Conroe Independent School District

2017-2018
Employee Benefits Guide

Human Resources/Employee Benefits

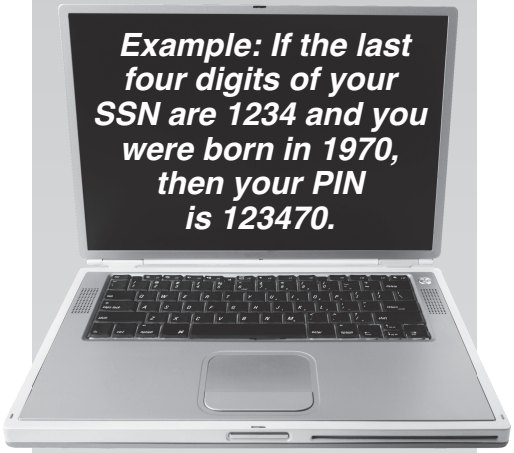
3205 West Davis • Conroe, Texas 77304-2098

936.709.7808 • benefitsoffice@conroeisd.net • www.conroeisd.net/hr/benefits

Benefits Contact Information

Enroll at https://ffga.benselect.com/enroll

Your PIN to login to the online benefits enrollment system is the last four digits of your Social Security number followed by the last two digits of your birth year.



FFenroll Call Center
First Financial Administrators
1-855-523-8422

Third Party Administrator
First Financial Administrators, Inc.
1-800-523-8422 • www.ffga.com

Mack Whiteman
Senior Account Executive
713-254-5264
mack.whiteman@ffga.com

Group Health Benefits

Medical and Prescription *(Group # 100087)*

Aetna Member Services	1-866-381-8933
Aetna Prescription Services	1-888-792-3862
Mail Order Services	1-800-227-5720
Aetna Specialty Pharmacy	1-866-782-2779
Beginning Right Maternity Program	1-800-272-3531
Behavioral Health Services	1-800-424-5679
Health Connections Disease Management Program	1-866-269-4500
Informed Health Line (24-hour Nurse Hotline)	1-800-556-1555
Navigator Help Desk	1-800-225-3375
Teladoc®	1-855-835-2362
Vision Discount Program	1-800-793-8616
	www.aetna.com

Alternate Plan *(Group #71200)*

America's Choice Healthplans	1-866-317-0167
	www.achonline.com

Dental

Aetna *(Group #737387)*	1-877-238-6200
	www.aetna.com

Vision

VSP *(Group #10-350759)*	1-800-877-7195
	www.vsp.com

Additional Voluntary Benefits

Accidental Death & Dismemberment Insurance *(Group # VAR 053228)*

Reliance Standard	1-800-435-7775
	www.reliancestandard.com

Cancer Insurance *(Group #11535 • Group #98894 [policies issued prior to 9/1/2012])*

Allstate	1-800-521-3535
	www.allstateatwork.com

Critical Illness Insurance *(Group #22863)*

Aflac	1-800-433-3036
	www.aflacgroupinsurance.com

Disability Insurance *(Group #645657-A)*

Standard Insurance Company	1-855-757-4717
	www.standard.com

Flexible Spending Accounts *(Health and Dependent Care)*

First Financial Administrators, Inc. *(Group #56160)*	1-866-853-3539
	www.ffga.com

Hospital Indemnity Insurance *(Group #896271)*

Humana	1-877-378-1505
	www.humana.com

Legal Protection Plan *(Group: Conroe ISD)*

Legal Access Plans	1-800-562-2929
	flpp.legalaccessplans.com

Life Insurance—Group Term *(Group #568676)*

UNUM	1-800-445-0402
	www.unum.com

Life Insurance - Term

American Fidelity	1-800-654-8489
	www.afadvantage.com

Life Insurance - Universal *(Group #SM2656)*

TEXASLIFE	1-800-283-9233
	www.texaslife.com

Long-Term Care Insurance

American Fidelity	
(Group #59887, policies issed prior to 9/1/2013)	1-800-654-8489
	www.afadvantage.com
LifeSecure *(Group #00711V)*	1-866-582-7701
	www.yourlifesecure.com

Other Benefits

403(b) and 457 Retirement Savings

First Financial Administrators, Inc.	1-800-523-8422
	www.ffga.com
Fidelity Investments *(457 Plan Option)*	1-800-343-0860
	www.mysavingsatwork.com

Conroe ISD Employee Health & Wellness Center 281-465-2873 *(South County)*
936-270-6000 *(North County)*
www.conroeisdclinic.com

Leave of Absence and Workers' Compensation

CISD Human Resources	936-709-7823
	www.conroeisd.net

Teacher Retirement System (TRS) 1-800-223-8778
www.trs.texas.gov

Table of Contents

This booklet is based on official plan documents and provides an overview of benefits options for the 2017-2018 plan year. Every attempt has been made to ensure its accuracy. If there is a conflict between statements in this guide and the plan documents, insurance contracts, or state and federal regulations, the plan documents, insurance contracts, and state and federal regulations will prevail. Plan documents are available online at www.conroeisd.net under Employees > Benefits > Plan Documents.

Introduction

Conroe Independent School District proudly offers an excellent benefit package to all qualifying employees and their eligible dependents. This booklet contains a summary outline of health coverage and the various voluntary benefit plans that are available for the 2017-2018 plan year. Conroe ISD has contracted First Financial Administrators, Inc. to administer our Section 125 Flexible Benefits Plan, 457 and 403(b) retirement plans, and to assist with benefits enrollment.

In an effort to give you a faster response to questions concerning your benefits, there is a toll-free number to call. If you have questions concerning how to enroll, how your benefits work, how to file a claim, or if you need other policy information, you may call First Financial Administrators, Inc. toll-free at 1-800-523-8422.

Section 125/Cafeteria Plan Information

The Section 125/Cafeteria Plan Benefit refers to Section 125 of the Internal Revenue Code of 1978. Simply put, the Cafeteria Plan allows you to deduct certain benefit premiums from your gross earnings, before federal taxes are figured. The amount you elect to have deducted "pre-tax" actually reduces your taxable income.

The benefit plan year is September 1 through August 31.

There are two very important issues to keep in mind regarding Cafeteria Plan participation:

1. Although all coverage is voluntary, every employee is required to complete online enrollment selections each year, even if you wish to keep your current benefits the same, or if no benefits are selected.
2. Any "pre-tax" elections made during annual enrollment will become effective September 1 and will remain in effect during the entire plan year. Changes are not permitted unless you experience a qualifying event under Section 125 regulations and request a change by contacting the CISD Benefits Office no later than 30 calendar days after the date of the qualifying event. Examples of these events include:
   - *Marriage/Divorce*
   - *Birth/Adoption*
   - *Death of a Spouse or Dependent*
   - *Change in Employment Status of a Spouse or Dependent*
   - *Change in Eligibility Status of a Spouse or Dependent*
   - *Open Enrollment of Spouse's or Dependent's Employer's Plan*
   - *Judgment/Decree/Court Order*
   - *Eligibility for Medicare or Medicaid*

Section 125 Frequently Asked Questions

Q. What is a Section 125 Plan?
A. It is an employer sponsored benefit plan which allows an employee to select from a list of available benefits, those benefits needed by the employee.

Q. What does this benefit program mean to me?
A. This program means that expenditures for items such as medical insurance premiums, dental insurance premiums, cancer and specified disease insurance premiums, vision insurance premiums, dependent care costs, and some medical expenses not covered by insurance can be paid with pre-tax dollars. The bottom line is you may have more dollars available to purchase other benefits you may need, or increase your take home pay.

Q. What happens if the tax law changes next year?
A. No one can predict what future changes may occur in the tax laws. This Section 125 Plan has been set up in accordance with current laws and regulations. If the laws change, appropriate steps will be taken to comply with any new rules.

Q. How do I enroll in the Section 125 Plan?
A. Enrollment selections must be completed in the online enrollment system and confirmed using an electronic signature. A representative from First Financial Administrators is available to meet with you to assist you with the enrollment process.

Q. Must I make elections before the effective date of the Plan?
A. Yes, you must make your open enrollment benefit elections prior to the beginning of the plan year, September 1, or prior to becoming eligible to participate in the Plan.

Q. Can I make changes in my elections during the plan year?
A. The only time tax law regulations will allow you to make a change is if a qualified status change occurs affecting your need for a benefit. Your change of election must be consistent with the change in status. Some examples of a status change are: marriage, divorce, death of a spouse or child, birth or adoption of a child, and a change in the employment status of you or your spouse.

Q. Who do I contact if I have a question regarding my benefits?
A. You may always call First Financial at 1-800-523-8422 for questions regarding your benefits, or if you have a specific question pertaining to coverage or claims you may contact the provider directly.

Change of Election Guidelines

Any premiums deducted on a pre-tax basis from the employee's paycheck will be "locked in" for the duration of the plan year, which begins September 1 and ends August 31. New enrollments and changes may only be requested during the annual enrollment period in July

unless a family status change or other qualified event, as identified by IRC Section 125, occurs such as*:

- Change in employee's legal marital status (i.e., marriage, divorce, death);
- Change in the number of employee's dependents (i.e., birth, adoption, death,);
- Change in employment status of employee, spouse, or dependent affecting eligibility;
- Dependent satisfies or ceases to satisfy eligibility requirements;
- HIPAA special enrollment rights;
- Judgments, decrees, or orders;
- Medicare or Medicaid entitlement;
- Family Medical Leave Act;
- COBRA qualifying events;
- Cancellation due to reduction in hours of service;
- Cancellation due to enrollment in a Qualified Health Plan;
- Change in coverage under another employer's plan (e.g., open enrollment of spouse's employer); or
- Loss of group health coverage sponsored by a governmental or educational institution.

* *Please note this is an outline only and does not indicate special facts and circumstances for various events and benefits.*

A change of election must be related to the reason for the change. The employee must request a change of election no later than 30 calendar days after the date of the qualifying event. For changes related to Medicaid and CHIP eligibility, the notification period is 60 days. Changes requested after this time frame will not be permitted until the next annual enrollment period.

Verifiable documentation of the qualifying event must be provided by the employee to the CISD Benefits Office in order for a request to be processed. For the loss or gain of employment by a spouse or dependent, verification from the other employer must include the following information:

- The effective date of employment or the date employment terminated; and
- The effective date of insurance coverage or the date coverage terminated/will terminate (the type of coverage must be specified).

If verification is provided in the form of a letter, it must contain a signature from an official of the company or the benefits counselor. If verification is provided in an email message, the other employer must send it directly to benefitsoffice@conroeisd.net.

Premiums deducted on a post-tax basis may be canceled at any time.

Approved change of election requests for enrollment are effective the first day of the month on or following the date all required documents are submitted to the CISD Benefits Office (exceptions may apply based on the qualifying event). Approved change of election requests for cancelation of coverage are effective the last day of the month in which all required documents are submitted to the CISD Benefits Office.

Employees must contact the CISD Benefits Office to complete a change of election.

Eligibility for Benefits

You are eligible to enroll in all available benefits if you are a regular full-time employee of CISD who is scheduled to work 18.75 hours or more each week. When you join a plan that provides dependent coverage, your legal spouse, under the laws of the state of Texas, and children are also eligible to join the plan (note the working spouse provision for medical coverage). In order to cover a dependent, you must buy coverage for yourself. No person may be covered as both an employee and a dependent, and no person may be covered as a dependent of more than one employee.

If your spouse is employed and has access to group medical coverage through his/her employer, he/she will not be eligible for Conroe ISD group medical coverage. If your spouse does not work, is not eligible for coverage, or has lost coverage as an active employee and been offered continuation coverage under COBRA, the spousal exclusion does not apply. If your spouse is covered by Medicare, the exclusion does not apply. If your spouse experiences a qualifying life event during the plan year, such as the loss of employment which results in a loss of medical coverage, he/she can be added to your Conroe ISD coverage within 31 calendar days of the event. Employees will be required to complete a **Spousal Medical Coverage** form during the enrollment process in order to include them as a covered individual.

A dependent child must be under the age of 26. On most plans, coverage will continue until the end of the month in which the child attains age 26. A dependent child includes your natural child, stepchild, legally adopted child, child under court order, or grandchild. A grandchild must be in your court-ordered custody or must reside with you and be claimed as a dependent according to IRS guidelines. Documentation, including birth certificates, tax records, or legal records, may be required to prove dependency status. A child who is unmarried, totally disabled, and primarily depends upon you for support and maintenance, prior to attaining age 26, is eligible for continued coverage beyond the maximum age limit. Proof of your child's disability is required to continue coverage.

Dependent Eligibility Audits

It is illegal to elect coverage for an ineligible person. Dependent eligibility audits may be conducted periodically to ensure covered dependents meet plan eligibility requirements. In the event of an audit, notices requesting proof of eligibility will be mailed to plan participants. Not responding to an audit request will result in termination of dependent coverage. If a dependent's eligibility status changes during the plan year, employees should contact the CISD Benefits Office immediately to request a change of election.

Member ID Cards

For plans that issue member ID cards to utilize benefits (medical and vision only), cards are typically mailed and received within 2-3 weeks of new hire enrollment completion or annual enrollment closure. If you require a replacement card, you will need to contact the plan carrier directly. Aetna and VSP allow their members the ability to print ID cards and submit requests for replacement cards through their websites. As a reminder, new cards for existing participants are not generated at the start of each plan year.

CISD Medical Coverage

CISD offers medical and prescription benefits through self-funded medical plans administered by Aetna. CISD does not participate in a fully funded medical insurance plan provided by an insurance company nor does it participate in TRS-ActiveCare. By contracting Aetna as our plan administrator, we have the added benefit of access to their provider networks and negotiated discounts. As our plan administrator, Aetna does not insure our employees, but rather processes and pays claims with money we provide. **All medical information on record with Aetna is confidential and is not shared with CISD.**

In the self-insured plans, CISD and its participating employees, as a group, pay for the entire cost of all our medical expenses. This is done through our premiums, coinsurance, copays, deductibles, and the school district contributions. CISD contributes $446 per month, per full-time employee (100% FTE), toward the medical premium. For example, the actual cost of the monthly premium for employee only coverage in the Aetna Whole Health Plan is $594. This cost sharing of premium is illustrated below.

Employee Monthly Cost $148.00
CISD Monthly Contribution $446.00
Total Monthly Cost $594.00

Employees working at least a 50% FTE but less than 100% will pay a portion of the District contribution equivalent to the percentage they are not employed. For example, an employee at 60% FTE will pay 40% of the District's contribution, or an additional $178.40 per month.

Utilization of these plans by our employees is what determines the actual costs for each plan. As employees, we have the responsibility to pay attention to the entire cost of our health care choices. The bottom line is that we are all paying for it. When annual expenditures exceed our annual revenue from the plans, we are faced with making changes in the premium structures and/or plan designs for the following year. CISD has the responsibility of operating plans that generate ample revenue to cover the expenses associated with each of the plans.

Conroe ISD Medical Plan Design for 2017-2018 Plan Year *(effective September 1, 2017)*

Plan Features	Aetna Whole Health		HDHP	
	Tier 1*: Aetna **Memorial Hermann ACN** Maximum Savings	**Tier 2*:** **Aetna Select** Higher Out-of-Pocket Costs	**In-Network**	**Out-of-Network**
Deductible				
Individual	$1,000 per plan year	$2,000 per plan year	$2,500 per calendar year	$3,500 per calendar year
Family	$2,000 per plan year	$4,000 per plan year	$5,000 per calendar year	$7,000 per calendar year
Out-of-Pocket Maximum (includes deductibles, copays, and coinsurance)				
Individual	$5,000 per plan year	$7,150 per plan year	$6,550 per calendar year	Unlimited
Family	$10,000 per plan year	$14,300 per plan year	$13,100 per calendar year	Unlimited
Office Visit				
Primary Care Physician	$30 copay	$50 copay	30% after deductible	50% after deductible
Specialist	$45 copay	$80 copay	30% after deductible	50% after deductible
Conroe ISD Employee Health & Wellness Center	$10	$10	$10	N/A
Walk-In Clinic	$45 copay	$45 copay	30% after deductible	50% after deductible
Preventive Care (subject to age and frequency limits)				
Routine Physical Exams, Preventive Care Immunizations, Well Woman Preventive Visits, Routine Cancer Screenings, Prenatal Care	$0 (Plan pays 100%)	$0 (Plan pays 100%)	$0 (Plan pays 100%)	$0 (Plan pays 100%) *coinsurance may apply if service is received from an out-of-network provider*
Hospital, Surgery, and Specialty Service				
Emergency Room	$350 copay	$350 copay	30% after deductible plus $150 copay	30% after deductible plus $150 copay
Urgent Care Center	$75 copay	$75 copay	30% after deductible	50% after deductible
Diagnostic Lab and X-Ray	$0 (plan pays 100%)	$0 (plan pays 100%)	30% after deductible	50% after deductible
Complex Imaging	$100 copay	$100 copay	30% after deductible	50% after deductible
Inpatient Hospital and Physician Care	10% after deductible	35% after deductible	30% after deductible $500 admission copay	50% after deductible plus
Teladoc Consultation	$40 copay	$40 copay	30% after deductible *($40 maximum)*	N/A
Pharmacy Benefits (Aetna Value Formulary)				
Prescription Drug Deductible *(waived for preferred generics)*	$200 per individual, per plan year	$200 per individual, per plan year	N/A	N/A
Prescriptions (Retail)				
Tier 1: Preferred Generics	$15		30% after deductible	Not covered
Tier 2: Preferred Brands	$60		30% after deductible	Not covered
Tier 3: Non-preferred Brands & Generics	$120		30% after deductible	Not covered
Specialty Care *(Aetna Specialty Pharmacy required after 1st fill at retail)*	$250		30% after deductible	Not covered
Prescriptions (Mail order)				
Tier 1: Preferred Generics	$30		30% after deductible	Not covered
Tier 2: Preferred Brands	$120		30% after deductible	Not covered
Tier 3: Non-preferred Brands & Generics	$240		30% after deductible	Not covered
Per Paycheck Costs**				
Employee Only	$74.00		$67.00	
Employee and Child(ren)	$270.00		$250.00	
Employee and Spouse	$442.00		$425.00	
Employee and Family	$491.00		$475.00	

** Deductibles and out-of-pocket maximums cross-apply when using both Tier 1 and Tier 2 providers in the same plan year.*

*** An additional $5 per paycheck is added for tobacco users.*

***Note:** Plan year is September 1 - August 31, and calendar year is January 1 - December 31.*

Aetna Whole Health– Memorial Hermann Accountable Care Network–Aetna Select *(Aetna Whole Health) (Group #100087)*

With this plan you'll get a care team of Memorial Hermann Accountable Care Network doctors, nurses, therapists and other health care providers. They'll work together, and with you, to help keep you healthy or improve your health. They'll also:

- Better coordinate your care because they can see how other network doctors are treating you, what medicines you're taking, your lab results, your health history and more;
- Use technology to spot medical problems early and develop personalized care plans to treat you; and
- Encourage you to play an active and informed role in your health and health care decisions.

