**: Use Employees Age at Plan Effective Date – September 1, 2015

**Elected Coverage**: Divided by $1,000.00 – Multiplied by Rate as Determined by Age

**Sample**: Age as of 9-1-15 = 47

Elected Coverage = $140,000

$140,000 Elected Coverage divided by 1,000 = 140 X $0.123 = $17.22 Monthly Cost

# Spouse Term Life Insurance

**PLEASE NOTE: SPOUSAL COVERAGE MAY NOT BE MORE THAN THE EMPLOYEE'S ELECTED COVERAGE. MARRIED KLEIN EMPLOYEES ARE NOT ELIGIBLE TO PURCHASE ADDITIONAL SUPPLEMENTAL LIFE INSURANCE FOR THEIR SPOUSE.**

| SPOUSE AGE / RATES | | | | | |
|---|---|---|---|---|---|
| START AGE | END AGE | MEMBER'S GENDER | MINIMUM COVERAGE | MAXIMUM COVERAGE | RATE PER $1,000 |
| 18 | 29 | BOTH | $10,000.00 | $500,000.00 | $0.049 |
| 30 | 34 | BOTH | $10,000.00 | $500,000.00 | $0.059 |
| 35 | 39 | BOTH | $10,000.00 | $500,000.00 | $0.069 |
| 40 | 44 | BOTH | $10,000.00 | $500,000.00 | $0.089 |
| 45 | 49 | BOTH | $10,000.00 | $500,000.00 | $0.129 |
| 50 | 54 | BOTH | $10,000.00 | $500,000.00 | $0.189 |
| 55 | 59 | BOTH | $10,000.00 | $500,000.00 | $0.269 |
| 60 | 64 | BOTH | $10,000.00 | $500,000.00 | $0.329 |
| 65 | 69 | BOTH | $10,000.00 | $500,000.00 | $0.469 |
| 70 | 74 | BOTH | $10,000.00 | $500,000.00 | $0.969 |
| 75 | 120 | BOTH | $10,000.00 | $500,000.00 | $1.999 |

**Cost Calculation**: Use Employees Age at Plan Effective Date – September 1, 2015

**Elected Coverage**: Divided by $1,000.00 – Multiplied by Rate as Determined by Age

**Sample**: Age as of 9-1-14 = 47

Elected Coverage = $140,000

$140,000 Elected Coverage divided by 1,000 = 140 X $0.123 = $17.22 Monthly Cost

**Reduction Schedule:** Applies to Employee (Supplemental) and Spouse (Supplemental) / **Base Age Reduction Schedule On:** Age of Employee or Spouse at Plan Effective Date

| AGE | PERCENT OF REDUCTION | MAXIMUM COVERAGE | REDUCTION BASIS |
|---|---|---|---|
| 65 | 65% | $500,000.00 | Originally elected benefit |
| 70 | 50% | $500,000.00 | Originally elected benefit |

# Dependent (Child) Term Life Insurance

Choice of coverage amount per child: $ 5,000 Cost = $0.88 per month
(All children listed in the supplement system will have the elected coverage) $10,000 Cost = $1.76 per month (Both benefits are GI)

**ATTENTION: MARRIED KLEIN EMPLOYEES: ONLY ONE PARENT MAY ELECT DEPENDENT TERM LIFE**

All the Supplemental Life policies include, but are not limited to, the following plan design features:

- **Accelerated Death Benefit**: In the event of a terminal illness, this provides for the early payment of up to 75% of the employee's coverage amount. The maximum benefit payable is $500,000 and the minimum benefit payable is $5,000 with the balance payable upon death. Life expectancy is defined as no longer than 24 months. This applies to Basic and Supplemental Life coverages
- **Enhanced AD&PL**: Additional accidental death benefits are payable for such things as passenger restraint and airbag, common accident, common carrier, childcare and education. This applies to Basic and Supplemental Life coverages
- **Portability**: Upon termination as a full-time employee, you and/or your spouse may continue the elected life insurance. Premiums are paid directly to the carrier and rates are age-banded. Portability is available to anyone who leaves the District, including retirement.


# Klein ISD Voluntary Benefits

## Voluntary Whole Life Insurance — UNUM

This plan highlight is a summary provided to help you understand your insurance coverage from Unum. Please refer to your policy for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

**Coverage Options**: Employee, Spouse, Child/Grandchild

**Benefit**: Based on your age at issue, the minimum benefit amount is $10,000. Coverage is in increments of $5,000.

**Employee**: Maximum benefit is $150,000 (ages 15 – 50); and $75,000 (ages 51 – 80).

**Spouse**: Maximum benefit $75,000, regardless of age.

**Child/Grandchild**: Minimum benefit is $10,000, and the maximum benefit is $50,000.

**Guarantee Issue**: **For Newly Eligible Employees**

Employee Age 15 – 50: $125,000

Age 51 – 80: $60,000

Spouse (Conditional GI) Age 15 – 80: $25,000

**Child/Grandchild**: Live Birth to age 26: $25,000

**Any amounts above the GI for Employee, Spouse and Child/Grandchild will require EOI.**

**Child/Grandchild coverage up to the Guarantee Issue limits does not require EOI at any time.**

**Premiums**: Guaranteed level based on insured's age at policy issue and will not increase due to age.

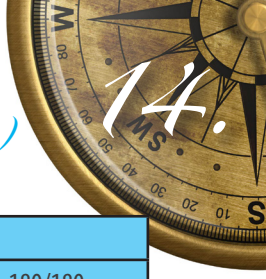
Policy is paid up at age 120 for Employee and Spouse; Policy is paid up at age 70 for Child/Grandchild

*GI is the amount of coverage that you may elect without answering medical questions.*

# Disability Insurance — The Hartford

| | |
|---|---|
| **What Is Disability?** | Disability is defined in The Hartford contract with your employer. Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical condition covered by the insurance, and as a result, your current monthly earnings are 80% or less than of your pre-disability earnings. Once you have been disabled for 24 months, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your current monthly earnings are 66 2/3% or less than of your pre-disability earnings. |
| **Am I Eligible?** | You are eligible if you are an active full time employee who works at least 20 hours per week on a regularly scheduled basis. |
| **How Much Coverage Should I Have?** | You may purchase coverage that will pay you a monthly flat dollar benefit in $100 increments between $200 and $7,500 that cannot exceed 66 2/3% of your current monthly earnings. Your plan includes a minimum benefit of 25% of your elected benefit. Earnings are defined as in The Hartford contract with your employer. |
| **When Can I Enroll?** | You can enroll during your scheduled enrollment period, within 31 days of the date you have a change in family status, or within 31 days of the completion of your eligibility waiting period as stated in your group policy. Electing or changing coverage outside of scheduled annual enrollment periods or qualified family status change periods is not permitted. |
| **How Long Do I Have To Wait Before I Can Receive My Benefit?** | You must be disabled for at least the number of days indicated by the elimination period that you select before you can receive a long term disability benefit payment.<br><br>For those employees electing an elimination period of 30 days or less, if you are confined to a hospital for 24 hours or more due to a disability, the elimination period will be waived, and benefits will be payable from the first day of disability. The elimination period that you select consists of two numbers. The first number shows the number of days you must be disabled by an injury before your benefits can begin. The second number indicates the number of days you must be disabled by a sickness before your benefits can begin. |
| **How Long Will My Disability Payments Continue?** | Premium Option: For the Premium benefit option – the table on the next page applies to disabilities resulting from sickness or injury.<br><br>Age Disabled Benefits Payable: Prior to Age 63 to Normal Retirement Age or 48 months, if greater Age 63 to Normal Retirement Age or 42 months, if greater Age 64 36 months, Age 65 30 months, Age 66 27 months, Age 67 24 months, Age 68 21 months, Age 69 and over 18 months. |
| **Does Pre-existing condition apply?** | In general, if you were diagnosed or received care for a condition before the effective date of your policy, you will be covered for a disability due to that condition only if you have not received treatment for your condition for 3 months before the effective date of your insurance, or you have been insured under this coverage for 12 consecutive months. |