This cooperative care approach makes it important to choose an Aetna Whole Health – Memorial Hermann Accountable Care Network primary care doctor to lead your care team. Also keep in mind that you'll save the most money and get the most coordinated care when you visit doctors and facilities within the Memorial Hermann Accountable Care Network, also known as your **Tier 1** option.

If you'd like, you may also use hospitals and doctors outside of the Aetna Whole Health – Memorial Hermann Accountable Care Network but still part of Aetna's larger Select network. This is your **Tier 2** option. Just know that when you do, you'll pay more for those services.

Finding a Provider

It's easy to find Aetna Whole Health – Memorial Hermann Accountable Care Network doctors. To choose a primary care doctor – or see which doctors and facilities are part of the network – before you enroll:

- Visit **www.aetna.com/docfind.**
- Type a name, specialty, procedure or condition in the "Search for" box.
- Enter your zip code or city and state in the "in" box.
- Choose **(TX) Aetna Whole Health – Memorial Hermann Accountable Care Network** from the "Select a Plan" drop down menu.

That's how you'll find an up to date list of providers in the Aetna Whole Health – Memorial Hermann Accountable Care Network.

Remember, you can still search for and visit **Tier 2** doctors and facilities in the Aetna Select network. Just know that you'll pay more for their services.

Assistance locating doctors and facilities may also be obtained by calling Aetna at 1-866-381-8933.

If you enroll your eligible child in the Aetna Whole Health medical plan and your child resides outside the plan's service areas, your child may be eligible for the dependent out-of-area medical plan. Be sure to list your child's address in the dependent section of FFenroll during enrollment, and contact the CISD Benefits Office for further assistance. Out-of-area medical plan documents are available online at www.conroeisd.net under Employees – Benefits – Plan Documents.

Providers are subject to change. It is your responsibility to check their status at the time of service.

High Deductible Health Plan (HDHP)

Aetna Choice POS II (Group # 100087)

HDHP participants have direct access to any physician, hospital or other health care provider (network or out-of-network) for covered services and supplies. The plan pays benefits differently depending on whether services and supplies are obtained through network or out-of-network providers. It is designed to lower your out-of-pocket costs when you use network providers for covered expenses. Because participants share in the cost of benefits, you will need to satisfy any applicable calendar-year deductible before the plan will begin to pay benefits.

Enrollment in the HDHP includes an optional Health Savings Account (HSA). An HSA permits an individual to set aside money to pay for unreimbursed medical costs in a separate account on a tax free basis. An HSA is similar to a health Flexible Spending Arrangement (FSA) except that the balance in an HSA can be carried over from year to year, unlike an FSA balance which must be spent during a plan year. Contributions to an HSA are in addition to premiums collected for the HDHP coverage. Maximum HSA contribution amounts for the 2017-2018 plan year are $3,400 for employee only coverage and $6,750 for employee family coverage. Participants who elect to contribute to an HSA are not eligible to enroll in the health FSA benefit.

Prescription Drug Coverage

The Aetna Value Formulary pharmacy plan is integrated with the medical plan. These pharmacy benefits help you pay for your prescriptions, with extras to help you stay healthy and save.

You get:

- Coverage for most drugs
- Mail-order convenience
- A choice of pharmacies, including retail chains
- Personal support for specialty medicine needs
- Online plan tools to find what you need fast: prices, forms, pharmacies, and more.

How does the plan work?

It's pretty straightforward. Each drug covered by the plan falls under a different level or tier. The lower the tier, the lower the price. The higher the tier, the higher the price.

Tip: To get the best price, let your doctor know which drugs your plan covers, including those in the lower tiers. You can find a listing at www.aetna.com/formulary.

If you take a higher-tier drug, Aetna may ask you to switch to another drug that costs less but is just as safe and effective. If needed, Aetna will give you a one-time fill of your regular medicine to ease your transition.

What do you pay?

Again, it's simple. You either pay a flat fee or a percentage of the drug's price, depending on the medical plan you choose. The exact cost depends on the tier your medicine is in.

Here's where to find exact costs:

Before you enroll This booklet gives you details that show what you'll pay for your medicine. Note the prescription drug deductible for the Aetna Whole Health plan. You can avoid this deductible by taking a preferred generic drug.

After you enroll Sign up for your member website at www.aetna.com. Then log in anytime to estimate drug costs or compare prices between a local pharmacy and mail order. Note some drugs may only be dispensed by Aetna Specialty Pharmacy.

If your physician prescribes, or you request, a brand-name drug when a generic equivalent is available, you must pay the difference in cost (if any) between the brand-name drug and the generic drug, plus the applicable copayment.

What medicine is covered?

This pharmacy benefits and insurance plan covers most drugs. However, some medications are not covered because there are similar products with the same active ingredients that are covered by the plan or are available over the counter, without a prescription. Exclusions apply in the following categories:

- Allergy
- Analgesics
- Antibiotics
- Antivirals
- Cardiovascular
- Central Nervous System (CNS)
  - Antidepressants/other
  - Antiseizure
  - Sedative-hypnotics
  - Attention deficit hyperactivity disorder
- Dermatological
- Endocrine
- Gastrointestinal (GI) – other
- Muscle relaxants
- Prescription GI – ulcer medicine
- Respiratory nasal/cough and cold
- Urinary

View the complete drug exclusion list online at: www.aetna.com/individuals-families-health-insurance/document-library/pharmacy/2017-exclusion-drug-list.pdf. If you are taking or being prescribed a medication on this list, consult your physician about an alternative medication.

Here's how to check:

Before you enroll Visit www.aetna.com/formulary. Then choose "Aetna Value Formulary" (the name of your drug guide). From there, you can find covered medicine, along with alternatives that cost less.

After you enroll Just log in to your member website at www.aetna.com to estimate drug costs. No Internet? Call Aetna at the number on your Aetna ID card.

Your safety comes first

This plan comes with safety checks on the drugs your doctor prescribes. That could mean you need special approval before a drug is covered, or Aetna might ask your doctor to prescribe another drug. Your doctor can always ask for an exception.

How do you get your medicine?

For occasional prescriptions Visit your local retail pharmacy for medicine you won't take too long, like antibiotics. For the best cost, use a network pharmacy. You can find one at www.aetna.com.

For ongoing prescriptions Use mail-order delivery for medicine you need all the time, like drugs to treat blood pressure, cholesterol, or diabetes. Your medicine is mailed quickly and safely to you, and you may get up to a 90-day supply for the cost of a 60-day supply.
Or …
Use **Aetna Specialty Pharmacy®** for medicine that treats more complex conditions, like rheumatoid arthritis and multiple sclerosis. Your medicine is packed securely, so it arrives safe and sound. Aetna can also help you with any questions you may have on dosage or side effects. Call toll-free 1-866-782-2779 for assistance.

Formulary classification, precertification list, and exclusion list subject to change. Changes are not based on the Conroe ISD plan year. Visit www.aetna.com for the most up-to-date information.

Aetna Navigator

After you enroll, you can better manage your plan, your health and your budget by registering at your secure member site, **www.aetnanavigator.com**. Here you can:

- Search **DocFind®**, the online provider directory, for doctors, hospitals, pharmacies and more in your area
- Check your personal health record and see reminders for important preventive screenings and tests
- Set and track your health, fitness and nutrition goals with **CarePass®** apps
- Use **Member Payment Estimator** to compare prices on tests and procedures, just like you'd shop for the best deals on travel or clothing
- Get discounts on over-the-counter vitamins, herbal and nutritional supplements, massage therapy and more
- Review your claims and pay your bills

Tip for Aetna Whole Health members: Always look for *Memorial Hermann Accountable Care Network* under the Plan Information heading to quickly spot your Tier 1 Aetna Whole Health – Memorial Hermann Accountable Care Network doctors and facilities. They will be listed on the "Best Results for Your Plan" tab in DocFind search results.

Teladoc®

Talk to a doctor anytime. Teladoc gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video, or mobile app visits. At $40 or less, it's an affordable alternative to costly urgent care and ER visits when you need care now.

Meet the doctors Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

Get the care you need Teladoc doctors can treat many medical conditions, including:

- Cold and flu symptoms
- Allergies
- Sinus problems
- Ear infections
- Urinary tract infections
- Respiratory infections
- Skin problems
- And more!

When can you use Teladoc? Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering ER or urgent care for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

Share with your PCP With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

How does Teladoc work?

Step 1: First time users must register online for a member account
Step 2: Request consult by web, phone, or mobile app
Step 3: Talk to the doctor
Step 4: Resolve the issue (if medically necessary, a prescription will be sent to your pharmacy of choice)
Step 5: Feel better

Teladoc is just a click or call away!
Online: Teladoc.com/Aetna
Phone: 1-855-Teladoc (1-855-835-2362)
App available on the App Store and from the Google Play™ store

Teladoc is being provided to fully-insured Aetna members and members of plans administered by Aetna. Teladoc is also provided to self-insured Aetna members and members of plans administered by Aetna whose employer has elected to offer the program to their employees. Teladoc and Teladoc physicians are independent contractors and are neither agents nor employees of Aetna or plans administered by Aetna. Teladoc is not available in all states. Teladoc does not replace the primary care physician. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulation and may not be available in certain states. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs, and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services.

Walk-In Clinics and Urgent Care Centers

Medical emergencies happen, but not every health need is a medical emergency. If you need care for minor illnesses like strep throat, seasonal allergies, and ear or eye infections, and you cannot get in to see your primary care physician, you may want to seek care from a walk-in clinic as an affordable alternative. If your situation is more than minor, such as a sprain, fracture, or other urgent injury, you may want to visit an urgent care center.

Always use your best judgment when seeking treatment for you and your family. If you have chest pain, trouble breathing, extensive bleeding, or other symptoms you believe put your life at risk, you should go to the emergency room (ER).

Providers are subject to change. For the most up-to-date list of in-network facilities, search online at www.aetna.com or using the Aetna Mobile app. It is your responsibility to check the network status at the time of service.

A Welcome Call from Aetna

Personalized help makes it easier for you to be healthy and well
That's why your Aetna plan offers phone support from a caring registered nurse. When you need that support the most. Or when you just need a little advice. And you don't have to pay a thing. It's all part of your Aetna health plan.

For special situations
We know the health care system can be complicated. Just think of the many times when speaking with someone who really knows health care issues would put your mind at ease. Times when you are:

- Planning for or coming home from a hospital stay
- Managing a medical condition, like asthma or diabetes
- Coordinating complex medical treatment among different doctors, hospitals, labs and other health care providers

Or everyday well-being
Of course, sometimes you don't have an urgent need for support. But you could benefit from guidance that helps you stay well. So you may also get a call from Aetna to:
- Discuss questions to ask your doctor
- Find out about Aetna health and wellness programs that might be right for you
- Learn about services available through your employer or in your community
- Talk about ways you can work toward good health

Your conversation is private
It's in your best interest to talk openly with your program nurse. Rest assured that everything you discuss is confidential. Aetna never shares your information with anyone, including your employer. So be sure to answer the phone when Aetna calls. It's a phone call that can make a big difference.

Make sure your employer has your correct phone number on file. This is the number Aetna will use to call you.

Aetna Special Programs

- **Aetna Natural Products and Services℠ Program** – Save on complimentary health care products and professional services not traditionally covered by your health benefit plan. All products and services are delivered through American Specialty Health Incorporated and its subsidiaries, American Specialty Health Networks, Inc., and Healthyroads, Inc.
- **Aetna Fitness℠ Discount Program** – Save on fitness club memberships, programs and other services that support your healthy lifestyle with services provided by GlobalFit™.
- **Aetna Health Connections℠ Disease Management Program** – An ongoing commitment to improve care for all members encourages Aetna to deliver comprehensive support services for the significant number of people who present with one or more chronic or recurring conditions, or are at high risk of developing additional chronic conditions. The program is based on a holistic, rather than condition-focused, view of each member and addresses more than 30 chronic conditions.
- **At Home Products** – Take advantage of money-savings discounts on health care products that you can use in the privacy and comfort of your home and that add up to savings for you and your family.
- **Aetna Book℠ Discount Program** – Discounts on books and other items purchased from the American Cancer Society Bookstore, the MayoClinic.com Bookstore and Pranamaya.
- **Simple Steps to a Healthier Life®** – An online program that can help you improve your overall health or simply fine-tune your daily habits. Get the support you need to be your healthiest.
- **Member Health Education Programs** – Through the use of educational materials, these innovative programs offer health education, preventive care and wellness programs that help promote a healthy lifestyle and good health. Advantages of these programs include: adolescent immunization reminders, adult preventive reminders, cancer screening, and childhood immunization reminders.
- **Informed Health® Line** – Provides telephone access to registered nurses experienced in providing information on a variety of health topics 24 hours per day, 365 days per year.
- **Numbers-to-Know** – Promotes blood pressure and cholesterol monitoring and can help encourage you to understand your illness, monitor your high blood pressure and high cholesterol, and work with your physician to develop an appropriate treatment plan.
- **National Medical Excellence Program** – Helps eligible plan participants access covered treatment for solid organ transplants, bone marrow transplants, and certain other rare or complicated conditions at participating facilities experienced in performing these services.
- **Aetna Vision Discount Program** – Receive discounts on eyeglasses, contact lenses and nonprescription items such as sunglasses and contact lens solutions at thousands of locations nationwide. Discounts off the provider's usual retail charge for Lasik surgery are also available through providers participating in the U.S. Laser Network.
- **Women's Health Care** – A variety of benefits and programs to promote good health throughout each distinct life stage including support for women with breast cancer, confidential genetic testing for breast and ovarian cancers, direct access for OB/GYN visits, and infertility case management and education.
- **Beginning Right Maternity Program℠** – Provides you with maternity health care information and guides you through pregnancy; also includes Pregnancy Risk Assessment.
- **Aetna Hearing℠ Discount Program** – Save on hearing exams, hearing aids, and other hearing services.
- **Aetna Weight Management℠ Discount Program** – Help with achieving your weight loss goals and developing a balanced approach to your active lifestyle. Receive discounts on the Calorie King®Program and products, eDiets® diet plans and products, Jenny Craig® weight loss programs and Nutrisystem® weight loss meal plans.

Availability of Summary of Benefits and Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: www.conroeisd.net under Employees – Benefits – Benefits Enrollment. A paper copy is also available, free of charge, by calling 936-709-7808.

Plan administered by: Aetna
www.aetna.com • 1-866-381-8933

Exclusions and limitations apply. *For a more detailed explanation of Aetna Whole Health and HDHP benefits you can review the summary plan documents online at www.conroeisd.net under Employees – Benefits – Plan Documents.*

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health care services. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.

Conroe ISD Employee Health & Wellness Center

Conroe ISD, in partnership with Memorial Hermann Medical Group, provides health and wellness centers where employees and their eligible dependents can obtain a variety of medical services at a reduced cost. The Health & Wellness Centers place a high priority on preventive health education, medical screenings, and lifestyle modifications to help you plan and achieve a lifetime of optimal health. The medical staff will spend extensive one-on-one time listening to understand your unique and individual health care needs.

Two convenient locations:

South County **CISD Employee Health & Wellness Center**
19675 I-45 South, Suite 100 • Conroe, TX 77385
(On the Oak Ridge Elementary School campus)
281-465-2873

Hours:
Monday.....8 a.m. to 5 p.m.
Tuesday/Wednesday/Thursday .....10 a.m. to 6 p.m.
Friday/Saturday .....8 a.m. to 12 p.m.
Sunday .....Closed

Summer Hours *(June 5 – August 16, 2017)*:
Monday/Tuesday/Thursday .....8 a.m. to 5 p.m.
Wednesday.....10 a.m. to 6 p.m.
Friday/Saturday .....8 a.m. to 12 p.m.
Sunday .....Closed

North County **Memorial Hermann Medical Group Conroe**
690 South Loop 336 W, Suite 140 • Conroe, TX 77304
936-270-6000

Hours:
Monday through Friday.....8 a.m. to 5 p.m.
Saturday/Sunday .....Closed

What kind of treatment can the Health & Wellness Center provide?
The Health & Wellness Center can handle nearly all of your routine illness and health needs. Providers can diagnose and treat minor medical problems, write prescriptions, give vaccinations, conduct physicals, perform diagnostic lab work on-site, and more.

How is the Health & Wellness Center staffed?
The Health & Wellness Center is staffed by nurse practitioners and medical assistants.

How can I be assured the medical care I receive at the Health & Wellness Center is of the highest quality?
When you visit the Health & Wellness Center with a health problem, you will be treated by a qualified, board-certified Nurse Practitioner who has advanced training in diagnosing and treating illnesses.

What is the cost for an employee to use the Health & Wellness Center?
The cost is $10 for Conroe ISD Aetna medical plan members. For all other employees, the cost is $50.

Can family members use the Health & Wellness Center?
Yes, as long as the family member is enrolled in a District medical plan with Aetna – children must be at least two years old. Family members not enrolled in a CISD medical plan may not use this facility.

Do I need to call ahead for an appointment?
Appointments are recommended and preferred. Walk-in patients for sick visits and acute care needs will be taken up to 45 minutes prior to closing time. Physicals, well-person, follow-up, and chronic care visits should be scheduled in advance to allow sufficient time to complete the visit and promote a better patient experience. To schedule your appointment, call the desired location or visit www.conroeisdclinic.com.

Can I select the CISD Employee Health & Wellness Center as my primary care physician (PCP) if I am enrolled in the District's Aetna Whole Health medical plan?
Yes. Employees and their family members (over the age of two) enrolled in the CISD Aetna Whole Health plan may select the CISD Employee Health & Wellness Center as their PCP. The center is not listed in Aetna's online provider directory; *the Aetna Provider ID is 4399474.*

Can the Health & Wellness Center refer me to a specialist if necessary?
Yes, as long as you have designated the Center as your PCP.

Does Conroe ISD have access to my personal health information?
No. In compliance with HIPAA (Health Insurance Portability and Accountability Act), your personal health information is completely confidential and is not shared with Conroe ISD or anyone else without your written permission.

Who manages the Health & Wellness Center?
The Health & Wellness Center is managed by Memorial Hermann Medical Group, which is part of Memorial Hermann Health System, one of the most trusted health systems in the nation.