# Premium Option – Monthly Premium Cost (12 payments per year)




| Annual Salary | Monthly Benefit | Sickness / Accident Elimination Period in Days | | | | |
|---|---|---|---|---|---|---|
| | | *14/14* | *30/30* | 60/60 | 90/90 | 180/180 |
| $3,600.00 | $200 | $6.46 | $5.32 | $3.64 | $3.14 | $2.42 |
| $5,400.00 | $300 | $9.69 | $7.98 | $5.46 | $4.71 | $3.63 |
| $7,200.00 | $400 | $12.92 | $10.64 | $7.28 | $6.28 | $4.84 |
| $9,000.00 | $500 | $16.15 | $13.30 | $9.10 | $7.85 | $6.05 |
| $10,800.00 | $600 | $19.38 | $15.96 | $10.92 | $9.42 | $7.26 |
| $12,600.00 | $700 | $22.61 | $18.62 | $12.74 | $10.99 | $8.47 |
| $14,400.00 | $800 | $25.84 | $21.28 | $14.56 | $12.56 | $9.68 |
| $16,200.00 | $900 | $29.07 | $23.94 | $16.38 | $14.13 | $10.89 |
| $18,000.00 | $1,000 | $32.30 | $26.60 | $18.20 | $15.70 | $12.10 |
| $19,800.00 | $1,100 | $35.53 | $29.26 | $20.02 | $17.27 | $13.31 |
| $21,600.00 | $1,200 | $38.76 | $31.92 | $21.84 | $18.84 | $14.52 |
| $23,400.00 | $1,300 | $41.99 | $34.58 | $23.66 | $20.41 | $15.73 |
| $25,200.00 | $1,400 | $45.22 | $37.24 | $25.48 | $21.98 | $16.94 |
| $27,000.00 | $1,500 | $48.45 | $39.90 | $27.30 | $23.55 | $18.15 |
| $28,800.00 | $1,600 | $51.68 | $42.56 | $29.12 | $25.12 | $19.36 |
| $30,600.00 | $1,700 | $54.91 | $45.22 | $30.94 | $26.69 | $20.57 |
| $32,400.00 | $1,800 | $58.14 | $47.88 | $32.76 | $28.26 | $21.78 |
| $34,200.00 | $1,900 | $61.37 | $50.54 | $34.58 | $29.83 | $22.99 |
| $36,000.00 | $2,000 | $64.60 | $53.20 | $36.40 | $31.40 | $24.20 |
| $37,800.00 | $2,100 | $67.83 | $55.86 | $38.22 | $32.97 | $25.41 |
| $39,600.00 | $2,200 | $71.06 | $58.52 | $40.04 | $34.54 | $26.62 |
| $41,400.00 | $2,300 | $74.29 | $61.18 | $41.86 | $36.11 | $27.83 |
| $43,200.00 | $2,400 | $77.52 | $63.84 | $43.68 | $37.68 | $29.04 |
| $45,000.00 | $2,500 | $80.75 | $66.50 | $45.50 | $39.25 | $30.25 |
| $46,800.00 | $2,600 | $83.98 | $69.16 | $47.32 | $40.82 | $31.46 |
| $48,600.00 | $2,700 | $87.21 | $71.82 | $49.14 | $42.39 | $32.67 |
| $50,400.00 | $2,800 | $90.44 | $74.48 | $50.96 | $43.96 | $33.88 |
| $52,200.00 | $2,900 | $93.67 | $77.14 | $52.78 | $45.53 | $35.09 |
| $54,000.00 | $3,000 | $96.90 | $79.80 | $54.60 | $47.10 | $36.30 |
| $55,800.00 | $3,100 | $100.13 | $82.46 | $56.42 | $48.67 | $37.51 |
| $57,600.00 | $3,200 | $103.36 | $85.12 | $58.24 | $50.24 | $38.72 |
| $59,400.00 | $3,300 | $106.59 | $87.78 | $60.06 | $51.81 | $39.93 |
| $61,200.00 | $3,400 | $109.82 | $90.44 | $61.88 | $53.38 | $41.14 |
| $63,000.00 | $3,500 | $113.05 | $93.10 | $63.70 | $54.95 | $42.35 |
| $64,800.00 | $3,600 | $116.28 | $95.76 | $65.52 | $56.52 | $43.56 |
| $66,600.00 | $3,700 | $119.51 | $98.42 | $67.34 | $58.09 | $44.77 |
| $68,400.00 | $3,800 | $122.74 | $101.08 | $69.16 | $59.66 | $45.98 |
| $70,200.00 | $3,900 | $125.97 | $103.74 | $70.98 | $61.23 | $47.19 |
| $72,000.00 | $4,000 | $129.20 | $106.40 | $72.80 | $62.80 | $48.40 |
| $73,800.00 | $4,100 | $132.43 | $109.06 | $74.62 | $64.37 | $49.61 |
| $75,600.00 | $4,200 | $135.66 | $111.72 | $76.44 | $65.94 | $50.82 |
| $77,400.00 | $4,300 | $138.89 | $114.38 | $78.26 | $67.51 | $52.03 |
| $79,200.00 | $4,400 | $142.12 | $117.04 | $80.08 | $69.08 | $53.24 |
| $81,000.00 | $4,500 | $145.35 | $119.70 | $81.90 | $70.65 | $54.45 |
| $82,800.00 | $4,600 | $148.58 | $122.36 | $83.72 | $72.22 | $55.66 |
| $84,600.00 | $4,700 | $151.81 | $125.02 | $85.54 | $73.79 | $56.87 |
| $86,400.00 | $4,800 | $155.04 | $127.68 | $87.36 | $75.36 | $58.08 |
| $88,200.00 | $4,900 | $158.27 | $130.34 | $89.18 | $76.93 | $59.29 |

*IF YOU ARE CONFINED IN A HOSPITAL FOR 24 HOURS AND CONTINUE UNDER A DOCTOR'S CARE FOR THE SAME INCIDENT IT QUALIFIES AS A REQUEST TO UTILIZE THE ELIMINATION PERIODS OF 14/14 OR 30/30.

MAXIMUM MONTHLY BENEFIT NOT TO EXCEED 7,500.00; CALL THE BENEFITS OFFICE IF YOU QUALIFY.

# Cancer and Specified Disease Insurance — All-State

This coverage is an individual supplemental plan that pays benefits directly to you. Cancer patients often incur substantial out-of-pocket expenses in addition to what is covered by their major medical plan, such as extended cancer treatment, parking expenses, travel, lost wages, etc. Cancer insurance can help reduce those costs. There are two plans available - the **Low Plan** and the **High Plan** with reasonable premiums and no medical questions. Upon initial enrollment as a new hire, the policy is GI. There is a pre-existing clause for any treatment within the last 12 months.

| ALLSTATE CANCER AND SPECIFIED DISEASE | | |
|---|---|---|
| **COVERED BENEFIT** | **LOW PLAN** | **HIGH PLAN** |
| Hospital Daily Benefit | $100 | $300 |
| Radiation/Chemotherapy | $10,000 | $30,000 |
| Blood / Blood Components | $10,000 | $10,000 |
| Surgery and Related Benefits | $3,000 | $6,000 |
| Wellness | $100 | $100 |
| Cancer Initial Diagnosis | $2,000 | $5,000 |
| Intensive Care | $300 | $800 |
| Employee Only Cost Per Month | $23.56 | $57.52 |
| Employee & Family Cost Per Month | $40.08 | $97.58 |

# Comprehensive Group Legal Plan

A pre-paid legal plan membership gives you access to quality legal advice when you need it. Legal Shield is available to employees eligible for TRS and who currently contribute to TRS and retirees that are considered full-time. Eligible dependents are spouses and dependent children up to the age of 21, as long as they are still living at home and never been married, or up to the age of 23 as long as they are a full-time student and never been married. Dependent children are not covered by the Identity Theft Shield. With Legal Shield, you know who to call when you have a legal need. You are empowered by knowing your legal rights. If you don't know your rights, you don't have any.

# Identity Theft Protection Benefit

You can also have the option to buy the standard plan that includes Identity Theft Protection. Identity Theft Shield will cover you and your spouse by continuously monitoring your credit. If your identity is stolen, the experts will take the necessary steps to restore your good name and credit for you

**Legal Services Only**: $15.76

**Legal Service and Identify Theft**: $25.70

# Long-Term Care Insurance

Long Term Care (LTC) is insurance that will pay benefits when an individual requires regular assistance with day-to-day functions like bathing, eating, dressing, or supervision due to a cognitive impairment. LTC insurance helps pay for care at home, in an adult day care center, assisted living facility or nursing home.

Texas Retirement Systems of Texas (TRS) offers long term care insurance which is underwritten by Genworth Life Insurance Company. As a TRS member you are eligible to enroll in LTC. For information or to request an enrollment packet, call Genworth at **1-866-659-1970** or go to www.genworth.com/groupltc **Use Group ID**: TRS and **Access Code**: groupltc.

# Retirement Investment Programs


You can start, stop, or change your contributions at any time. Each plan has an administrator who handles enrollment, changes and signature authorization. The law allows you to participate in one or both.

**Klein ISD 457(b) Plan**: Administered by **Empower Retirement Services** (Formerly Great West)

- On-Line paperless enrollment and changes www.gwrs.com
- Low cost, self-directed investment options range from no-risk to high-risk
- No 10% federal tax penalty for early withdrawal prior to age 59 ½
- Toll Free Help Line – Trained Retirement Specialist **1-800-701-8255**.

**Klein ISD 403(b) 403(b)(7) Plan**: Administered by **JEM Resource Partners, Inc**.

- Due to a new Federal 403(b) law, all starts, stops and changes will be done on-line through JEM Resource Partners (JEM) at www.region10rams.org
- Federal Tax penalty of 10% for early withdrawal prior to age 59 ½
- Toll Free Help Line **1-800-943-9179**.

| KLEIN ISD RETIREMENT PLANS COMPARISON CHART | | |
|---|---|---|
| | 457 (b) | 403 (b) |
| **THIRD PARTY ADMINISTRATOR** | Administered by Empower Retirement Services | Administered by JEM Resources Partners |
| **CUSTOMER SERVICE NUMBER** | 1.800.701.8255 | 1.800.943.9179 |
| **ENROLLMENT PROCESS** | Call Great West Retirement Services or visit them at www.GWRS.com | Visit them online at: www.region10rams.org |
| **WHEN CAN I ENROLL?** | Start, stop, or change your contributions at any time | Start, stop, or change your contributions at any time |
| **2015 CONTRIBUTION LIMIT** | $18,000 | $18,000 |
| **2015 AGE 50+ CATCH-UP LIMIT** | $6,000 | $6,000 |
| **CONTRIBUTION PRE-TAXED** | YES | YES |
| **TAX-DEFERRED EARNINGS** | YES | YES |
| **HARDSHIP WITHDRAWALS** | YES | YES |
| **10% IRS PENALTY FEE FOR EARLY FUND WITHDRAWAL** | NO | YES |
| **TYPES OF INVESTMENT PRODUCTS** | No load and load-waived mutual funds | Qualified investments approved by TRS including fixed annuity, variable annuity, and mutual fund |
| **FEES** | No administration fees - Only fund management fees | Due to the wide variety of 403 (b) products there are many variations of fees being charged |

# Retention and Sick Leave Program

Person eligible for this program are employees in a permanent status that are regularly scheduled to work a minimum of 20 hours per week and enrollment is automatic. The District will contribute funds to a 401(a) tax deferred trust account each year an employee meets the criteria for the retention and sick leave program. This annual program begins each September 1st, and ends the following August 31st.

Under this program, Klein ISD will make a contribution if you:

1. Were employed by KISD on September 1st, and
2. Were absent 3 or fewer sick or personal days during that contract, and
3. Are employed by KISD on the following September 1st
4. Have contributed a minimum of $200 to your own retirement plan that you set up, either the Klein 457 or 403(b) program. All contributions to these plans must occur by salary deduction by your last pay check prior to August 31st. (August 20th pay check for 24 pays, July 5th pay check for 21 pays and June 20th for 20 pays) THEN you qualify to receive the following from KISD:
    - Teachers and other professionals: $300 each year you qualify
    - All other employees: $150 each year qualify.

**PLEASE NOTE: ALL FOUR OF THE ABOVE CRITERIA MUST BE MET IN ORDER TO RECEIVE A CONTRIBUTION FROM THIS RETENTION & SICK LEAVE PROGRAM.**

This money will be funded the following September for the previous school year and placed into a 401(a) retirement plan in your name. Each year you qualify, the District contribution becomes vested according to the following schedule: AFTER 1 year – 30%; AFTER 2 years – 60%; AFTER 3 year – 100%. If you retire, become disabled or die after you have received this benefit, you become 100% vested with all contributions in your account at that time.

# Accumulated Retiree Leave Reimbursement Plan

Upon retirement from Klein ISD, an "eligible employee", as described below, shall be entitled to reimbursement for an unlimited amount of unused state personal, state sick leave, or local sick leave days.