For more information or to schedule an appointment, call the preferred location or visit www.conroeisdclinic.com.

CISD Alternate Plan

America's Choice Healthplans (Group # 71200)

Employees who have declined the CISD medical plan because they have other medical coverage are eligible to enroll in the CISD Alternate Plan. Information on the other medical plan, including the name of the insurance company, must be submitted during enrollment. Benefits of the plan include hospital indemnity, dental, term life, and accidental death and dismemberment coverage. There is no cost to employees electing to participate in the CISD Alternate Plan. An enrollment election is required each year during the annual enrollment period to continue coverage; otherwise, coverage will terminate at the end of the plan year.

Hospital Indemnity Benefit

Daily Inpatient Allowance.....$165
Daily Maximum.....365 days

Dental Benefit

(This plan may be used at the discretion of any dental office.)
Deductible.....$50
Waived for Preventive Care .....yes
Preventive.....100%
Basic.....80%
Major.....50%
Calendar Year Maximum.....$1,000

Group Life through One America

Term Life $10,000
Accidental Death and Dismemberment.....$15,000

Life & AD&D amounts will be reduced by 35% at 65, 55% at 70, 70% at 75, 80% at 80, 85% at 85, 90% at 90, and will terminate at retirement.

Plan administered by:
America's Choice Healthplans
PO Box 922043 • Houston, TX 77292-2043
www.achonline.com • 1-866-317-0167

Information included in this benefit description provides only a general overview of some of the important features of the plan. The plan document will set forth, in detail, limitations and exclusions, as well as the rights and obligations of the employer and employee.

Dental Coverage

Aetna (Group # 737387)

CISD offers its employees two types of dental plans: a fully insured Dental Maintenance Organization (DMO®) plan and a self-funded Participating Dental Network (PDN) plan. The network-only DMO plan offers predictable out-of-pocket costs, while the PDN plan allows you to see any licensed dentist.

Dental Maintenance Organization (DMO) Plan

Get the benefit of wide coverage, plus the bonus of cost savings with the Aetna DMO plan. This plan combines the advantages of coordinated care from a primary care dentist (PCD) with a broad range of services to keep members smiling.

Plan features:
- DMO is available at a lower cost than a traditional dental PPO insurance plan.
- Select a participating PCD from Aetna's DMO network.
- Eligible preventive, basic and major services are covered.
- PCD referrals and preauthorization are only required when specialty care is needed.
- No referrals are needed for orthodontia, when covered.
- There are no deductibles or dollar maximums, though certain age, frequency and orthodontia limits may apply.
- There are no waiting periods.
- There are no claim forms to file.

Each family member may select a different PCD. A directory of participating dentists is available online at www.aetna.com/docfind (select Dental Maintenance Organization).

The schedule below is a small portion of the benefits available:

Code	Description	Copay
	Office Visit	$5
D0210	X-rays - complete series	$0
D1110	Cleaning - adult	$0
D1120	Cleaning - child	$0
D1351	Sealants (permanent molars) - under age 16	$0
D2331	Filling (two surfaces) - anterior	$0
D2392	Filling (two surfaces) - posterior	$45
D2751	Crown - porcelain fused to base metal	$225
D3320	Root canal - bicuspid	$70
D4355	Debridement	$60
D5110	Complete denture - upper	$275
D7140	Extraction - erupted tooth or exposed root	$0
Comprehensive orthodontic treatment - adolescent or adult		$1,945

Current Dental Terminology© 2015 American Dental Association

Benefits are provided by: Aetna
PO Box 14094 • Lexington, KY 40512
www.aetna.com • 1-877-238-6200

Participating Dental Network (PDN) Plan

With the Aetna PDN plan, you have the freedom to see any licensed dentist you choose but may save more by seeing a dentist in the Aetna Dental PPO/PDN network.

Plan features:

- Visit any licensed dentist without a referral.
- Eligible preventive, basic and major services are covered.
- Because contracted rates with network dentists are often lower than their regular fees, you may save money by staying in-network and receive more services before reaching your maximum benefit amount per plan year.
- There are no claim forms to file when using in-network providers.

Plan Benefits:

- Preventive Services ..... Plan pays 100%
  (e.g. cleanings, exams, x-rays)
- Basic Services ..... Plan pays 80%
  (e.g. fillings, uncomplicated extractions, scaling, and root planing)
- Major Services ..... Plan pays 50%
  (e.g. crowns, dentures, and root canals)
- Orthodontic Services ..... Plan pays 50%
- Individual Deductible ..... $50 *(waived for preventive services)*
- Family Deductible ..... $150 *(waived for preventive services)*

Plan Waiting Periods
(for New Participants not previously enrolled in any Conroe ISD Aetna dental plan):

- Basic Services ..... 6 month wait
- Major Services ..... 6 month wait
- Orthodontic Services *(for Children Under Age 19)* ..... 12 month wait

Plan Exclusions:
Implants, orthodontia for individuals age 19 years and older, cosmetic dentistry and TMJ. **All other dental procedures are covered – no pre-authorizations required. Age and frequency limits may apply.**

Maximum Benefit Amount Per Person Per Plan Year:
High Plan "A" $1,200
Low Plan "B" $800

Dental Plan features	DMO	PDN Low	PDN High
Plan Basics			
Individual Deductible (waived for preventive services)	None	$50 per plan year	$50 per plan year
Family Deductible (waived for preventive services)	None	$150 per plan year	$150 per plan year
Maximum Benefit Amount per Person	Unlimited	$800 per plan year	$1,200 per plan year
Primary Care Dentist Required	Yes	No	No
Referrals to Specialists Required	Yes	No	No
Out-of-Network Coverage	No	Yes	Yes
Plan Benefits			
Preventive Services (e.g., cleanings, exams, x-rays)	$0 (plan pays 100%)	$0 (plan pays 100%)	$0 (plan pays 100%)
Basic Services (e.g., fillings, scaling, root planing)	Based on copay schedule	20% after deductible	20% after deductible
Major Services (e.g., crowns, dentures, root canals)	Based on copay schedule	50% after deductible	50% after deductible
Orthodontic Services	Based on copay schedule	50%* after deductible	50%* after deductible
Waiting Periods (for new CISD Aetna dental participants only, where applicable)			
Preventive Services (e.g., cleanings, exams, x-rays)	None	None	None
Basic Services (e.g., fillings, scaling, root planing)	None	6 months	6 months
Major Services (e.g., crowns, dentures, root canals)	None	6 months	6 months
Orthodontic Services	None	12 months*	12 months*
Per Paycheck Costs			
Employee Only	$7.97	$13.36	$22.46
Employee and Child(ren)	$12.74	$24.59	$38.62
Employee and Spouse	$13.54	$27.39	$41.43
Employee and Family	$18.00	$41.45	$55.49

**Children under age 19 (no coverage for adults).*

The plans do not cover dental work, including orthodontic treatment, which began before a member is covered under the plan.

Plan administered by:
Aetna
PO Box 14094
Lexington, KY 40512
www.aetna.com
1-877-238-6200

For full details regarding these plans, please review the plan documents online at www.conroeisd.net under Employees—Benefits—Plan Documents.

Vision Plan

VSP (Group # 10-350759)

If you are looking for eye insurance that will help you save money, be healthy and look great then you landed in the right place. With VSP, your vision insurance provides you access to the tools you need to keep your eyes healthy and vision sharp, so you can experience life's moments clearly.

Save Money. VSP is good for your eyes and your wallet because you always get the lowest out-of-pocket costs in vision care. You don't have to cut coupons or wait for a sale – your savings are built into your VSP plan. Plus, you can use a flexible savings account for any out-of-pocket costs, including co-pays, at your VSP doctor's office.

Be Healthy. Your Annual WellVision Exam® is an important part of your overall health routine. During your exam, a VSP doctor will look for vision problems and early signs of other health conditions, like diabetes, high blood pressure, and high cholesterol.

Look Great. VSP gives you access to hundreds of options on styles and designer frames. Plus, VSP offers a wide selection of great brands for you to choose from.

Personalized Care with Great Choices. VSP maintains the highest credentialing requirements for eye doctors to ensure you always receive the very best care. And, VSP offers the largest network of doctors so that you can choose to see who's right for you.

Focus® Plan Summary

	VSP Choice Network + Affiliates	Out of Network
Deductibles	$10 Exam $10 Eye Glass Lenses or Frames*	$10 Exam $10 Eye Glass Lenses or Frames*
Annual Eye Exam	Covered in Full	Up to $45
Lenses (per pair)		
Single Vision	Covered in Full	Up to $30
Bifocal	Covered in Full	Up to $50
Trifocal	Covered in Full	Up to $65
Lenticular	Covered in Full	Up to $100
Progressive	See lens options	N/A
Contacts		
Fit & Follow Up Exams	15% discount See Additional Focus Features	No benefit
Elective	Up to $130	Up to $105
Medically Necessary	Covered in Full	Up to $210
Frames	$130**	Up to $70
Frequencies (months)	Based on date of service	Based on date of service
Exam/Lens/Frame	12/12/12	12/12/12

** Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
*** The Costco allowance will be the wholesale equivalent.*

Lens Options (member cost)*

	VSP Choice Network + Affiliates *(Other than Costco)*	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lense and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	No benefit
Solid Plastic Dye	$15 (except Pink I & II)	No benefit
Plastic Gradient Dye	$17	No benefit
Photochromatic Lenses *(Glass & Plastic)*	$31-$82	No benefit
Scratch Resistant Coating	$17-$33	No benefit
Anti-Reflective Coating	$43-$85	No benefit
Ultraviolet Coating	$16	No benefit

**Lens Option member costs vary by prescription, option chosen and retail locations.*

Additional Focus® Choice Network Features:

Contact Lenses Elective – Allowance includes fitting, exam and lenses. The cost of the fitting and evaluation is deducted from the contact allowance. Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses.

Additional Glasses – 20% discount off the retail price on additional pairs of prescription glasses (complete pair).

Frame Discount – VSP offers a 20% discount off the remaining balance in excess of the frame allowance.

Laser Vision Care – VSP offers an average discount of 15% on LASIK and PRK. The maximum out-of-pocket per eye for members is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.

Low Vision – With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Per Paycheck Costs:
Employee Only $4.40
Employee and Child(ren) $9.46
Employee and Spouse $10.34
Employee and Family $15.96

Benefits are provided by:
VSP • www.vsp.com • 1-800-877-7195

These are highlights of plan benefits provided by Ameritas Life Insurance Corp. This is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, please review the VSP plan document online at www.conroeisd.net under Employees – Benefits – Plan Documents.

Flexible Spending Accounts

First Financial Administrators, Inc. (Group # 56160)

You can lower your taxable income by setting aside money directly from your paycheck into health and dependent care flexible spending accounts (FSAs). This tax-free money can be used to pay for eligible health care and dependent care expenses. Examples of eligible expenses are provided later in this section. For a comprehensive list of eligible expenses, go to www.ffga.com.

You choose the amount you want deducted from each of your paychecks based on your projected eligible expenses for the plan year, which begins September 1 and ends August 31. Conroe ISD offers the following FSA options:

Health FSA funds can be used to pay for out-of-pocket medical, dental, and vision expenses such as copays, deductibles, coinsurance, medical supplies and equipment, mental health and substance abuse treatment, orthodontia, eyeglasses, contact lenses, and common health care purchases such as contact lens solution and first aid supplies. You can contribute between $120 ($10 per paycheck) and $2,600 ($108.33 per paycheck) per year.

Your full annual election for health FSA funds will be available to you at the beginning of the plan year. For example, if you elect to participate in the health care FSA plan and contribute $50 per paycheck, you will have access to your annual election of $1,200 as soon as your coverage begins.

Dependent care FSA funds can be used to pay for child care services for your eligible dependent children under age 13 or for services to care for other qualified dependent family members, such as elder care. In order to be eligible, the care must allow you (and your spouse if you are married) to be gainfully employed, seek gainful employment, or attend school full-time. Dependent care FSA funds cannot be used for dependent health care costs. You can contribute up to $5,000 per year ($208.33 per paycheck) or $2,500 if married and filing separate tax returns.

Dependent care FSA funds are available as deposits are received. Unlike the health FSA, you may only be reimbursed for the expenses you claim up to the amount available in your account. If you submit a dependent care expense voucher in excess of your account balance, the balance of the amount due will be forwarded to you as additional account contributions are received.

Claims for dependent care FSA funds must be submitted within 90 days of the end of the plan year or coverage end date, as applicable. Any unused funds in your account at the end of the plan year or coverage end date will be forfeited and cannot be returned to you.

Individuals making an adjusted gross income of $28,000 or less may be better off taking an itemized deduction on their federal tax return instead of using a dependent care FSA.

Important notes:

- Both FSAs have "use-it-or-lose-it" rules, which means you forfeit any funds remaining in your account at the end of the plan year. For this reason, you may want to conservatively estimate the eligible expenses you and your family will incur during the plan year (September 1 through August 31).
- Expenses must be incurred during the plan year in which funds are contributed. If you have funds remaining in your health FSA when the plan year ends, you will have a two-and-a-half-month grace period to incur eligible claims; any unused funds in your account at the end of the grace period will be forfeited and cannot be returned to you.
- Expenses reimbursed under an FSA cannot be reimbursable to you by a third party, such as your medical insurance company.
- Contribution amounts cannot be changed during the plan year unless you experience a change in status, as discussed in another section of this guide.
- Once you have been reimbursed your maximum annual election amount, you will not be reimbursed for any more expenses.
- Expenses reimbursed under this plan cannot be used when calculating deductions for your federal income tax return.
- You may review your FSA account balances online at www.ffga.com by registering for an online account. You can also use the **FF Flex Mobile App** for Apple® and Android™ devices to access your account information, submit claims, upload receipts, and more.
- If you (or your spouse) contributes to a health savings account (HSA), you are not eligible to contribute to a health FSA.

FFA Benefits Card

The First Financial Administrators, Inc. Benefits Card is available for direct access to health FSA and dependent care FSA funds. One card will be sent to participating employees, and additional cards may be requested for spouses and dependent children (ages 18-26) for no additional fee. If the card is lost or stolen, the replacement cost is $10.00; this fee will be deducted from the account balance. Use of the card for eligible transactions requires a signature and not a PIN; transactions must always be processed as credit.

The IRS requires validation of most transactions, so you must submit receipts for verification of expenses when requested. An itemized receipt must list the provider name, patient name, date of service, a brief description of services received, and the amount you are responsible for. An explanation of benefits (EOB) which can be obtained from your insurance carrier, is also acceptable documentation. If you fail to substantiate by providing the necessary documentation within 60 days of the transaction, your card will be suspended until the itemized receipt or EOB is received.

If funds remain in your account at the end of the plan year and you continue to participate in the FSA benefit during the following plan year, you may also use the debit card during the 2½ month grace period; otherwise, the card will be deactivated and a claim must be submitted for reimbursement. Additionally, if you continue to participate, the system will deduct all remaining funds from your old plan year (during the grace period) before deducting from the balance of the new plan year.

Your FFA Benefits Card cannot be used past your termination date. If you have available funds in your account, a manual claim will be required.

Where to use your FFA Benefits Card:

- Pharmacies
- Physician Offices
- Vision Care Offices
- Medical Clinics
- Emergency Rooms
- In-Store Pharmacies
- Dental Offices
- Medical Facilities
- Hospitals

Examples of eligible and ineligible FSA expenses

For a complete list, go to www.ffga.com. Select view employer benefits, type in "Conroe ISD," and select Flex Eligible Expenses from the quick links box.

Account type

Health FSA *Eligible expenses*

- Alcoholism/Substance abuse treatment
- Ambulance service
- Asthma treatments
- Athletic bandages and braces
- Bandages and gauze pads
- Blood pressure monitoring devices
- Breast pump and breast milk storage bottles or bags
- Chiropractor treatment
- Coinsurance, copayments and deductibles for medical, dental and vision care
- Condoms
- Contact lenses, materials and equipment
- Contraceptives
- Crutches
- Dental care
- Dentures
- Diabetic monitors and supplies
- Durable medical equipment
- Eye exams
- Eyeglasses and related accessories and cleaning supplies
- First aid kit and first aid supplies
- Hearing aids and hearing aid batteries
- Heating pads
- Hospital care
- Incontinence supplies
- Infertility treatment
- Insoles
- Laser eye surgery/lasik/radial keratotomy
- Lip balm with SPF 15 or greater
- Medical records charge
- Nebulizer
- Online or telephone consultation with a medical professional
- Orthodontia
- Pill boxes, pill cutters, pill sorters and pill organizers
- Pregnancy and fertility kits, ovulation monitors and pregnancy tests
- Prenatal vitamins
- Prescription drugs and medicines*
- Prosthesis
- Reading glasses
- Saline nasal spray and sinus rinse
- Sunscreen with SPF 15 or greater
- Telephone or television for a hearing impaired individual
- Thermometer
- Transportation expenses for person to receive medical care
- Walker
- Wheelchair

Health FSA *Ineligible expenses*

- Autopsy
- Aromatherapy
- Baby bottles
- Bug spray, unless combined with sunscreen SPF 15 or greater
- Child care
- Cosmetic procedures that simply improve your appearance, such as face lifts, Botox, dermabrasion, hair transplants, hair removal (electrolysis), liposuction, rhinoplasty and sclerotherapy
- Cosmetics
- Daycare
- Diapers and diaper services
- Diet foods
- Expenses reimbursed by any other health plan or source
- Face wash
- Feminine hygiene products
- Formula
- Funeral expenses
- Hair regrowth or removal
- Illegal operations and treatments
- Insurance premiums

- Late payment provider fees
- Long-term care services
- Marriage counseling
- Maternity clothes
- Missed appointment fees
- Moisturizer
- No-show fees
- Physician retainer fee (for on-call or concierge services)
- Prepayment of medical expenses
- Preschool
- Prescription drugs and medicines obtained from other countries
- Sunscreen with SPF < 15 or suntan lotion; sun protective (SPF) clothing
- Surrogate mother expenses
- Tattoo removal
- Teeth whitening/bleaching
- Toiletries
- Toothbrushes, toothpaste, dental floss, mouthwash etc.

Dependent Care FSA *Eligible expenses*

- Adult day care
- After-school care or extended day care programs
- Child care
- Daycare
- Elder care
- Nanny
- Preschool or nursery school

Dependent Care FSA *Ineligible expenses*

- Child support payments
- Child care payments qualifying as alimony
- Coinsurance, copayments and deductibles for medical, dental and vision services
- Health and medical care costs
- Payments made to someone you can claim as a dependent
- Travel between your home and the dependent care location

**Drugs and medicines must be primarily for medical care, not for personal, general health or cosmetic purposes, and must be legally procured. In addition, over-the-counter expenses will qualify only if the medicine or drug is prescribed or is insulin. A prescription for this purpose is one written by an individual legally licensed to issue prescriptions, meeting the same legal requirements and including the same information as required for a drug or medicine that is available by prescription only. The prescription must be submitted with the expense reimbursement request but the prescription does not have to be filled by a pharmacist.*

Plan administered by:

First Financial Administrators, Inc.
PO Box 670329 • Houston, TX 77267-0329
www.ffga.com • 1-866-853-3539

Accidental Death and Dismemberment Insurance

Reliance Standard (Group # VAR 053228)

Accidents by their sudden nature often leave families unprepared to meet the resulting financial impact. With this in mind, CISD offers employees a Group Voluntary Accidental Death & Dismemberment (AD&D) Insurance Plan.

Benefits

The plan offers you protection 24 hours a day, 365 days a year, against losses from covered accidents on or off the job, on business, on vacation or at home. The plan provides you coverage as a passenger (not a crew member) in any civilian or corporate owned or leased aircraft licensed to carry passengers and piloted by a duly qualified licensed pilot.

If an injury results in death or dismemberment within one year of a covered accident which occurs while insured, benefits will be paid for

Loss of:

Life .....Full Benefit Amount
Two or More Members* .....Full Benefit Amount
Speech and Hearing .....Full Benefit Amount
One Member* .....1/2 Benefit Amount
Speech or Hearing .....1/2 Benefit Amount
Thumb & Index Finger (same hand) .....1/4 Benefit Amount

** "Member(s)" means: hand, foot or eye*

You may select benefit amounts of AD&D insurance from $10,000 (minimum) to $500,000 (maximum) in increments of $10,000. Amounts in excess of $150,000 are limited to ten times your annual salary. Benefit Amounts reduce at age 75, to 50% and at age 80, to 25%, of the pre-age 75 amount and terminate at retirement.

Under the family plan, you may also cover your spouse and dependent child(ren). The Benefit Amount which applies to insured dependents is based on the composition of the family at the time of loss and is a percentage of your Benefit Amount as follows:

Spouse with no covered Dependent Child(ren) 60%
Spouse with covered Dependent Child(ren) 60%
Each Dependent Child 15%
Each Dependent Child (if no spouse) 20%

Additional Benefits: Reserve-National Guard Coverage, Exposure and Disappearance Coverage, Seat Belt and Air Bag Benefit, Increased Dismemberment Benefit for Insured Children, Education and Survivor Benefit, Coma Benefit, and Conversion Privilege.

What is not covered

Benefits are not paid for a loss: (1) to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or (2) caused by suicide, or intentionally self-inflicted injuries; or (3) caused by or resulting from war or any act of war, declared or undeclared; or (4) caused by an accident that occurs while in the armed forces of any country; (5) serving as a pilot or crew member in any aircraft; or (6) sustained during the Insured's commission or attempted commission of an assault or felony.

Limitations

Reliance Standard may contest any claim submitted during the first two years that your insurance is in force. Insurance coverage is incontestable after it has been in force two years during your lifetime except for non-payment of premium.

Your Beneficiary

Benefits are paid to the person you have named during your enrollment for loss of your life. Benefits for other covered losses will be paid to you. You are the beneficiary of your dependent's benefits.

Per Paycheck Costs:

Employee Only .....$0.11 per $10,000
Employee and Family .....$0.185 per $10,000

Enrollment in this plan is not a contract; benefits are determined in accordance with the master contract on file with the Policyholder.

Benefits are provided by:

Reliance Standard Life Insurance Company
PO Box 8330 • Philadelphia, PA 19101-8330
www.reliancestandard.com • 1-800-435-7775

Group Voluntary Cancer and Specified Disease Insurance

Allstate Benefits (Group # 11535)

No one likes to think about getting cancer. But in the US, men have slightly less than a 1 in 2 lifetime risk of developing cancer; for women, the risk is a little more than 1 in 3.[1] Cancer may not be preventable, but you can protect yourself from some of the costs.

[1] *Cancer Facts & Figures, American Cancer Society, 2010*

Allstate Benefits (AB) group voluntary cancer coverage provides cash benefits for cancer and 29 specified diseases, and can help cover the costs of specific cancer and specified disease treatments and expenses as they happen.

Being diagnosed with cancer or a specified disease can be difficult on anyone both emotionally and financially. Having the right coverage to help when sickness occurs or when undergoing treatments for cancer is important. Our cancer coverage can help provide added financial security when it is needed most:

- Benefits paid directly to you unless otherwise assigned
- Coverage for you or your entire family
- No evidence of insurability required at initial enrollment (enrolling after your initial enrollment period requires evidence of insurability)
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts (primary insured only)
- Includes coverage for 29 other specified diseases
- Portable

Summary of Benefits

Hospital and Related Benefits		**Low**	**Medium**	**High**
Continuous Hospital Confinement *(daily)*		$300	$300	$400
Government or Charity Hospital *(daily)*		$300	$300	$400
Private Duty Nursing Services *(daily)*		$300	$300	$400
Extended Care Facility *(daily)*		$300	$300	$400
At Home Nursing *(daily)*		$300	$300	$400
Hospice Care Center *(daily)*		1. $300	1. $300	1. $400
Hospice Care Team *(per visit)*		2. $300	2. $300	2. $400
Radiation, Chemotherapy, and Related Benefits				
Radiation/Chemotherapy for Cancer *(every 12 mos.)*		$7,500*	$15,000*	$30,000*
Blood, Plasma, and Platelets *(every 12 mos.)*		$7,500*	$15,000*	$30,000*
Medical Imaging *(yearly)*		$375*[4]	$750*[4]	$1,500*[4]
Hematological Drugs *(yearly)*		$150*	$300*	$600*
Surgery and Related Benefits				
Surgery		$1,500*[2]	$3,000*[2]	$4,500*[2]
Anesthesia *(% of surgery)*		25%	25%	25%
Ambulatory Surgical Center *(daily)*		$250	$500	$750
Second Opinion		$200	$400	$600
Bone Marrow or Stem Cell Transplant	1. Autologous	1. $500[4]	1. $1,000[4]	1. $1,500[4]
	2. Non-autologous	2. $1,250[4]	2. $2,500[4]	2. $3,750[4]
	3. Non-autologous for leukemia	3. $2,500[4]	3. $5,000[4]	3. $7,500[4]
Miscellaneous Benefits				
Inpatient Drugs and Medicine *(daily)*		$25	$25	$25
Physician's Attendance *(daily)*		$50	$50	$50
Ambulance *(per confinement)*		$100	$100	$100
Non-Local Transportation *(per trip or mile)*		Coach Fare or $0.40	Coach Fare or $0.40	Coach Fare or $0.40
Outpatient Lodging *(daily)*		$50*[1]	$50*[1]	$50*[1]
Family Member Lodging *(daily)* and Transportation *(per trip or mile)*		$50* Coach Fare or $0.40	$50* Coach Fare or $0.40	$50* Coach Fare or $0.40
Physical or Speech Therapy *(daily)*		$50	$50	$50
New or Experimental Treatment *(every 12 mos.)*		$5,000*	$5,000*	$5,000*
Prosthesis		$2,000*[3]	$2,000*[3]	$2,000*[3]
Hair Prosthesis *(every 2 years)*		$25	$25	$25
Nonsurgical External Breast Prosthesis		$50*	$50*	$50*
Anti-Nausea Benefit *(yearly)*		$200*	$200*	$200*
Waiver of Premium *(primary insured only)*		Yes	Yes	Yes
Additional Benefits				
Cancer Initial Diagnosis		$5,000[5]	$5,000[5]	$5,000[5]
Wellness *(yearly)*		$100[4]	$100[4]	$100[4]
Intensive Care	1. Intensive Care Confinement (daily)	1. $300	1. $300	1. $300
	2. Step-down Confinement (daily)	2. $150	2. $150	2. $150
	3. Air/Surface Ambulance	3. Charges	3. Charges	3. Charges

** Benefit pays for charges/costs up to amount listed*
[1] Limit $2,000/12 mo. period
[2] Based on procedure up to maximum shown
[3] Per amputation
[4] Payable once/per covered person/per calendar year
[5] One time benefit

Limitations, Exclusions, and Exceptions

Pre-Existing Condition: (a) AB does not pay benefits for a pre-existing condition, during the 12-month period beginning on the date that person's coverage starts. (b) A pre-existing condition is a disease or condition for which symptoms existed within the 12-month period prior to the effective date; or (c) medical advice or treatment was recommended or received from a medical professional within the 12-month period prior to the effective date. (d) A pre-existing condition can exist even though a diagnosis has not yet been made.

Cancer and Specified Disease Benefits Exclusions and Limitations: (a) AB does not pay for any loss, except for losses due to cancer or a specified disease. (b) Benefits are not paid for conditions caused or aggravated by cancer or a specified disease. Treatment and services must be needed due to cancer or a specified disease and be received in the United States or its territories. For the *Surgery, New or Experimental Treatment and Prosthesis* benefits, AB pays 50% of the applicable maximum when specific charges are not obtainable as proof of loss.

For the *Radiation/Chemotherapy for Cancer* benefit AB does not pay for: (a) any other chemical substance which may be administered with or in conjunction with radiation/chemotherapy; or (b) treatment planning consultation; management; or the design and construction of treatment devices; or basic radiation dosimetry calculation; or any type of laboratory tests; X-ray or other imaging used for diagnosis or monitoring; or the diagnostic tests related to these treatments; or (c) any devices or supplies including intravenous solutions and needles related to these treatments.

Intensive Care Benefits Exclusions and Limitations: (a) Benefits are not paid for: (1) attempted suicide or intentional self-inflicted injury; (2) intoxication or being under the influence of drugs not prescribed by a physician; or (3) alcoholism or drug addiction. (b) Benefits are not paid for confinements to a care unit that does not qualify as a hospital intensive care unit including progressive care, subacute intensive care, intermediate care, private rooms with monitoring, step-down and other lesser care units. (c) Benefits are not paid for step-down confinements in the following units: telemetry or surgical recovery rooms; post-anesthesia care; progressive care; intermediate care; private monitored rooms; observation units in emergency rooms; or other facilities that do not meet the standards for a step-down hospital intensive care unit. (d) Benefits are not paid for continuous intensive care confinements occurring during a hospitalization prior to the effective date. (e) Children born within 10 months of the effective date are not covered for confinement occurring or beginning during the first 30 days of the child's life. (f) We do not pay for ambulance if paid under the cancer and specified disease ambulance benefit.

Per Paycheck Costs:

	Low	**Medium**	**High**
Employee Only	$12.21	$17.30	$27.19
Employee and Child(ren)	$17.19	$24.55	$38.84
Employee and Spouse	$19.39	$27.05	$41.91
Employee and Family	$24.37	$34.29	$53.55

Benefits are provided by:
American Heritage Life Insurance Company
1776 American Heritage Life Dr • Jacksonville, FL 32224
www.allstateatwork.com • 1-800-521-3535

Group Cancer and Specified Disease benefits provided by policy GVCP3, or state variations thereof. This information highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy itself sets forth, in detail, the rights and obligations of both the policyholder (employer) and the insurance company. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation© 2012 Allstate Insurance Company. www.allstate.com or www.allstateatwork.com

Critical Illness Insurance

Aflac (Group #22863)

Aflac can help ease the financial stress of surviving a critical illness.

Chances are you may know someone who's been diagnosed with a critical illness. You can't help notice the difference in the person's life—both physically and emotionally. What's not so obvious is the impact a critical illness may have on someone's personal finances.

That's because while a major medical plan may pay for a good portion of the costs associated with a critical illness, there are a lot of expenses that may not be covered. And, during recovery, having to worry about out-of-pocket expenses is the last thing anyone needs.

That's the benefit of an Aflac Group Critical Illness plan.

It can help with the treatment costs of covered critical illnesses, such as a heart attack or stroke.

More importantly, the plan helps you focus on recuperation instead of the distraction of out-of-pocket costs. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned) – giving you

the flexibility to help pay bills related to treatment or to help with everyday living expenses.

Understanding the facts can help you decide if the Aflac group Critical Illness plan makes sense for you.

Fact number 1:
An estimated 83.6 million American adults – greater than one in three – have one or more types of cardiovascular disease (CVD).[1]

Fact number 2:
$108.9 billion – the amount of money coronary heart disease costs the United States. This total includes the cost of health care services, medications, and lost productivity.[2]

[1] American Heart Association/American Stroke Association 2013 Statistical Fact Sheet
[2] Centers for Disease Control and Prevention Heart Disease Fact Sheet 2015

Here's why the Aflac Group Critical Illness plan may be right for you: For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. The Aflac Group Critical Illness plan is just another innovative way to help make sure you're well protected under our wing.

But it doesn't stop there. Having group critical illness insurance from Aflac means that you may have added financial resources to help with medical costs or ongoing living expenses.

The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Stroke
  - Skin Cancer
  - Sudden Cardiac Arrest
  - Severe Burn
  - Coma
  - Loss of Sight
  - Loss of Speech
  - Bone Marrow Transplant (Stem Cell Transplant)
  - Heart Attack (Myocardial Infarction)
  - Kidney Failure (End-Stage Renal Failure)
  - Non-Invasive Cancer
  - Major Organ Transplant
  - Coronary Artery Bypass Surgery
  - Paralysis
  - Loss of Hearing
- Health Screening Benefit

Features:

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four days.

How it works:

Aflac Group Critical Illness Advantage coverage is selected.
⇩
You experience chest pains and numbness in the left arm.
⇩
You visit the emergency room.
⇩
A physician determines that you have suffered a heart attack.
⇩
Aflac Group Critical Illness Advantage pays a First Occurrence Benefit of $10,000[1].

[1]Amount payable based on $10,000 First Occurrence Benefit

Benefits Overview

Covered critical illnesses:

Cancer (internal or invasive)	100%
Heart attack (myocardial infarction)	100%
Stroke (ischemic or hemorrhagic)	100%
Major organ transplant	100%
Kidney failure (end-stage renal failure)	100%
Bone marrow transplant (stem cell transplant)	100%
Sudden cardiac arrest	100%
Severe Burns*	100%
Coma**	100%
Paralysis**	100%
Loss of sight/hearing/speech**	100%
Non-invasive cancer	25%
Coronary artery bypass surgery	25%

* This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.
** These benefits are payable for loss due to a covered underlying disease or a covered accident.

Initial Diagnosis We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

Additional Diagnosis We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

Reoccurrence We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

Child Coverage at no Additional Cost Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge. Children-only coverage is not available.

Costs

Employee Monthly Premiums by Benefit Amount

Employee – Nontobacco User

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$5.10	$7.19	$9.27	$11.36	$13.44	$15.53	$17.61	$19.70	$21.78	$23.87
30-39	$6.42	$9.83	$13.23	$16.63	$20.04	$23.44	$26.84	$30.24	$33.65	$37.05
40-49	$9.66	$16.31	$22.95	$29.60	$36.24	$42.89	$49.53	$56.18	$62.82	$69.46
50-59	$15.27	$27.53	$39.78	$52.03	$64.29	$76.54	$88.79	$101.05	$113.30	$125.55
60-69	$23.31	$43.60	$63.89	$84.18	$104.47	$124.76	$145.05	$165.34	$185.63	$205.92

Employee – Tobacco User

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$5.96	$8.89	$11.83	$14.76	$17.70	$20.63	$23.57	$26.50	$29.44	$32.37
30-39	$8.33	$13.65	$18.96	$24.28	$29.59	$34.90	$40.22	$45.53	$50.85	$56.16
40-49	$13.47	$23.93	$34.38	$44.84	$55.29	$65.74	$76.20	$86.65	$97.11	$107.56
50-59	$22.81	$42.59	$62.38	$82.17	$101.95	$121.74	$141.52	$161.31	$181.10	$200.88
60-69	$34.69	$66.35	$98.02	$129.68	$161.35	$193.02	$224.68	$256.35	$288.01	$319.68

Spouse Monthly Premiums by Benefit Amount

Spouse – Nontobacco User

Issue Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$5.10	$6.15	$7.19	$8.23	$9.27	$10.32	$11.36	$12.40	$13.44
30-39	$6.42	$8.12	$9.83	$11.53	$13.23	$14.93	$16.63	$18.33	$20.04
40-49	$9.66	$12.99	$16.31	$19.63	$22.95	$26.28	$29.60	$32.92	$36.24
50-59	$15.27	$21.40	$27.53	$33.65	$39.78	$45.91	$52.03	$58.16	$64.29
60-69	$23.31	$33.46	$43.60	$53.75	$63.89	$74.04	$84.18	$94.33	$104.47

Spouse – Tobacco User

Issue Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$5.96	$7.42	$8.89	$10.36	$11.83	$13.29	$14.76	$16.23	$17.70
30-39	$8.33	$10.99	$13.65	$16.31	$18.96	$21.62	$24.28	$26.93	$29.59
40-49	$13.47	$18.70	$23.93	$29.16	$34.38	$39.61	$44.84	$50.06	$55.29
50-59	$22.81	$32.70	$42.59	$52.49	$62.38	$72.27	$82.17	$92.06	$101.95
60-69	$34.69	$50.52	$66.35	$82.19	$98.02	$113.85	$129.68	$145.52	$161.35

Skin Cancer Benefit We will pay $250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

Waiver of Premium If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.

Successor Insured Benefit If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

Health Screening Benefit ***(Employee and Spouse only)*** We will pay $100 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year. This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

Covered Health Screening Tests Include:
- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Spiral CT screening for lung cancer
- Stress test on a bicycle or treadmill
- Thermography

Progressive Disease Rider
Amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease).....100%
Sustained multiple sclerosis 100%

These benefits will be based on the face amount in effect on the critical illness date of diagnosis.

Optional Benefits Rider
Benign brain tumor 100%
Advanced Alzheimer's disease 25%
Advanced Parkinson's disease 25%

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis.

Notices

If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under the plan could be assigned. This means that you may not receive any of the benefits outlined in the plan. Please check the coverage in all health insurance plans you already have or may have before you purchase the insurance outlined in this summary to verify the absence of any assignments or liens.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

The plan has limitations and exclusions that may affect benefits payable. This booklet is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

Underwritten by:
Continental American Insurance Company, an Aflac subsidiary
2801 Devine Street • Columbia, SC 29205
www.aflacgroupinsurance.com • 1-800-433-3036

Disability Insurance

Standard Insurance Company (Group # 645657-A)

Standard Insurance Company has prepared the following material to provide you with information about the Voluntary Disability insurance available to you. It is not intended to provide a detailed description of the coverage. Please note that defined terms and provisions from the *group policy* are *italicized* throughout the information.