For this benefit an "eligible employee" means an employee who has a minimum of ten years of consecutive service in Klein ISD immediately preceding retirement is eligible for retirement and begins receiving benefits under TRS on an unreduced pension/annuity immediately upon separation from the District. The rate of reimbursement shall be based on the daily rate of substitute pay effective at the time of the employee's retirement.

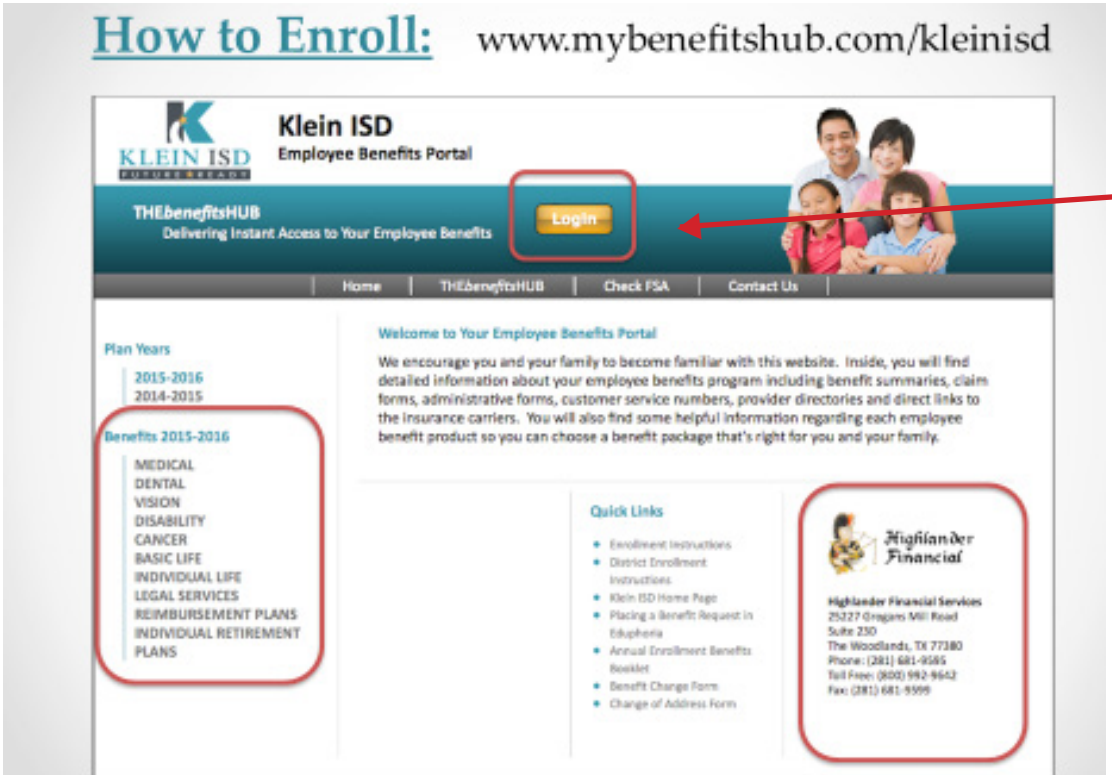
1. Eligible employees who are classified as exempt under the Fair Labor Standards Act (see DEA (LOCAL) shall receive one-half of long term certified substitute teacher daily rate of pay. (Effective December 3, 2013 the rate would be $80.00 per day as substitute pay was $160.00 per day), and
2. Eligible employees who are classified as non-exempt under the Fair Labor Standards Act (see DEA (LOCAL) shall receive one-half of non-degreed substitute teacher daily rate of pay. (Effective December 3, 2013 the rate would be $40.00 per day as substitute pay was $80.00 per day).

Any payment due under this policy shall be made as a contribution to the employee's account under the District's 401(a) plan. The District will process this benefit in October, February, May and July. A letter will go to the retiree that will explain the benefit and also provide a contact with our administrator. The options available to the retiree will also be explained.