Features

Chances are you already purchase home, auto and life insurance to protect yourself against the threat of loss. And you probably have health insurance to guard against costly medical bills. So, what steps have you taken to help shield yourself, your lifestyle and those who count on you from an unexpected loss of income? Would you be able to meet your financial obligations if you became disabled and unable to work?

Group Long Term Disability (LTD) insurance is designed to pay a monthly benefit to you in the event you cannot work because of a covered illness or injury. This benefit replaces a portion of your income, thus helping you to meet your financial commitments in a time of need.

By sponsoring group Voluntary LTD insurance for educators and administrators from Standard Insurance Company, your *employer* offers you an excellent opportunity to help protect yourself and your lifestyle. The advantages to you include: Convenience – with premiums deducted directly from your paycheck, you do not have to worry about mailing monthly payments; and Peace of Mind – you can take comfort and satisfaction in knowing that you have taken a step toward securing your income during a period of a covered *disability.*

Commonly Asked Questions

When does my insurance coverage become effective? The effective date of your coverage depends on when you become a *member* and when you apply for insurance. If you apply and agree to pay premiums, your coverage becomes effective on:
- The date you become eligible if you apply on or before that date; OR
- The first of the month coinciding with or next following the date you apply if you apply within 31 days of becoming eligible; OR
- The first day of the next plan year following the end of the Annual Enrollment Period, if you apply during the Annual Enrollment Period.

In every case, you must also meet an *active work* requirement before your insurance becomes effective. If you do not apply for this coverage within 31 days of becoming eligible, and later decide to do so, you must wait until your employer holds an annual enrollment.

Will I have to provide information regarding my medical history to become insured? The Standard does not require medical history information to become insured under this Voluntary LTD insurance plan at initial and annual enrollments. If applicable, *evidence of insurability* satisfactory to The Standard may be required for reinstatement of terminated coverage.

What is a preexisting condition? At any time during the 90-day period just before your insurance becomes effective, a *preexisting condition* is a mental or physical condition whether or not diagnosed or misdiagnosed:
- For which you have consulted a *physician* or other licensed medical professional; received medical treatment, services or advice; undergone diagnostic procedures, including self-administered procedures; or taken prescribed drugs or medications,

- Which, as a result of any medical examination, including routine examination, was discovered or suspected.

When am I considered disabled?
Own Occupation Period: During the *benefit waiting period* and the *own occupation period,* you are considered disabled if, as a result of *physical disease, injury, pregnancy* or *mental disorder:*

- You are unable to perform with reasonable continuity the *material duties* of your own occupation, and
- You suffer a loss of at least 20 percent of your *indexed pre-disability earnings* when working in your *own occupation.*

You are not *disabled* merely because your right to perform your *own occupation* is restricted, including a restriction or loss of license. During the *own occupation period* you may work in another occupation while you meet the *own occupation definition of disability.* However, you will no longer be *disabled* when your *work earnings* from another occupation meet or exceed 80% of your *indexed pre-disability earnings.*

Any Occupation Period: Thereafter, you are considered *disabled* if, as a result of *physical disease, injury, pregnancy* or *mental disorder,* you are unable to perform with reasonable continuity the *material duties* of *any occupation* which you are able to perform, whether due to education, training or experience:

- Which is available at one or more locations in the national economy, and
- In which you can be expected to earn at least 60 percent of your *indexed pre-disability earnings* within 12 months following your return to work, regardless of whether you are working in that or any other occupation.

What are the maximum benefit periods? The maximum periods for which benefits are payable are determined by your age when *disability* begins, as shown in the tables below:

Option A: Maximum benefit to age 65 for both accident and sickness

Age	Maximum Benefit Period
59 or younger	To age 65
60-64	5 years
65-68	To age 70
69 or older	1 year

Option B: Maximum benefit to age 65 for accident and 5 years for sickness

For *disability* caused by accidental *injury:*

Age	Maximum Benefit Period
61 or younger	To age 65, or for 3 years 6 months, if longer
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

For *disability* due to any other cause:

Age	Maximum Benefit Period
61 or younger	To age 65, or for 5 years, whichever is shorter
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

How is the LTD benefit amount calculated? The *LTD benefit* amount is determined by multiplying your insured *pre-disability earnings* by a specified benefit percentage. This amount is then reduced by other income you receive or are eligible to receive while *LTD benefits* are payable. This other income is referred to as *deductible income.*

In the following example, the *LTD benefit* amount is 60 percent of insured *pre-disability earnings.* If your monthly earnings (or *pre-disability earnings*) before becoming *disabled* were $2,000 and you now receive a monthly Social Security disability benefit of $600 and a monthly state disability benefit of $200, your monthly *LTD benefit* would be calculated as follows:

Insured *pre-disability earnings*	$2,000
LTD benefit percentage	x 60%
	$1,200
Less Social Security disability benefit	– $600
Less state disability income benefit	– $200
Amount of *LTD benefit*	**$400**

What is deductible income? *Deductible income* is income you receive or are eligible to receive while *LTD benefits* are payable. During the first 12 months that *LTD benefits* are payable, *deductible income* includes but is not limited to:

- Benefits under any worker's compensation law or similar law
- Amounts due from your *employer's* sabbatical leave plan, or similar leave of absence plan, less the cost of paying a substitute teacher if required to do so
- Amounts due from your *employer's* assault leave plan, or similar leave of absence plan, paid as a result of your being physically assaulted while acting in your official capacity
- Earnings from work activity while you are *disabled*, plus the earnings you could receive if you worked as much as you are able to considering your *disability*
- Any amount you receive by compromise, settlement or other method as a result of a claim for any of the above

Exceptions to *deductible income* include but are not limited to:

- Any cost of living increase in any *deductible income* other than *work earnings*, if the increase becomes effective while you are eligible for the *deductible income*
- Reimbursement for hospital, medical, or surgical expense
- Reasonable attorney fees incurred in connection with a claim for *deductible income*
- Benefits from any individual disability insurance policy
- Early retirement benefits under the Federal Social Security Act which are not actually received
- Group credit or mortgage disability insurance benefits
- Accelerated death benefits paid under a life insurance policy
- Any contract or escrow earnings earned from your *employer* for work performed during the regular, contracted school year, but paid during the summer
- Benefits from the following: profit sharing plan; thrift or savings plan; deferred compensation plan; plan under IRC Section 401(k), 408(k), 408(p), or 457; individual retirement account (IRA); tax sheltered annuity (TSA) under IRC Section 403(b); stock ownership plan; or Keogh (HR-10) plan

What are some of the other features and services provided with this coverage? The following features and services are provided:

- It covers *disabilities* that occur 24 hours a day, both on and off the job.
- It includes an Employee Assistance Program and WorkLife Services, provided and administered by Horizon Behavioral Services, to offer support, guidance and resources to help you and your family resolve personal issues.
- Since premium payments are made with "after-tax" dollars, *LTD benefits* are federally tax-free under current federal tax law.
- If your *employer* makes an approved work-site modification that enables you to return to work while disabled, The Standard will reimburse your *employer* up to a pre-approved amount for some or all of the cost of the modification.
- While *LTD Benefits* are payable, you may qualify to participate in a rehabilitation plan that prepares you to return to work; if you qualify, The Standard may pay for return to work expenses you incur, such as job search, training and education and *family care expenses*.
- If you die while *LTD Benefits* are payable, and on the date you die you have been continuously *disabled* for at least 180 days, a *survivors benefit* equal to three times your unreduced *LTD benefit* may be payable; any *survivors benefit* payable will first be applied to any overpayment of your claim due to The Standard.

Standard Insurance Company Monthly Rate Tables

Option A: Maximum benefit period to age 65 for both accident and sickness:

Annual Earnings	Monthly Earnings	Monthly Disability Benefit	Accident/Sickness Benefit Waiting Period (in days) Cost Per Month					
			0 / 3*	14 / 14*	30 / 30*	60 / 60	90 / 90	180 / 180
3,600	300	200	8.98	7.00	5.92	3.84	3.32	2.48
5,400	450	300	13.47	10.50	8.88	5.76	4.98	3.72
7,200	600	400	17.96	14.00	11.84	7.68	6.64	4.96
9,000	750	500	22.45	17.50	14.80	9.60	8.30	6.20
10,800	900	600	26.94	21.00	17.76	11.52	9.96	7.44
12,600	1,050	700	31.43	24.50	20.72	13.44	11.62	8.68
14,400	1,200	800	35.92	28.00	23.68	15.36	13.28	9.92
16,200	1,350	900	40.41	31.50	26.64	17.28	14.94	11.16
18,000	1,500	1,000	44.90	35.00	29.60	19.20	16.60	12.40
19,800	1,650	1,100	49.39	38.50	32.56	21.12	18.26	13.64
21,600	1,800	1,200	53.88	42.00	35.52	23.04	19.92	14.88
23,400	1,950	1,300	58.37	45.50	38.48	24.96	21.58	16.12
25,200	2,100	1,400	62.86	49.00	41.44	26.88	23.24	17.36
27,000	2,250	1,500	67.35	52.50	44.40	28.80	24.90	18.60
28,800	2,400	1,600	71.84	56.00	47.36	30.72	26.56	19.84
30,600	2,550	1,700	76.33	59.50	50.32	32.64	28.22	21.08
32,400	2,700	1,800	80.82	63.00	53.28	34.56	29.88	22.32
34,200	2,850	1,900	85.31	66.50	56.24	36.48	31.54	23.56
36,000	3,000	2,000	89.80	70.00	59.20	38.40	33.20	24.80
37,800	3,150	2,100	94.29	73.50	62.16	40.32	34.86	26.04
39,600	3,300	2,200	98.78	77.00	65.12	42.24	36.52	27.28
41,400	3,450	2,300	103.27	80.50	68.08	44.16	38.18	28.52
43,200	3,600	2,400	107.76	84.00	71.04	46.08	39.84	29.76
45,000	3,750	2,500	112.25	87.50	74.00	48.00	41.50	31.00
46,800	3,900	2,600	116.74	91.00	76.96	49.92	43.16	32.24
48,600	4,050	2,700	121.23	94.50	79.92	51.84	44.82	33.48
50,400	4,200	2,800	125.72	98.00	82.88	53.76	46.48	34.72
52,200	4,350	2,900	130.21	101.50	85.84	55.68	48.14	35.96
54,000	4,500	3,000	134.70	105.00	88.80	57.60	49.80	37.20
55,800	4,650	3,100	139.19	108.50	91.76	59.52	51.46	38.44
57,600	4,800	3,200	143.68	112.00	94.72	61.44	53.12	39.68
59,400	4,950	3,300	148.17	115.50	97.68	63.36	54.78	40.92
61,200	5,100	3,400	152.66	119.00	100.64	65.28	56.44	42.16
63,000	5,250	3,500	157.15	122.50	103.60	67.20	58.10	43.40
64,800	5,400	3,600	161.64	126.00	106.56	69.12	59.76	44.64
66,600	5,550	3,700	166.13	129.50	109.52	71.04	61.42	45.88
68,400	5,700	3,800	170.62	133.00	112.48	72.96	63.08	47.12
70,200	5,850	3,900	175.11	136.50	115.44	74.88	64.74	48.36
72,000	6,000	4,000	179.60	140.00	118.40	76.80	66.40	49.60
73,800	6,150	4,100	184.09	143.50	121.36	78.72	68.06	50.84
75,600	6,300	4,200	188.58	147.00	124.32	80.64	69.72	52.08
77,400	6,450	4,300	193.07	150.50	127.28	82.56	71.38	53.32
79,200	6,600	4,400	197.56	154.00	130.24	84.48	73.04	54.56
81,000	6,750	4,500	202.05	157.50	133.20	86.40	74.70	55.80
82,800	6,900	4,600	206.54	161.00	136.16	88.32	76.36	57.04
84,600	7,050	4,700	211.03	164.50	139.12	90.24	78.02	58.28
86,400	7,200	4,800	215.52	168.00	142.08	92.16	79.68	59.52
88,200	7,350	4,900	220.01	171.50	145.04	94.08	81.34	60.76
90,000	7,500	5,000	224.50	175.00	148.00	96.00	83.00	62.00
91,800	7,650	5,100	228.99	178.50	150.96	97.92	84.66	63.24
93,600	7,800	5,200	233.48	182.00	153.92	99.84	86.32	64.48
95,400	7,950	5,300	237.97	185.50	156.88	101.76	87.98	65.72
97,200	8,100	5,400	242.46	189.00	159.84	103.68	89.64	66.96
99,000	8,250	5,500	246.95	192.50	162.80	105.60	91.30	68.20
100,800	8,400	5,600	251.44	196.00	165.76	107.52	92.96	69.44
102,600	8,550	5,700	255.93	199.50	168.72	109.44	94.62	70.68
104,400	8,700	5,800	260.42	203.00	171.68	111.36	96.28	71.92
106,200	8,850	5,900	264.91	206.50	174.64	113.28	97.94	73.16
108,000	9,000	6,000	269.40	210.00	177.60	115.20	99.60	74.40
109,800	9,150	6,100	273.89	213.50	180.56	117.12	101.26	75.64
111,600	9,300	6,200	278.38	217.00	183.52	119.04	102.92	76.88
113,400	9,450	6,300	282.87	220.50	186.48	120.96	104.58	78.12
115,200	9,600	6,400	287.36	224.00	189.44	122.88	106.24	79.36
117,000	9,750	6,500	291.85	227.50	192.40	124.80	107.90	80.60
118,800	9,900	6,600	296.34	231.00	195.36	126.72	109.56	81.84
120,600	10,050	6,700	300.83	234.50	198.32	128.64	111.22	83.08
122,400	10,200	6,800	305.32	238.00	201.28	130.56	112.88	84.32
124,200	10,350	6,900	309.81	241.50	204.24	132.48	114.54	85.56
126,000	10,500	7,000	314.30	245.00	207.20	134.40	116.20	86.80
127,800	10,650	7,100	318.79	248.50	210.16	136.32	117.86	88.04
129,600	10,800	7,200	323.28	252.00	213.12	138.24	119.52	89.28
131,400	10,950	7,300	327.77	255.50	216.08	140.16	121.18	90.52
133,200	11,100	7,400	332.26	259.00	219.04	142.08	122.84	91.76
135,000	11,250	7,500	336.75	262.50	222.00	144.00	124.50	93.00
136,800	11,400	7,600	341.24	266.00	224.96	145.92	126.16	94.24
138,600	11,550	7,700	345.73	269.50	227.92	147.84	127.82	95.48
140,400	11,700	7,800	350.22	273.00	230.88	149.76	129.48	96.72
142,200	11,850	7,900	354.71	276.50	233.84	151.68	131.14	97.96
144,000	12,000	8,000	359.20	280.00	236.80	153.6	132.80	99.20

Option B: Maximum benefit period to age 65 for accident and 5 years for sickness:

Annual Earnings	Monthly Earnings	Monthly Disability Benefit	Accident/Sickness Benefit Waiting Period (in days) Cost Per Month					
			0 / 3*	14 / 14*	30 / 30*	60 / 60	90 / 90	180 / 180
3,600	300	200	7.98	6.16	5.32	3.44	2.94	2.24
5,400	450	300	11.97	9.24	7.98	5.16	4.41	3.36
7,200	600	400	15.96	12.32	10.64	6.88	5.88	4.48
9,000	750	500	19.95	15.40	13.30	8.60	7.35	5.60
10,800	900	600	23.94	18.48	15.96	10.32	8.82	6.72
12,600	1,050	700	27.93	21.56	18.62	12.04	10.29	7.84
14,400	1,200	800	31.92	24.64	21.28	13.76	11.76	8.96
16,200	1,350	900	35.91	27.72	23.94	15.48	13.23	10.08
18,000	1,500	1,000	39.90	30.80	26.60	17.20	14.70	11.20
19,800	1,650	1,100	43.89	33.88	29.26	18.92	16.17	12.32
21,600	1,800	1,200	47.88	36.96	31.92	20.64	17.64	13.44
23,400	1,950	1,300	51.87	40.04	34.58	22.36	19.11	14.56
25,200	2,100	1,400	55.86	43.12	37.24	24.08	20.58	15.68
27,000	2,250	1,500	59.85	46.20	39.90	25.80	22.05	16.80
28,800	2,400	1,600	63.84	49.28	42.56	27.52	23.52	17.92
30,600	2,550	1,700	67.83	52.36	45.22	29.24	24.99	19.04
32,400	2,700	1,800	71.82	55.44	47.88	30.96	26.46	20.16
34,200	2,850	1,900	75.81	58.52	50.54	32.68	27.93	21.28
36,000	3,000	2,000	79.80	61.60	53.20	34.40	29.40	22.40
37,800	3,150	2,100	83.79	64.68	55.86	36.12	30.87	23.52
39,600	3,300	2,200	87.78	67.76	58.52	37.84	32.34	24.64
41,400	3,450	2,300	91.77	70.84	61.18	39.56	33.81	25.76
43,200	3,600	2,400	95.76	73.92	63.84	41.28	35.28	26.88
45,000	3,750	2,500	99.75	77.00	66.50	43.00	36.75	28.00
46,800	3,900	2,600	103.74	80.08	69.16	44.72	38.22	29.12
48,600	4,050	2,700	107.73	83.16	71.82	46.44	39.69	30.24
50,400	4,200	2,800	111.72	86.24	74.48	48.16	41.16	31.36
52,200	4,350	2,900	115.71	89.32	77.14	49.88	42.63	32.48
54,000	4,500	3,000	119.70	92.40	79.80	51.60	44.10	33.60
55,800	4,650	3,100	123.69	95.48	82.46	53.32	45.57	34.72
57,600	4,800	3,200	127.68	98.56	85.12	55.04	47.04	35.84
59,400	4,950	3,300	131.67	101.64	87.78	56.76	48.51	36.96
61,200	5,100	3,400	135.66	104.72	90.44	58.48	49.98	38.08
63,000	5,250	3,500	139.65	107.80	93.10	60.20	51.45	39.20
64,800	5,400	3,600	143.64	110.88	95.76	61.92	52.92	40.32
66,600	5,550	3,700	147.63	113.96	98.42	63.64	54.39	41.44
68,400	5,700	3,800	151.62	117.04	101.08	65.36	55.86	42.56
70,200	5,850	3,900	155.61	120.12	103.74	67.08	57.33	43.68
72,000	6,000	4,000	159.60	123.20	106.40	68.80	58.80	44.80
73,800	6,150	4,100	163.59	126.28	109.06	70.52	60.27	45.92
75,600	6,300	4,200	167.58	129.36	111.72	72.24	61.74	47.04
77,400	6,450	4,300	171.57	132.44	114.38	73.96	63.21	48.16
79,200	6,600	4,400	175.56	135.52	117.04	75.68	64.68	49.28
81,000	6,750	4,500	179.55	138.60	119.70	77.40	66.15	50.40
82,800	6,900	4,600	183.54	141.68	122.36	79.12	67.62	51.52
84,600	7,050	4,700	187.53	144.76	125.02	80.84	69.09	52.64
86,400	7,200	4,800	191.52	147.84	127.68	82.56	70.56	53.76
88,200	7,350	4,900	195.51	150.92	130.34	84.28	72.03	54.88
90,000	7,500	5,000	199.50	154.00	133.00	86.00	73.50	56.00
91,800	7,650	5,100	203.49	157.08	135.66	87.72	74.97	57.12
93,600	7,800	5,200	207.48	160.16	138.32	89.44	76.44	58.24
95,400	7,950	5,300	211.47	163.24	140.98	91.16	77.91	59.36
97,200	8,100	5,400	215.46	166.32	143.64	92.88	79.38	60.48
99,000	8,250	5,500	219.45	169.40	146.30	94.60	80.85	61.60
100,800	8,400	5,600	223.44	172.48	148.96	96.32	82.32	62.72
102,600	8,550	5,700	227.43	175.56	151.62	98.04	83.79	63.84
104,400	8,700	5,800	231.42	178.64	154.28	99.76	85.26	64.96
106,200	8,850	5,900	235.41	181.72	156.94	101.48	86.73	66.08
108,000	9,000	6,000	239.40	184.80	159.60	103.20	88.20	67.20
109,800	9,150	6,100	243.39	187.88	162.26	104.92	89.67	68.32
111,600	9,300	6,200	247.38	190.96	164.92	106.64	91.14	69.44
113,400	9,450	6,300	251.37	194.04	167.58	108.36	92.61	70.56
115,200	9,600	6,400	255.36	197.12	170.24	110.08	94.08	71.68
117,000	9,750	6,500	259.35	200.20	172.90	111.80	95.55	72.80
118,800	9,900	6,600	263.34	203.28	175.56	113.52	97.02	73.92
120,600	10,050	6,700	267.33	206.36	178.22	115.24	98.49	75.04
122,400	10,200	6,800	271.32	209.44	180.88	116.96	99.96	76.16
124,200	10,350	6,900	275.31	212.52	183.54	118.68	101.43	77.28
126,000	10,500	7,000	279.30	215.60	186.20	120.40	102.90	78.40
127,800	10,650	7,100	283.29	218.68	188.86	122.12	104.37	79.52
129,600	10,800	7,200	287.28	221.76	191.52	123.84	105.84	80.64
131,400	10,950	7,300	291.27	224.84	194.18	125.56	107.31	81.76
133,200	11,100	7,400	295.26	227.92	196.84	127.28	108.78	82.88
135,000	11,250	7,500	299.25	231.00	199.50	129.00	110.25	84.00
136,800	11,400	7,600	303.24	234.08	202.16	130.72	111.72	85.12
138,600	11,550	7,700	307.23	237.16	204.82	132.44	113.19	86.24
140,400	11,700	7,800	311.22	240.24	207.48	134.16	114.66	87.36
142,200	11,850	7,900	315.21	243.32	210.14	135.88	116.13	88.48
144,000	12,000	8,000	319.20	246.40	212.80	137.60	117.60	89.60