# How To Enroll for Benefits

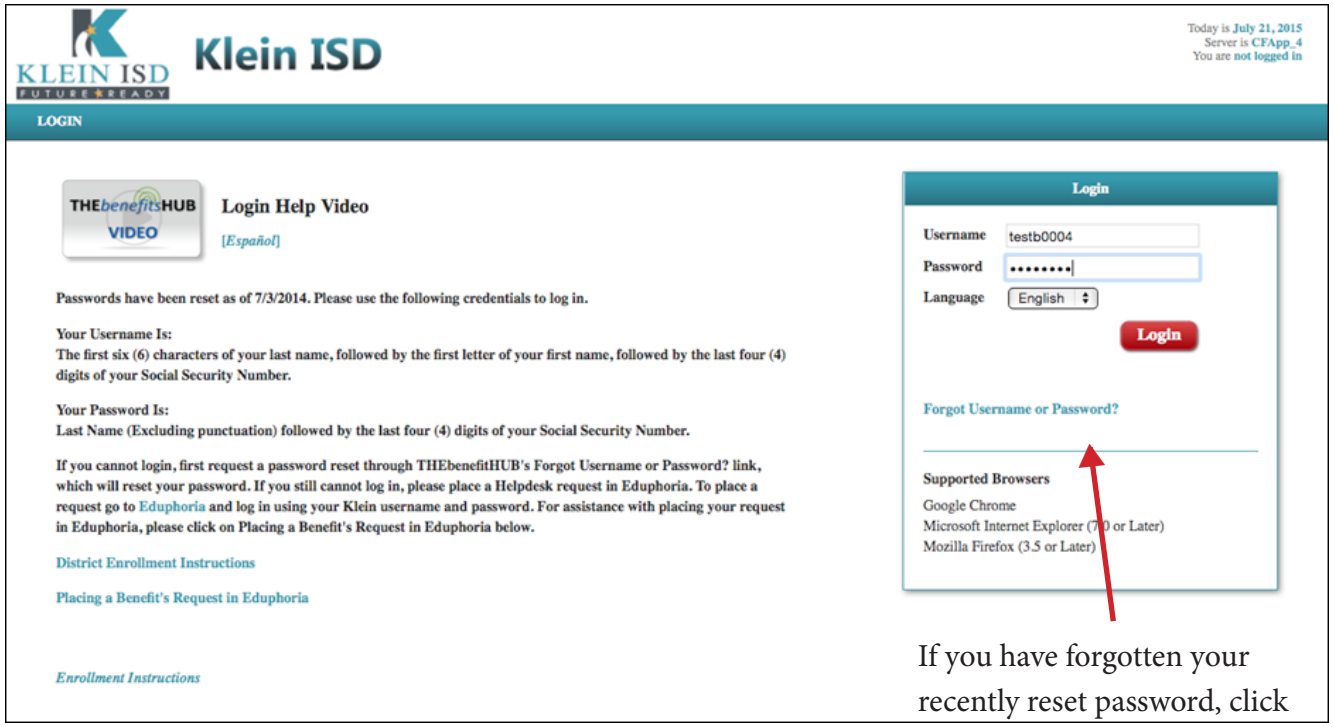


Step 1: GO TO: **http://www.mybenefitshub.com/kleinisd/2015-2016/Home.**




Click the "*Login*" Button

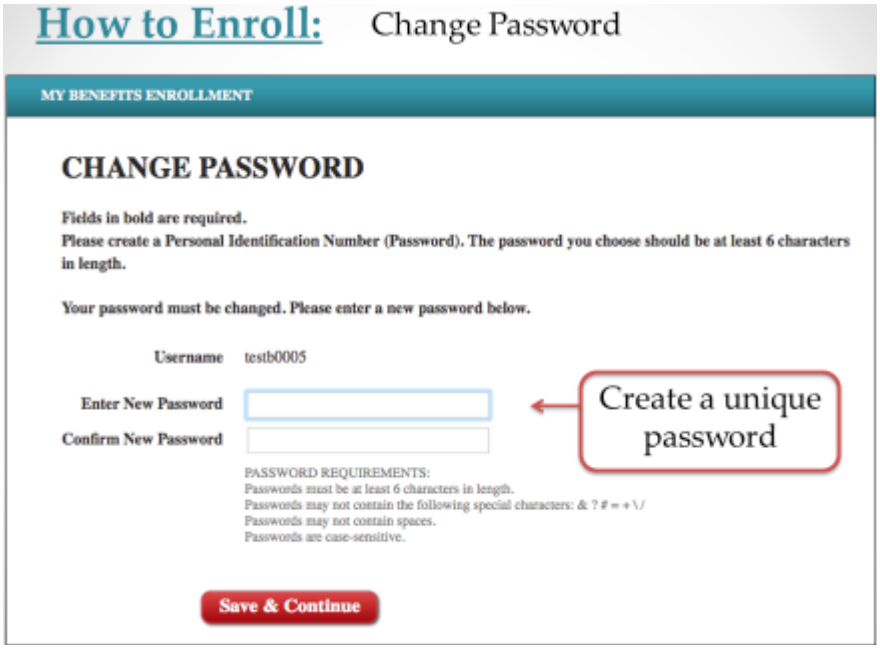
STEP 2: ENTER YOUR USER NAME AND PASSWORD, THEN CLICK "LOGIN"




If you have forgotten your recently reset password, click *"Forgot Username or Password"*

# How To Enroll for Benefits (Cont'd)

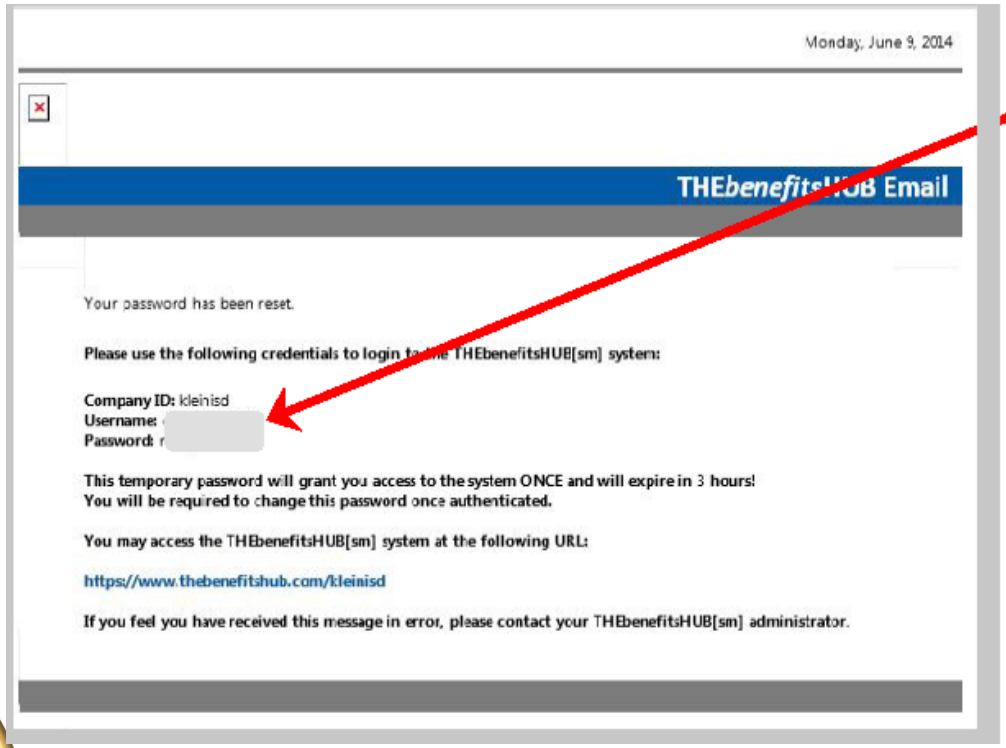
STEP 3: CLICKING ON "FORGOT USERNAME OR PASSWORD?" - BY DOING THIS YOU WILL BE TAKEN TO THE SCREEN IMAGE BELOW




STEP 4: WITHIN A FEW MINUTES, YOU WILL GET AN EMAIL FROM THE BENEFITSHUB. THE EMAIL WILL LOOK LIKE THIS IN YOUR INBOX:

| | | |
|---|---|---|
| system@thebenefitshub.com | THEbenefitsHUB Employee Login | Monday mm/dd/yy (time) |

STEP 5: WHEN YOU OPEN THE EMAIL IT WILL APPEARS SIMILAR TO THE IMAGE BELOW:




Your username and password will be located here

Note: This is a temporary password that will expire after 3 hours

You will be required to change this password once you have logged into the HUB


# Payroll Deduction Glossary

What you will see on your 2015 payroll check. IMPORTANT: BE SURE TO REVIEW YOUR PAY CHECK TO ENSURE YOUR DEDUCTIONS ARE CORRECT.
**https://eac.spihost.net/kle/eac5/Login.aspx or http://knet/** - Quick Links ---> Employee Access Center

| | TYPE OF COVERAGE | COVERAGE LEVEL | TAX ELECTION |
|---|---|---|---|
| EXAMPLES | 1 | 2 | 3 |
| DESCRIPTION ON PAY CHECK | HDTRS-1 | EF | B |
| | VISION | EC | A |
| | FC DEN | EO | B |

| TYPE OF COVERAGE | COVERAGE |
|---|---|
| BASICLIFE | Basic Life Insurance $10,000 (District Paid) |
| CANCERAS | Cancer Insured by Allstate |
| DHMO | Dental DHMO Insured by Cigna |
| PPODEN | Dental Indemnity Insured by Cigna |
| DISABIL | Disability Insured by Hartford Life |
| FLEX DEP | Flex Dependent Care Reimbursement Account |
| FLEX MED | Flex Medical/Dental Reimbursement Account |
| LEGAL STD | Group Legal Plan Standard |
| LEGALS IDA | Group Legal Plan Standard with Identity Theft |
| TMLIFE E | Supplemental Term Life Employee Coverage by Aetna |
| TMLIFE S | Supplemental Term Life Spouse Coverage by Aetna |
| TMLIFE C | Supplemental Term Life Child Coverage by Aetna |
| HDTRS-1 | TRS ActiveCare – 1HD Plan |
| ACSLCT | TRS ActiveCare – Select Aetna ACO |
| TRSAC-2 | TRS ActiveCare – 2 Plan |
| WHLIFE E | Whole Life Insurance Employee Coverage by Hartford |
| WHLIFE S | Whole Life Insurance Spouse Coverage by Hartford |
| WHLIFE C | Whole Life Insurance Child Coverage by Hartford |
| VISION | VSP Vision Plan |
| 457 RSPLAN | Klein 457 Retirement Savings Plan |
| 403B | Klein 403B Retirement Savings Plan |

| COVERAGE LEVEL | DESCRIPTION |
|---|---|
| EO | Employee Only is covered |
| EC | Employee and Child(ren) are covered |
| ES | Employee and Spouse are covered |
| EF | Employee and Family are covered |

| TAX ELECTION | DESCRIPTION |
|---|---|
| B | Before Tax or Cafeteria |
| A | After Tax or Non-Cafeteria |