* First day hospital benefit included.

- If you are hospitalized for at least four hours during the *benefits waiting period*, the *benefit waiting period* will be satisfied and benefits become payable on the date of hospitalization; **this feature is included only on Voluntary LTD insurance coverage for educators and administrators plans with 0 day accident/3 day sickness, 14 day accident / 14 day sickness, or 30 day accident/30 day sickness benefit waiting periods (accident means for *disability* caused by accidental injury; sickness means for *disability* caused by *physical disease, pregnancy,* or *mental disorder).***
- If you are severely disabled, as determined by The Standard according to your *group policy,* the *Lifetime Security Benefit* extends your *LTD benefits* beyond the regular LTD *maximum benefit period* while you remain severely disabled; this feature is included only on Voluntary LTD insurance coverage for educators and administrators plans with a *maximum benefit period* to age 65 for both accident and sickness (accident means for *disability* caused by accidental injury; sickness means for *disability* caused by *physical disease, pregnancy,* or *mental disorder).*
- During the first 24 months immediately after you return to work from your *disability*, your *work earnings* may be adjusted for *family care expenses* you pay to a licensed care provider for the care of your *family* which is necessary in order for you to work; the adjustment caps at $250 per *family member* or $500 for all *family members* per month; *family member* includes your child (age 11 and younger) or your child (age 12 and older), spouse, parent, grandparent, sibling, or other close *family member* residing in your home who is incapable of self-sustaining employment due to mental retardation or physical handicap, and is dependent upon you for support and maintenance.
- As a result of an accident, if you suffer a *loss* as defined under the *group policy,* you will be considered *disabled* for the applicable *minimum benefit period*, even if this causes *LTD benefits* to be paid beyond the end of the *maximum benefit period.*
- A fast and safe payment method of The Standard Secure Card℠ which offers bank debit card-style convenience for monthly *LTD benefit* payment delivery.

What exclusions apply to this coverage? You are not covered for a *disability* caused or contributed to by any of the following:

- Your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot
- An intentionally self-inflicted *injury*, while sane or insane
- *War* or any act of *war* (declared or undeclared, and any substantial armed conflict between organized forces of a military nature)
- The loss of your professional or occupational license or certification
- A *preexisting condition* or the medical or surgical treatment of a *pre-existing condition* unless on the date you become *disabled*, you have been continuously insured under the *group policy* for a specified period of time, and you have been *actively at work* for at least one full day after the end of the specified period

What plan limitations apply to this coverage? *LTD benefits* are not payable for any period when you are:

- Not under the ongoing care of a *physician* in the appropriate specialty as determined by The Standard
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by The Standard, unless your *disability* prevents you from participating
- Confined for any reason in a penal or correctional institution
- Able to work and earn at least 20 percent of your *indexed pre-disability earnings,* but you elect not to work; during the first 24 months after the end of the *benefit waiting period* the responsibility to work is limited to work in your *own occupation;* thereafter, the responsibility to work includes work in *any occupation*

In addition, payment of *LTD benefits* is limited in duration in the following situations:

- You reside outside of the United States or Canada
- Your *disability* is caused or contributed to by *mental disorders,* substance abuse or other limited conditions, including but not limited to chronic fatigue conditions, allergy or sensitivity to chemicals or the environment, chronic pain conditions, carpal tunnel or repetitive motion syndrome, temporomandibular joint disorder or craniomandibular joint disorder

Costs

Employees may select a monthly LTD benefit in $100 increments ranging from a minimum of $200 to a maximum of $8,000, based on their earnings. You may not elect an amount in excess of 66 2/3 percent of your pre-disability earnings. Use the rate tables on page 16 and follow these steps to find the monthly cost for your desired level of coverage:

1. Choose the maximum benefit period for which benefits are payable: Option A – Maximum benefit to age 65 for both accident and sickness, or Option B – Maximum benefit to age 65 for accident and 5 years for sickness.
2. Find the maximum LTD benefit available to you by locating the amount of your earnings in either the Annual Earnings or Monthly Earnings column. If your earnings fall between two amounts, you must select the lower amount. The Monthly LTD Benefit amount associated with these earnings is the maximum amount you can receive.
3. Select the desired Monthly LTD Benefit between the minimum and maximum amounts.
4. Select the desired Benefit Waiting Period (in days).
5. The amount in the intersection of the Monthly Disability Benefit row and the Benefit Waiting Period column is the monthly cost for that selection. The amount deducted from each paycheck will be the result of this amount divided by two.

Note regarding the Annual Enrollment Period: If you are insured and elect to increase the amount of your LTD Benefit, decrease the amount of your Benefit Waiting Period, or increase your Maximum Benefit Period, a Preexisting Condition Limitation may apply.

Your LTD Benefit will be subject to the Preexisting Condition Limitation if you elect:

1. **An increase of more than $300 in the amount of your LTD Benefit**
2. **A decrease of more than one level in the length of your Benefit Waiting Period; or**
3. **An increase in the length of your Maximum Benefit Period.**

Your eligibility for First Day Hospital Benefit will be subject to the Preexisting Condition Limitation if you elect a decrease of more than one level in your Benefit Waiting Period and that change adds First Day Hospital Benefit to your insurance.

Claim forms and instructions on how to file a claim with The Standard are available at www.conroeisd.net under Departments – Human Resources – Benefits – Forms.

Benefits are provided by:

Standard Insurance Company
900 SW Fifth Avenue • Portland, OR 97204-1282
www.standard.com • 1-855-757-4717

Hospital Indemnity Insurance

Humana (Group # 896271)

Cash benefits help pay for hospital visits
Humana Hospital Indemnity pays cash benefits when you're hospitalized. You can use the benefits however you want – to help pay medical bills or everyday living expenses such as housing, car payments, utility bills, childcare, groceries, and credit card bills.

Here are some more benefits to you

- Receive a cash benefit regardless of any other insurance you have
- Don't worry about a physical exam; it's not required
- Pay your premiums through payroll deduction

Here's how it works
You'll be reimbursed a specified amount for covered hospital confinement, physical exams, and doctor's office visits. Benefits are paid directly to you, and you can use the cash however you want. It's that simple. If you want a little extra peace of mind and a cash benefit if you need it, Humana can help you.

Coverage type
Group hospital indemnity product that provides benefits for hospitalization, emergency room, doctor visits, intensive care unit (ICU), surgery, lab/X-ray, and wellness.

Benefit plan

Hospital Indemnity:

Package One

If a covered person is confined as an inpatient in a hospital, pays $100 per day for 15 days per confinement.

Package Two

If a covered person is confined as an inpatient in a hospital, pays $200 per day for 15 days per confinement.

Hospital first occurrence:

Package One

If a covered person is confined as an inpatient in a hospital for the first time during a calendar year, pays $250 per day up to four days.

Package Two

If a covered person is confined as an inpatient in a hospital for the first time during a calendar year, pays $500 per day up to four days.

Intensive care unit (ICU)/cardiac care unit (CCU)/burn unit:

Package One

Pays $100 per day when a covered person is confined to a intensive care unit, cardiac care unit, or burn unit; maximum of 30 days per year.

Package Two

Pays $200 per day when a covered person is confined to a intensive care unit, cardiac care unit, or burn unit; maximum of 30 days per year.

Additional included benefits and plan information

Waiver of premium: Maximum waiver of premium benefit is limited to a total of 12 consecutive months per disability. This waives an employee's premium if he or she becomes totally disabled for at least 90 days after the effective date of coverage. There is no lifetime maximum.

Waiting Period for maternity is 300 days.

This is not a complete disclosure of plan qualifications and limitations. Please access our website at Disclosure.Humana.com to obtain a completed list for the Workplace Voluntary Benefit products. Please review this information before applying for coverage. The amount of benefits provided depends on the plan selected. Premiums will vary according to the selection made.

Costs

Benefit: Package One monthly premiums

	Non Tobacco User				Tobacco User			
Age	Employee	Employee & Child(ren)	Employee & Spouse	Employee & Family	Employee	Employee & Child(ren)	Employee & Spouse	Employee & Family
18-35	$11.49	$19.29	$21.19	$26.96	$13.93	$21.73	$24.58	$30.36
36-49	$10.86	$18.78	$19.93	$25.86	$13.13	$21.05	$23.10	$29.03
50-59	$14.57	$19.03	$27.34	$30.68	$17.77	$22.22	$31.79	$35.15
60-64	$20.46	$24.40	$39.12	$42.07	$25.12	$29.07	$45.64	$48.60

Benefit: Package Two monthly premiums

	Non Tobacco User				Tobacco User			
Age	Employee	Employee & Child(ren)	Employee & Spouse	Employee & Family	Employee	Employee & Child(ren)	Employee & Spouse	Employee & Family
18-35	$21.19	$36.78	$40.59	$52.14	$26.08	$41.65	$47.37	$58.92
36-49	$19.93	$35.76	$38.06	$49.91	$24.46	$40.29	$44.41	$56.23
50-59	$27.34	$36.27	$52.87	$59.58	$33.74	$42.67	$61.79	$68.52
60-64	$39.10	$47.00	$76.46	$82.35	$48.46	$56.32	$89.47	$95.41

Underwritten by:

Kanawha Insurance Company, a Humana company
210 South White Street, PO Box 7777 • Lancaster, SC 29721
www.humanaworkplacevoluntary.com • 1-855-448-6982

Legal Protection Plan

Legal Access Plans, L.L.C.

We have been putting people in touch with quality local attorneys and helping them solve problems since 1971.

The RIGHT Benefits + the RIGHT Attorney + the RIGHT Help = Peace of Mind

More than 7 out of 10 people will have the need for an attorney this year.

We understand that when you have a legal need, it can be the most important event in your life, when it is occurring. We also know that finding an attorney can be stressful and take tons of your time. This is why we do things the way we do. Our processes are designed to help you save time when locating an attorney, and reduce your stress by providing you a personal contact within our offices that is there for YOU.

When you have the need for an attorney, we will save you time by locating or matching you to the most applicable attorney in your area with availability. This can save you hours of your time. The attorneys in our network must meet the most rigorous credentials on the market today.

We will also follow up with you to ensure everything is OK and to see how else we can be of further assistance. We believe that good service is essential, especially in a world today where good service is scarce.

How the Plan Works

When you have a legal, financial, or identity need, give us a call, it's that easy to get started. We will walk you through the steps and be right with you the entire time. Allow us to help you.

Legal Benefits

- **Unlimited number of FREE initial 1/2 hour consultations** by phone, in person, or online (where available). One half hour per legal topic.
- **Simple Wills** prepared for eligible family members.
- **Document Review** of many types of legal documents.
- **Dispute Resolution** to attempt to resolve legal disputes.
- **Lawsuit/Litigation Procedural Guide** – Legal analysis of the typical steps involved in lawsuits or litigation.
- **Guaranteed Reduced Rates** – Members receive a 25% discount on hourly rates from Plan Attorneys when legal representation is needed.
- **Small Claims Court Preparation** – Consultation at no additional cost by phone with attorney on small claims lawsuits.

Exclusive Flat Fee Services

Traffic Tickets $89.00
Bankruptcy Chapter 7.....$750.00
Name Change.....$155.00
Will with Minor Trust $170.00
Non-Support (Spouse/Child).....$239.00
Divorce (Simple) $210.00
Corporation (Regular).....$239.00
Non-Commercial Real Estate $175.00

Legal Coverage for the Entire Family – All dependents under the age of 23 are covered under the Plan, while residing at home or away at school. ***The Plan also covers the parents of both the member and the member's spouse.***

Additional Benefits

Financial Benefits

- Financial Counseling
- Debt Management Programs
- Family Budgeting Help
- Financial Planning Services

Legal Benefits

- Mediation, when available
- Elder Law Resources
- Online Resources

LifeLock Benefits

- LifeLock Identity Alert™ System: Proactive solution for validation of no fraudulent activity
- eRecon™: Searches known criminal websites for the illegal selling or trading of your personal information
- TrueAdress™: Reduces the risk of identity theft through the method of change-of-address
- WalletLock™: Helps replace contents of a lost or stolen wallet*
- Pre-Approved Credit Card Opt-Out: Reduce the risk of identity theft through stolen mail
- Remediation: With LifeLock available 24 hours a day 7 days a week, if you become a victim of identity theft while a member of LifeLock because of a failure in our services, we will help you fix it, up to $1 million. (Restrictions apply. See LifeLock.com for details).

* *This benefit summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. Exclusions and limitations do exist within this plan. More complete descriptions of benefits and the terms under which they are provided are contained in the plan booklet that you will receive upon enrolling in the Plan. If this benefits summary conflicts in any way with the documents issued to your employer/association, the policy shall prevail.*

Plan Members may call for assistance anytime. 1-800-562-2929

Per Paycheck Costs:
Employee (and Family).....$7.25

Benefits are provided by:
Legal Access Plans, L.L.C.
5850 San Felipe, Suite 600 • Houston, TX 77057
flpp.legalaccessplans.com • 1-800-562-2929

Life Insurance - Group Term

Unum Life Insurance Co. of America (Group # 568676)

Please review the following description of the Unum Life Insurance Company of America (Unum) term life insurance plan for CISD employees.

Coverage Amount Options

Employee: Up to 5 times salary in increments of $10,000. Not to exceed $500,000. Benefits will be paid to the designated beneficiary.

Spouse: Up to 100% of employee amount in increments of $5,000. Not to exceed $500,000. Benefits will be paid to the employee.

Child: Up to 100% of employee coverage amount in increments of $2,000. Not to exceed $10,000. The maximum death benefit for a child between the ages of live birth and 6 months is $1,000. Benefits will be paid to the employee.

Coverage amount(s) will reduce according to the following schedule:
Age 70 .....Insurance reduces to 65% of original amount
Age 75 .....Insurance reduces to 50% of original amount
Note: *Coverage may not be increased after a reduction*

Guarantee Issue

Current Employees: If you and your eligible dependents are enrolled in the plan and wish to increase your coverage, you may apply on or before July 31, 2017, for any amount of additional coverage up to $200,000 for yourself and any amount of additional coverage up to $25,000 for your spouse; any amount over the Guarantee Issue Amount(s) will be subject to evidence of insurability. If you and your eligible dependents are not currently enrolled in the plan and have not previously been denied coverage due to evidence of insurability, you may apply on or before July 31, 2017, for any amount of coverage up to $200,000 for yourself and any amount of coverage up to $25,000 for your spouse; any amount over the Guarantee Issue Amount(s) will be subject to evidence of insurability.

Employees hired on or after 9/1/2017: If you enroll within 31 days of your full-time hire date, you may apply for any amount of coverage up to $200,000 for yourself and any amount of coverage up to $25,000 for your spouse. Any coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability. If you and your eligible dependents do not enroll within 31 days of your full-time hire date, you can apply for coverage only during an annual enrollment period and will be required to furnish evidence of insurability for the entire amount of coverage.

If you and your eligible dependents enroll within 31 days of your full-time hire date, and later, wish to increase your coverage, you may increase your coverage, with evidence of insurability, at anytime during the year. However, you may wait until the next annual enrollment and only coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability.

Additional Benefits

Life Planning Financial and Legal Resources: This personalized financial counseling service provides expert, objective financial counseling to survivors and terminally ill employees at no cost to you. This service is also extended to you upon the death or terminal illness of your covered spouse. The financial consultants are master level consultants. They will help develop strategies needed to protect resources, preserve current lifestyles, and build future security. At no time will the consultants offer or sell any product or service.

Portability: If you retire, reduce your hours or leave your employer, you can take this coverage with you according to the terms outlined in the contract.

Accelerated Benefit: If you become terminally ill and are not expected to live more than twelve months, you may request up to 50% of your life insurance amount up to $750,000, without fees or present value adjustments. A doctor must certify your condition in order to qualify for this benefit. Upon your death, the remaining benefit will be paid to your designated beneficiary(ies). This feature also applies to your covered dependents.

Waiver of Premium: If you become disabled (as defined by your plan) and are no longer able to work, your premium payments will be waived during the period of disability.

Retained Asset Account: Benefits of $10,000 or more are paid through the Unum Retained Asset Account. This interest bearing account will be established in the beneficiary's name. He or she can then write a check for the full amount or for $250 or more, as needed.

Limitations/Exclusions/Termination of Coverage

Suicide Exclusion: Life benefits will not be paid for deaths caused by suicide in the first 24 months after your effective date of coverage. No increased or additional benefits will be payable for deaths caused by suicide occurring within 24 months after the day such increased or additional insurance is effective.

Termination of Coverage: Your coverage and your dependents' coverage under the Summary of Benefits ends on the earliest of:
- The date the policy or plan is cancelled;
- The date your eligible group is no longer covered;
- The last day of the period for which you made any required contributions; unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in the certificate of coverage;
- For dependent's coverage, the last day of the month of the date of your death.

In addition, coverage for any one dependent will end on the earliest of:
- The date your coverage under a plan ends;
- The last day of the month in which your dependent ceases to be an eligible dependent;
- For a spouse, the last day of the month of the date of divorce or annulment.

Unum will provide coverage for a payable claim which occurs while you and your dependents are covered under the policy or plan.

Effective Date of Coverage

Coverage elected during annual enrollment will become effective on 9/1/2017; applications subject to evidence of insurability may be effective after this date. For employees who become eligible on or after August 1, 2016, please see your Plan Administrator for your effective date.

Delayed Effective Date of Coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Dependent: Insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Exception: infants are insured from live birth.

"Totally disabled" means that, as a result of an injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.

Changes to Coverage

Each year you and your spouse will be given the opportunity to change your Life coverage. You and your spouse may purchase additional Life coverage up to the Guarantee Issue amounts without evidence of insurability if you are already enrolled in the plan. Life coverage over the Guarantee Issue amounts will be medically underwritten and will require evidence of insurability and approval by Unum's Medical Underwriters. The suicide exclusion will apply to any increase in coverage.

Term Life Coverage Rates: Rates shown are your monthly deduction

Age Band	Employee per $1,000	Spouse per $1,000	Child per $1,000
≤ 24	$0.03	$0.06	$0.04
25-29	$0.03	$0.06	
30-34	$0.04	$0.08	
35-39	$0.07	$0.11	
40-44	$0.08	$0.18	
45-49	$0.12	$0.32	
50-54	$0.19	$0.52	
55-59	$0.35	$0.82	
60-64	$0.43	$1.26	
65-69	$0.74	$1.86	
70-74+	$1.20	$1.86	

***Note:** The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have.*

Insurance Age: Your rate is based on your insurance age, which is your age immediately prior to and including the anniversary/effective date. *Your rate is based on your age as of 9/1/2016. Your spouse's rate is based on his/her age as of 9/1/2016.*

Cost Calculation: To calculate your per paycheck cost, complete the following by selecting your coverage amount and rate (based on your insurance age).

	Coverage Amount	Increment	Rate		Monthly Cost
Employee	$ _____	÷ $1,000 x	$ _____	=	$ _____
Spouse	$ _____	÷ $1,000 x	$ _____	=	$ _____
Children	$ _____	÷ $1,000 x	$ 0.04	=	$ _____
			Total Monthly Cost	=	$ _____

Total Monthly Cost $ _____ ÷ 2 = $ _____ **Per Paycheck Cost**

This information is a summary provided to help you understand your insurance coverage from Unum. Some provisions may vary or not be available in all states. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern. For complete details of coverage, please refer to policy form number C.FP-1, et al.

Life Planning is provided by Ceridian, Inc. The services are subject to availability and may be withdrawn by Unum without prior notice.

Underwritten by:

Unum Life Insurance Company of America
2211 Congress Street • Portland, ME 04122
www.unum.com • 1-800-445-0402

Life Insurance - Term

American Fidelity Assurance Co.

Life Insurance is an important purchase to make. It is impossible for life insurance to emotionally compensate for a loss, but it may help ease the financial obligations left to your loved ones such as your mortgage, college tuition, other debts, and daily living expenses.

AF Term Life® Insurance offers protection during your peak earning years when you have financial responsibilities such as paying a mortgage or supporting your family. Your policy covers you during a term period, either 10, 20, or 30 years. You decide which term is best for your financial situation.

AF Term Life® Lets You Choose

- Rates guaranteed not to increase during the initial term period you choose.[1]
- Guaranteed death benefit amount during the term you choose.
- A death benefit amount that is generally paid tax-free.[2]
- A policy that you own. Take it with you if you leave employment at the same rate.
- You may renew the policy at the end of the Term Period until the Insured reaches age 90. You may convert to a whole life insurance policy before the policy anniversary following age 75.

1 Premiums are adjusted upon renewal.
2 Please consult your tax consultant for your specific situation.

Product Features

- Easy application
- Minimal health questions[1]
- No medical tests[1]
- Accelerated Death Benefit
- Interim coverage[2]
- Employee issue maximum up to $200,000[3]
- Spouse issue maximum up to $50,000[3]
  - Individual policy or rider
- Issue minimum:
  - 10- & 20-year term: $25,000
  - 30-year term: $10,000
- Issue ages:
  - 10-year term: 18-70
  - 20-year term: 18-60
  - 30-year term: 18-50

1 Issuance of the policy may depend on the answer to these questions.
2 You will be covered from the date of your application if you are insurable for the requested coverage on the date the application is signed. This Interim Coverage will remain in force until the policy has been issued or declined.
3 Face amounts vary based on issue age. Spouse face amounts are also based on whether the employee purchases coverage at the same time.

Costs

Premiums are based on the issue age of the insured, the face amount requested, and whether or not the insured is a nicotine user. The FFenroll Form Library includes AF Term Life rate tables. For more information on AF Term Life insurance, please contact Mack Whiteman with First Financial Administrators at 713-254-5264 or mack.whiteman@ffga.com.

Additional Options

Waiver of Premium This rider waives the premium for the base policy and any attached riders if the base insured becomes totally disabled, as defined in the rider, for at least six consecutive months. If your total disability ceases, you simply resume premium payments; there is no requirement for payment of back premiums. Issue age is 18-55. The rider terminates at age 60.

Accidental Death Benefit This rider provides the insured an additional death benefit if death is the result of an accident. Face amount is equal to the face amount on the base policy. Issue age is 18-65. The rider terminates at insured's age 70.

Spouse Term Rider[1] This rider provides level term life insurance coverage on your spouse. Face amount must be equal to or less than the base policy.

Children's Term Rider[2] This rider provides level term life insurance protection for all your eligible children who are between the ages of one month through age 18. Coverage remains on each child until age 26 or marriage of the child prior to age 26. One premium covers all eligible children. Two benefit levels are available: $10,000 and $20,000.

1 Premiums are adjusted upon renewal. Coverage may be renewed for each additional renewal period up to the spouse's age 90, while the base policy is in force.
2 Your covered child may convert this rider for up to five times the amount of coverage to any form of permanent insurance offered by American Fidelity Assurance Company.

Notice to Applicant

Before American Fidelity Assurance Company (AF) can issue a policy, they must first evaluate or "underwrite" your application. The purpose of this is to: 1) be sure you qualify for the insurance requested; and 2) determine the correct premium rate. Your answers to the questions on the application provide the basis for evaluation. AF will use only the information you provide on the application. The information they obtain about you is treated as confidential. We will only disclose your nonpublic financial or medical information to other entities as permitted or required by law. With your prior written authorization, AF or their reinsurers may disclose information in their files to other life insurance companies to which you apply for life or health insurance which have first agreed in writing with us to maintain the confidentiality of such information. You have the right to request information about such disclosures, and to know what information is in your file and seek correction of any data that you think is wrong.

This is a brief description of the coverage and does not constitute the actual policy. For actual benefits, limitations, exclusions and other provisions, please refer to the policy. Additional riders are subject to general underwriting guidelines and coverage is not guaranteed.

Underwritten by:

American Fidelity Assurance Company
2000 N. Classen Boulevard • Oklahoma City, OK 73106
www.afadvantage.com • 1-800-654-8489

Life Insurance - Universal

Texas Life Insurance Co. (Group # SM2656)

Voluntary permanent life insurance can be an ideal complement to the group term and optional term your employer might provide. Designed to be in force when you die, this voluntary universal life product is yours to keep, even when you change jobs or retire, as long as you pay the necessary premium. Group and voluntary term, on the other hand, typically is not portable if you change jobs and, even if you can keep it after you retire, usually costs more and declines in death benefit.

The policy, PURELIFE-plus, is underwritten by Texas Life Insurance Company, and it has these outstanding features:

- **High Death Benefit.** With one of the highest death benefits available at the worksite, PURELIFE-plus gives your loved ones peace of mind, knowing there will be significant life insurance in force should you die prematurely.
- **Minimal Cash Value.** Designed to provide high death benefit, PURELIFE-plus does not compete with the cash accumulation in your employer-sponsored retirement plans.
- **Long Guarantees.** Enjoy the assurance of a policy that has a guaranteed death benefits to age 121 and level premium that guarantees coverage for a significant period of time *(after the guaranteed period, premiums may go down, stay the same, or go up).*
- **Refund of Premium.** Unique in the marketplace, PURELIFE-plus offers you a refund of 10 years' premium, should you surrender the policy if the premium you pay when you buy the policy ever increases. *(Conditions apply.)*
- **Accelerated Death Benefit Rider.** Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92% of the death benefit, minus a $150 administrative fee. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. *(Conditions apply.)*

You may apply for this permanent, portable coverage, not only for yourself, but also for your spouse, minor children and grandchildren.

Amounts of coverage available on spouse

Spouse's Issue Age	Spouse's Minimum Face Amount	Spouse's Maximum Face Amount *If employee does not apply*	Spouse's Maximum Face Amount *If employee also applies*
17-49	$25,000	$25,000	$50,000
50-60	$10,000	$10,000	$25,000
61 & Older	N/A	N/A	N/A

Costs

Premiums are based on the issue age of the insured, the face amount requested, and whether or not the insured is a tobacco user. The FFenroll Form Library includes Texas Life Insurance Company premium tables. For more information on Texas Life universal life insurance, please contact Mack Whiteman with First Financial Administrators at 713-254-5264 or mack.whiteman@ffga.com.

Underwritten by:

Texas Life Insurance Company
900 Washington Avenue/PO Box 830 • Waco, TX 76703-0830
www.texaslife.com • 1-800-283-9233

Long-Term Care Insurance

Life Secure Insurance Company (Group #00711V)

Why Long Term Care?

Long term care assists people who cannot perform essential daily activities on their own; things like eating, dressing, and using the bathroom. This is usually due to a chronic illness or degenerative condition.

Long term care can be provided in a variety of places, whether at home or at an assisted living facility, a nursing home or other setting. It consists mostly of "custodial care", or assistance with daily activities, rather than medical care that would be covered by your health plan.

Who Needs It?

These days, we're living longer than ever. And as life spans grow, more of us need long term care. In fact, it's estimated that over 60% of people 65 and over will need long term care assistance during their lives – either at home or in a facility.[1]

And long term care can get expensive. Costs range from an average of $19 per hour for a home health aide to $108 per day in an assisted living facility and $213 per day in a nursing home.[2]

Programs like Medicare pay for little or no long term care expenses, and you must be impoverished to qualify for Medicaid coverage. Without a plan, potential long term care expenses may become a significant out-of-pocket responsibility. LifeSecure helps you plan ahead, giving you more worry-free years. And it's simpler and more affordable than you might think.

[1] Long-Term Care Financing: Policy Options for the Future, Georgetown University, LTC Financing Project; Feder, Komisar, Friedman, June 2007.

[2] Genworth Financial 2011 Cost of Care Survey, April 2011.

Standard Benefits

Benefit Bank You choose an amount between $75,000 and $1,000,000. Your Benefit Bank represents the lifetime dollar benefit amount available to you. Your Benefit Bank balance is reduced by any benefits paid to you or on your behalf.

Monthly Benefit Access Limit You choose 1%, 2% or 3% of your Benefit Bank (3% Monthly Benefit Access Limit not available for Benefit Bank amounts over $500,000.). Your Monthly Benefit Access Limit represents the dollar benefit amount available on a monthly basis for your long term care needs. The original dollar amount is calculated as a percentage of your Benefit Bank.

Benefit Bank		Access Limit		Monthly Benefit
$300,000	x	1%	=	$3,000

Benefit Payout Structure. When you become eligible for benefits, we will reimburse you for covered long term care expenses up to your full Monthly Benefit each calendar month. These covered expenses include care at home through a home care agency or independent provider, or in an assisted living facility, adult day care center or in a nursing home. Hospice care is also covered.

If you do not incur covered expenses up to your full Monthly Benefit for a given calendar month, 50% of your unused monthly benefit will be available to you as a Flexible Benefit. The Flexible Benefit is not restricted by the definition of covered expenses. This benefit is designed to provide greater flexibility in the types of care, services and products available to you under this policy, such as: care provided by a family member or other informal caregiver, construction of a wheelchair access ramp, or installation of grab bars in your bathroom.

Guaranteed Future Purchase Offers This feature is included in your coverage as a standard feature if you have rejected both of the optional inflation protection benefits described under Optional Benefits. Under the Guaranteed Future Purchase Offers, you will be offered the opportunity to increase your current Benefit Bank and Monthly Benefit by 15% every three years. You may accept each offer without submitting evidence of insurability.

Waiver of Premium Your premiums are waived beginning on the first day you start receiving benefits. As long as you continue to receive benefits, additional premiums will not be required. Premium payments will again be required after 30 days of not receiving benefits.

Benefit Wait Period You are eligible to begin receiving benefits upon completion of a 90-day Benefit Wait Period. This is a period of time during which you meet the benefit triggers for this coverage. You do not need to be receiving paid services in order to accumulate Benefit

Wait Period days, and your Benefit Wait Period need only be met once during your lifetime.

LifeSecure Care Advisor Services A LifeSecure Care Advisor is available to you and your family from the day you receive your policy. The LifeSecure Care Advisor can help you with everything from long term care questions to recommendations for assisted living facilities to arrangements for personal care or services.

Spouse or Domestic Partner Discounts If you and your spouse or partner both apply and are accepted, a 30% premium discount will apply to both policies. If your spouse or partner does not apply, or is not accepted, a 10% discount will still apply to your policy.

Optional Benefits (available for additional premium)

Refund of Premium Upon Death Option If you die while your policy is in force for 5 or more years, a percentage of the premiums (less benefits paid) is refunded to a beneficiary. The percentage of payback equals 25% of the premiums paid if death occurs in policy years 5–9; 50% in years 10 –14; and 75% in years 15 and beyond. Your policy must be in force at the time of death for the Refund of Premium Upon Death Option benefits to be payable.

Automatic Compound Inflation Protection Benefit (3% or 5%) If you elect this option, we will automatically increase your current Monthly Benefit and your remaining Benefit Bank by 3% or 5% each year. The increase will be effective on each anniversary of your policy effective date, even while you are receiving benefits. NOTE: You must reject the Automatic 5% Compound Inflation Protection Benefit before you can elect the Automatic 3% option.

Non-Forfeiture Benefit If your policy is in force for at least three full years, and then terminates due to non-payment of premium, this optional benefit allows you to retain a reduced paid-up amount of coverage. You will have a revised Benefit Bank equal to the greater of: (a) 100% of the sum of all premiums paid; or (b) one times your Monthly Benefit. NOTE: If this Benefit is not selected, the Contingent Non-forfeiture Benefit will be included in your policy.

Policy Limitations and Exclusions

Charges for care or services provided by a family member, as well as care or services for which no charge is made in the absence of insurance, are excluded under the reimbursable covered expenses portion of the policy. However, such care or services may be payable under the Flexible Benefit.

No benefits, including the Flexible Benefit, will be payable under the Policy for: a loss that occurs while this Policy is not in force; or an illness, treatment or medical condition that is due to war or act of war, whether declared or not; or an illness, treatment or medical condition that results from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury; or expenses for treatment or rehabilitation related to alcoholism or drug addictions; or expenses for services or items to the extent that such expenses are reimbursable under Medicare, or would be so reimbursable but for the application of a deductible or coinsurance amount; or care or services, unless otherwise required by law, for which benefits are duplicated or provided under a governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or care or services provided outside the United States of America, its territories or possessions, or Canada.

A senior counseling program is provided by the Area Agency on Aging under the authority of the Texas Health and Human Services Commission.

Health Information Counseling and Advocacy Program (HICAP)
701 W. 51st W-352 • Austin, Texas, 78751
1-800-252-9240.

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Benefits are provided by:
LifeSecure Insurance Company
10559 Citation Drive, Suite 300 • Brighton, MI 48116
www.yourlifesecure.com • 1-866-582-7701

Voluntary Retirement Plans

The District makes available to all employees, including full-time, part-time, and substitute, voluntary 403(b) and 457 plans. These plans allow employees to save a portion of their income for retirement without paying tax on the contributions until they are withdrawn from the plan. Maximum deferral amounts are set by the IRS for each calendar year, and deferrals may not exceed 100% of an employee's wages. Establishment of these accounts and changes in contribution amounts may be made at any time.

403(b) Plans

A 403(b) Plan allows you to invest tax deferred income in fixed annuities; variable annuities; and/or mutual funds while earning tax deferred interest. The term 403(b) is used synonymously with 403(b)(7), Tax Deferred Annuity (TDA), and Tax Sheltered Annuity (TSA). To contribute to a 403(b) account, you must select an approved vendor; these companies have signed the Contract Provider Agreement with First Financial Administrators. Approved 403(b) providers for Conroe ISD are posted online at www.ffga.com.

Distributions are available upon termination of employment, death, disability, retirement, or certain types of hardships. Distributions may be rolled into an IRA, 403(b) or 401(k) plan, or they can be used to buy back years from TRS service. There is a 10% penalty imposed by the IRS for funds withdrawn prior to age 59 1/2, in addition to normal tax consequences, for qualified distributions.