# Important Contact Information

| BENEFIT | CARRIER | TELEPHONE NUMBER / WEBSITE |
|---|---|---|
| **Medical Plans** TRS ActiveCare | Aetna | 1.800.222.9205 / www.trsactivecareaetna.com |
| **Prescription/Pharmacy Plan** (Rx Bin 0004336) | Caremark | 1.800.222.9205 / www.trsactivecareaetna.com |
| **Dental Plans**<br>**DHMO** (Group # 3338947)<br>**DPPO** (Group # 3338947) | Cigna | 1.800.244.6224 / www.mycigna.com |
| **Vision Plan** (Group # 30039963) | VSP | 1.800.877.7195 / www.vsp.com |
| **Flexible Spending Account (FSA) Plan** | Boon-Chapman | 1.800.252.9653, Select Option 6 |
| **Cobra** (Continuation of Coverage)<br>**Medical** - TRS Active Care<br>**Dental, Vision and FSA** | <br>Aetna<br>Boon-Chapman | <br>1.855.820.9198<br>1.800.252.9653, Select Option 5 |
| **Cancer & Specified Disease**<br>**Disability Insurance** (File A Claim) (Group # 395330) | Highlander Financial | 281.681.9595 or 1.800.992.9642 |
| **Life and AD&D Insurance** (Group # 813279) | Aetna | 1.800.826.7448 |
| **Whole Life Insurance** | Unum | 281.681.9595 or 1.800.826.7448 |
| **Long Term Care**<br>(Use Group ID: TRS /Access Code groupltc) | Genworth | 1.866.659.1970 / www.genwork.com/groupltc |
| **Group Legal Services w/Legal Shield** | Highlander Financial | 281.681.9595 or 1.800.992.9642 |
| **Klein ISD 403(b) (7) Plans** | JEM Resource Partners | 1.800.943.9179 / www.jemtpa.com |
| **Klein ISD 457 Plan** (Group # 350202-01) | Empower Retirement Services | 1.800.701.8255 / www.gwrs.com |
| **KLEIN ISD BENEFIT OFFICE** | | |
| Rick Stockton, Director | 832.249.4690 | rstockton@kleinisd.net |
| Winni Attaway, Wellness Coordinator | 832.249.4162 | wattaway@kleinisd.net |
| Kaye Parker, Benefits Supervisor | 832.249.4691 | cparker4@kleinisd.net |
| Julie Huff, Benefits Specialist A-M | 832.249.4673 | jhuff2@kleinisd.net |
| Fran Bearden, Benefits Specialist N-Z | 832.249.4674 | fbearden1@kleinisd.net |

# Required Health Notices

Company Name (the "Company")
KLEIN ISD

Effective Date
SEPTEMBER 1, 2015

Creditable Plan Name(s)
Aetna, Cigna

Plan Administrator:

Director of Benefits and Risk Management

Klein ISD

7200 Spring Cypress Road
Klein, Texas 77379
Telephone: 832.249.4690

HIPAA Privacy Official

Director of Benefits and Risk Management

Telephone: 832.249.4690

HIPAA Special Enrollment Deadline
30 days

Members of Organized Health Care Arrangement

Aetna, Cigna, Vision Services Plan (VSP), Unum, The Hartford, Boone Chapman, and Willis, Inc.

See page 25 for Important Information concerning your Medicare Part D Coverage.

## Women's Health and Cancer Rights Notice

The Company is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Company's plan(s) provide medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description/Policy booklet or contact the Plan Administrator.

## Newborn and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean 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).

## HIPAA Notice of Privacy Policy and Procedures

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is provided to you on behalf of the Company about the Plan. It pertains only to health care coverage provided under the Plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources Department, or contact the Plan's HIPAA Privacy Official).

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

**Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations**

- Treatment: Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
- Payment: Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- Health care operations: The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

**Other Uses and Disclosures of Your PHI Not Requiring Authorization**

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor**: The Plan may disclose PHI to the employers (such as the Company) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for


preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.

- **To the Plan's Service Providers**: The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
- **Required by law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For public health activities**: The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For health oversight activities**: The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to descendants:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For research purposes**: In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To avert threat to health or safety**: In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For specific government functions**: The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

**Uses and Disclosures Requiring Authorization**

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

**Uses and Disclosures Requiring You to Have an Opportunity to Object**

The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- To request restrictions on uses and disclosures: You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- To choose how the Plan contacts you: You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- To request amendment of your PHI: If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

**How to Complain about the Plan's Privacy Practices**

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed on the first page of these notices. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

**Notification of a Privacy Breach**

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

**Contact Person for Information, or to Submit a Complaint**

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see first page). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

**Organized Health Care Arrangement Designation**

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

## HIPAA Notice of Special Enrollment Rights

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 later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment by the HIPAA Special Enrollment Deadline after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 by the HIPAA Special Enrollment Deadline, after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator. Note: Additional information may be required if the plan requires that persons declining coverage under the plan state, in writing, the reason(s) for declining coverage.

# Important Notice from the Company About Your Prescription Drug Coverage and Medicare under the Creditable Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage 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. The Company has determined that the prescription drug coverage offered by the Creditable Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

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

**Enrolling in Medicare—General Rules**

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.


**Late Enrollment and the Late Enrollment Penalty**

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

If after your initial Medicare Part D enrollment period, you go 63 continuous days or longer without "creditable" prescription drug coverage (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

**Compare Coverage**

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. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed at the beginning of the Required Notices section of this guide.

**Coordinating Other Coverage with Medicare Part D**

Generally speaking, if you decide to join a Medicare drug plan while covered under the Company Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Company Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or Web address listed at the end of this notice.

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

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

Contact the Plan Administrator 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 the Company changes. You also may request a copy.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'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 call 1-877-486-2048.

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 whether or not you are required to pay a higher premium (a penalty).**

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

KLEIN ISD
FUTURE READY

Keeping You Connected

*While information in this Benefit Booklet is believed to be correct at the time of printing, this information is for education and reference purposes only. This material is in summary form. The provisions in each plan are governed by the Summary Plan Description, or the Certificate of Coverage, or the Group/Individual contract of that plan.*