How do I establish a new 403(b) account?

1. Select a vendor from the list of approved providers.
2. Contact an agent/financial advisor. Be aware that your agent must have completed the agent enrollment on the First Financial Administrators, Inc. website (www.ffga.com) prior to submitting business. Do you need an agent? Call a First Financial Retirement Services Specialist at 1-800-523-8422 or log on to www.ffga.com to search for agents in your area.
3. Complete a First Financial 403(b) Salary Reduction Agreement (SRA) and fax or mail the form directly to First Financial. **Only the First Financial SRA** form will be accepted to start and/or make any changes to your 403(b) accounts. Requests must be in writing. (Please send vendor applications to the vendor.)
4. Agent signatures are only required on new accounts. New means you are starting contributions to a new vendor or you are establishing contribution deductions with a new school district.
5. Check with a First Financial Retirement Services Specialist for due dates so requests are processed in the desired time.

457 Plans

A 457 Plan allows you to invest Tax Deferred income while earning tax deferred interest. CISD offers four 457 plan options:

- **SecurePlus Elite** A flexible premium deferred annuity issued by National Life Group. It is not a mutual fund, variable annuity, or any instrument that participates directly in stock or equity investments. Unlike mutual funds and stock or equity investments, SecurePlus Elite is an annuity with important insurance features, such as the tax deferral, death benefit, and annuitization features. SecurePlus Elite also differs from variable annuities in that it offers protection from market loss, a feature not always found in variable annuities.
- **RetireMax Millennium Flex** A flexible premium deferred annuity, designed by National Life Group, for ongoing 457 contributions and transfers from other qualified vehicles. RetireMax Millennium Flex preserves your accumulated savings, guarding against losses from exposure to market fluctuation. The interest rate applicable at issue is declared in advance, and interest rates may be adjusted periodically. Rates always meet or exceed minimums guaranteed in the policy form. RetireMax Millennium Flex offers additional interest; each premium received in the first policy year will receive an additional five percent interest for 12 months.
- **Tax Vantage** A compromise fixed annuity issued by Fidelity Security

Life Insurance Company (FSL) to fund your IRC 457 retirement plan. It is competitive and simple, yet flexible. Primary features include: no front-end sales charge, no deferred sales charge for benefit responsive events at participant level, no annual or quarterly administration charge, no 10% IRS penalty for withdrawals prior to age 59½, and client friendly technology and communication.

- **Fidelity Investments** Numerous tools and resources are available to help you plan for your retirement. Find a retirement account option that fits your needs with Fidelity Investments.

Distributions are available upon termination of employment, death, disability, retirement, or certain types of hardships. Distributions may be rolled into an IRA, 403(b) or 401(k) plan, or they can be used to buy back years from TRS service. There is no penalty imposed by the IRS for funds withdrawn prior to age 59 1/2 for qualified distributions.

How do I establish a new or make changes to an existing 457 account?

If it is for a National Life Group or FSL account, contact Mack Whiteman with First Financial Administrators at 1-800-523-8422 or 713-254-5264, or by email at Mack.Whiteman@ffga.com.

If it is for a Fidelity Investments account:

1. Complete a Fidelity Investments 457(b) Enrollment Form. The form is available online at http://403b.com under Library – Forms.
2. The Conroe ISD plan number is 84568. To obtain information on investment options, please call a Fidelity representative at 1-800-343-0860 or visit their website, www.fidelity.com.
3. Once you receive confirmation of your account from Fidelity, complete a First Financial Deferred Compensation Agreement and fax or mail the form directly to FFA, attention Retirement Services Department.

*** *Only the First Financial Deferred Compensation Agreement form will be accepted to start or make changes (i.e. increase, decrease or stop) to your 457 account contributions.*

Contribution limits for 2017

Under Age 50 .....$18,000
Age 50 and Above.....$24,000

Enrollment and/or changes to either type of voluntary retirement plan may be completed at any time during the year. They are not part of the New Hire or Open Enrollment processes.

Save Consistently

Saving a little each pay period is easy with payroll deduction. It's like paying yourself first each payday. And because payroll deductions occur "behind the scenes", you'll never miss the extra cash! As little as $25 per paycheck can get you started.

Save Early

The sooner you start to save, the more likely you are to reach your retirement goals. These two profiles perfectly illustrate the benefits of getting started today!

Both Don and Maria plan to retire at age 65.
They each earn an average return of 7% on their retirement savings*
Whose retirement savings will go further?

Paychecks are Semi-Monthly

Don starts saving for retirement at age 45		**Maria starts saving for retirement at age 25**	
Paycheck contributions	$150	Paycheck contributions	$50
Years to retirement	20	Years to retirement	40
Total Contributions	$72,000	Total Contributions	$48,000
Balance at retirement	$152,278	Balance at retirement	$264,387

* *These hypothetical investment returns are for illustrative purposes only and are not indicative of any particular investment or performance. Balances shown are before reduction for taxes. Amounts withdrawn from a qualified plan are taxable when distributed.*

Note: ***Conroe ISD does not hire or contract with any financial agent other than First Financial Administrators, Inc. No financial agent "representing" Conroe ISD will ever call you at home or send you an email. Further, agents are prohibited from soliciting or conducting business on District property. Because investment strategies are a personal decision that each employee should investigate on his/her own, Conroe ISD makes no recommendation or approval of individual 403(b) plans, their sales representatives, agents, or financial advisors.***

CONROE INDEPENDENT SCHOOL DISTRICT

Notice to Employees: Requirements of the Affordable Care Act

As of January 1, 2014, the Affordable Care Act (ACA) requires you to have health insurance for yourself and your dependents. Some people are exempt from this requirement. To learn how to apply for an exemption, see Questions and Answers on the Individual Shared Responsibility Provision, **www.irs.gov/Affordable-Care-Act/ Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision**. If you do not have health insurance and you are not exempt, you may be subject to a penalty (see **https://www. healthcare.gov/fees/fee-for-not-being-covered/**).

Enrollment in a Conroe Independent School District (ISD) Aetna medical plan satisfies the requirement to have health insurance. The *Conroe ISD Employee Benefits booklet* explains who is eligible to enroll in a medical plan. Enrollment in another plan, such as through a spouse, parent, or association, also satisfies the requirement to have health insurance if the plan provides minimum essential coverage.

As an alternative to a Conroe ISD Aetna medical plan or another health insurance program, you may enroll in insurance through the Health Insurance Marketplace. In Texas, the Marketplace is a federal government program that offers "one-stop shopping" to find and compare private health insurance options. Most individuals are eligible to enroll in insurance through the Marketplace. Open enrollment for the Marketplace occurs each year beginning November 1 for coverage beginning January 1 of the next calendar year. If you do not enroll by January 31, you cannot enroll in a Marketplace plan for that calendar year unless you qualify for a Special Enrollment Period. For information on the Marketplace, see **www.healthcare.gov.**

You may be eligible for a premium tax credit or other assistance toward insurance obtained through the Marketplace, depending on your household income. More information on the premium tax credit and other cost-sharing provisions is available at **www.healthcare.gov.** Please note that the District will not contribute to premium costs if you enroll in insurance through the Marketplace. Also, you will lose the benefit of paying the premium with pre-tax income if you purchase insurance through the Marketplace.

You must decide whether to enroll in the Conroe ISD Aetna medical plan within your first 31 calendar days of employment, if you are eligible. If you decide not to enroll in the Conroe ISD Aetna medical plan during the new hire enrollment period, you will not be able to enroll again until the next annual enrollment period unless you experience a special enrollment event. On the other hand, if you decide to enroll in the Conroe ISD Aetna medical plan during your new hire enrollment period, the District's cafeteria plan does not permit you to drop insurance before the end of the plan year unless a family status change or other qualified event, per IRC Section 125, occurs.

Basic Information About Health Care Offered By The District

If you decide to shop for coverage in the Marketplace, below is the employer information you will enter at **healthcare.gov** to find out if you are eligible for a premium tax credit.

This information is numbered to correspond to the Marketplace application.

3. Employer name Conroe Independent School District		**4. Employer Identification Number** (EIN) 746000556
5. Employer Address 3205 West Davis		**6. Employer phone number** 936-709-7808
7. City Conroe	**8. State** TX	**9. Zip code** 77304
10. Who can we contact about employee health coverage at this job? Conroe ISD Human Resources Department - Benefits Office		
11. Phone number *(if different from above)*		**12. Email address** benefitsoffice@conroeisd.net

The District offers health coverage through Aetna to all eligible employees and their eligible dependents. Eligibility is described in the Conroe ISD Employee Benefits Guide. The coverage offered by Aetna meets the minimum value standard, and the cost of this coverage to you is intended to be affordable.

Additional information
The Conroe ISD plan year begins September 1 and ends August 31. Annual enrollment takes place July 1-31. If you have questions or concerns about the health insurance offered through the District, please refer to **www.conroeisd.net/hr/benefits** or contact the Conroe ISD Benefits Office at 936-709-7808.

Questions about the Marketplace and how the Affordable Care Act impacts you as an individual should be addressed to **www.healthcare.gov** or your personal attorney.

Women's Health and Cancer Rights

Under the Conroe ISD health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) All stages of reconstruction of the breast on which a mastectomy has been performed;
(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) Prostheses; and
(4) Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your Aetna ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, **www.cms.gov/home/regsguidance.asp**, and this U.S. Department of Labor website, **www.dol.gov/ebsa/consumer_info_health.html**.

Medicare Part D Notice of Creditable Coverage

Important Notice from Conroe Independent School District (ISD) 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 Conroe ISD 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 Medicare's and Conroe ISD'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. Conroe ISD has determined that the prescription drug coverage offered by its Aetna medical benefits plans 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 15 to December 7. However, if you lose your creditable prescription drug coverage, through no fault of your own, you will be eligible for a two-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?
Most participants in the Conroe ISD medical plan administered by Aetna should probably not take any action to enroll in a Medicare Part D plan because the Conroe ISD plan covers prescription drug expenses in addition to health expenses. If you enroll in a Medicare prescription drug plan, there is no coordination of benefits between Conroe ISD's medical plan and Medicare Part D.

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 Conroe ISD 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 19 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
Refer to the Conroe ISD website, www.conroeisd.net. Conroe ISD does not provide advice or counseling to participants regarding Medicare Part D plans and rules. NOTE: You'll get this notice each year. 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 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, therefore, whether or not you are required to pay a higher premium (a penalty).*

Administered by: Human Resources Department/Benefits Office
Conroe Independent School District
3205 West Davis, Conroe, TX 77304
936-709-7859
www.conroeisd.net/hr

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 are 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 program or CHIP. 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 (1-877-543-7669)** 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 electronically 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 January 31, 2017. Contact your State for more information on eligibility.

State	Program(s)	Website(s)	Phone Number(s)
Alabama	Medicaid	http://www.myalhipp.com 1-855-692-5447	
Alaska	Medicaid	http://myakhipp.com/ and http://dhss.alaska.gov/dpa/pages/medicaid/default.aspx	1-866-251-4861
Arkansas	Medicaid	http://myarhipp.com	1-855-692-7447
Colorado	Medicaid & CHIP	Medicaid: https://www.healthfirstcolorado.com/ CHIP: Colorado.gov/hcpf/child-health-plan-plus	Medicaid Phone: 1-800-221-3943 CHIP Phone: 1-800-359-1991
Florida	Medicaid	https://www.flmedicaidtplrecovery.com/hipp	1-877-357-3268
Georgia	Medicaid	http://dch.georgia.gov/medicaid (Click on Health Insurance Premium Payment [HIPP])	404-656-4507
Indiana	Medicaid	For low-income adults: http://www.in.gov/fssa/hip All others: http://www.indianamedicaid.com	For low-income adults: 1-877-438-4479 For all others: 1-800-403-0864
Iowa	Medicaid	http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-888-346-9562
Kansas	Medicaid	http://www.kdheks.gov/hcf	785-296-3512
Kentucky	Medicaid	http://chfs.ky.gov/dms/default.htm	1-800-635-2570
Louisiana	Medicaid	http://www.dhh.louisiana.gov/index.cfm/subhome/1/n/	331 1-888-695-2447
Maine	Medicaid	http://www.maine.gov/dhhs/ofi/public-assistance/index.html	1-800-422-6003
Massachusetts	Medicaid & CHIP	http://www.mass.gov/eohhs/gov/departments/masshealth	1-800-462-1120
Minnesota	Medicaid	http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	1-800-657-3739
Missouri	Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana	Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
Nebraska	Medicaid	http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx	1-855-632-7633
Nevada	Medicaid	http://dwss.nv.gov	1-800-992-0900
New Hampshire	Medicaid	http://www.dhhs.nh.gov/oii/documents/hippapp.pdf	603-271-5218
New Jersey	Medicaid & CHIP	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid CHIP: http://www.njfamilycare.org/index.html	Medicaid Phone: 609-631-2392 CHIP: 1-800-701-0710
New York	Medicaid	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina	Medicaid	https://dma.ncdhhs.gov	919-855-4100
North Dakota	Medicaid	http://www.nd.gov/dhs/services/medicalserv/medicaid	1-844-854-4825
Oklahoma	Medicaid & CHIP	http://www.insureoklahoma.org	1-888-365-3742
Oregon	Medicaid	http://healthcare.oregon.gov/pages/index.aspx and http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
Pennsylvania	Medicaid	http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm	1-800-692-7462
Rhode Island	Medicaid	www.eohhs.ri.gov	401-462-5300
South Carolina	Medicaid	http://www.scdhhs.gov	1-888-549-0820
South Dakota	Medicaid	http://dss.sd.gov	1-888-828-0059
Texas	Medicaid	https://www.gethipptexas.com	1-800-440-0493
Utah	Medicaid & CHIP	Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip	1-877-543-7669
Vermont	Medicaid	http://www.greenmountaincare.org	1-800-250-8427
Virginia	Medicaid & CHIP	Medicaid: http://www.coverva.org/programs_medicaid.cfm CHIP: http://chipofvirginia.org/	Medicaid: 1-800-432-5924 CHIP: 1-855-242-8282
Washington	Medicaid	http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premiumpayment-program	1-800-562-3022 ext 15473
West Virginia	Medicaid	http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx	1-877-598-5820
Wisconsin	Medicaid & CHIP	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf	1-800-362-3002
Wyoming	Medicaid	http://wyequalitycare.acs-inc.com/	307-777-7531

To see if any more states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

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

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

Continuation Coverage Rights Under COBRA

Introduction

You are receiving 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."

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; 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 60 days after the qualifying event occurs. You must provide this notice to: Conroe ISD Benefits Office.

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, 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**.

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

If you have questions about COBRA continuation coverage, please contact the Conroe ISD Benefits Office at 936-709-7808.

Notes:

Expense Worksheets

Health Care Expenses (Out-Of-Pocket)

Medical Expenses such as:	**Estimated Annual Cost**
Deductibles	$ _____
PCP and Specialist Visit Copays	$ _____
Coinsurance Amounts	$ _____
Prescription Drug Costs	$ _____
Smoking Cessation Programs	$ _____
Dental Expenses such as:	
Deductibles, Coinsurance, & Copays	$ _____
Orthodontia Costs	$ _____
Dentures, including replacements	$ _____
Vision Care Expenses such as:	
Eyeglasses or Contacts	$ _____
Contact Lens Solution	$ _____
Vision Surgery	$ _____
Other Qualified Expenses	$ _____

Total $ _____

The maximum health FSA contribution amount for the 2017-2018 plan year is $2,600 *($108.33 per paycheck).*

Dependent Care Expenses

Type of Expense	**Estimated Annual Cost**
Child Care Expenses	$ _____
Other Employment Related Dependent Care Costs	$ _____

Total $ _____

The maximum dependent care FSA contribution amount for the 20178-2018 plan year is $5,000 *($208.33 per paycheck).*
If married and filing separate tax returns, the maximum is $2,500 *($104.16 pear paycheck).*

These totals give you a good idea of the amounts you may elect to contribute to your flexible spending accounts. Consider all other factors that will affect your out-of-pocket costs during the upcoming plan year and adjust the amounts if necessary. It is better to underestimate than to overestimate.

2017-2018 Benefits Estimator Worksheet

Medical Premium*

	Aetna Whole Health	Aetna HDHP	Anticipated Cost Per Paycheck
Employee Only	$74.00	$67.00	
Employee + Child(ren)	$270.00	$250.00	
Employee + Spouse	$442.00	$425.00	
Employee + Family	$491.00	$475.00	$ _____

**Add $5 if anyone enrolled is a tobacco user.*

Dental Premium

	Aetna DMO	Aetna PDN High "A"	Aetna PDN Low "B"	
Employee Only	$7.97	$22.46	$13.36	
Employee + Child(ren)	$12.74	$38.62	$24.59	
Employee + Spouse	$13.54	$41.43	$27.39	
Employee + Family	$18.00	$55.49	$41.45	$ _____

Vision Premium

Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family	
$4.40	$9.46	$10.34	$15.96	$ _____

Health FSA Contribution *(Use FSA Expenses Worksheet; divide total by remaining number of pay periods in plan year)* $ _____

AD&D Premium

Employee Only .....$0.11 per $10,000 in coverage
Employee + Family .....$0.185 per $10,000 in coverage $ _____

Cancer Premium

	Low	Medium	High	
Employee Only	$12.21	$17.30	$27.19	
Employee + Children	$17.19	$24.55	$38.84	
Employee + Spouse	$19.39	$27.05	$41.91	
Employee + Family	$24.37	$34.29	$53.55	$ _____

Critical Illness Premium
(Refer to costs on page 13; divide by two) $ _____

Disability Premium *(Refer to Standard Insurance Company Rate Table on Page 16; divide rate by two)* $ _____

Hospital Indemnity Premium
(Refer to costs on page 18; divide by two) $ _____

Legal Protection Premium $7.25 $ _____

Life Insurance Premium - *Group Term*
(Refer to Term Life Coverage Rates on Page 20; divide monthly cost by two)

Employee Only	$ _____
Spouse	$ _____
Child(ren)	$ _____

Life Insurance Premium - *Term*
(Refer to AF Term Life rate tables in FFenroll Form Library; divide rate by two) $ _____

Life Insurance Premium - *Universal*
(Refer to TEXASLIFE Monthly Premium Table in FFenroll Form Library; divide premium by two) $ _____

Long-Term Care Premium
(Must be determined by a First Financial account representative) $ _____

Dependent Care FSA Contribution *(Use FSA Expenses Worksheet; divide total by remaining number of pay periods in plan year)* $ _____

Total $ _____

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