Memo

To: Cypress-Fairbanks ISD Substitutes, Temporary, Seasonal and Part-Time Employees
From: Cypress-Fairbanks ISD Insurance Department
Date: May 1, 2016
Re: 2016-2017 Health Care Election / Decline Form

Cypress-Fairbanks ISD offers health Insurance to eligible Substitute, Temporary, Seasonal, and Part-time employees through TRS-ActiveCare. To be eligible, the district must reasonably expect the substitute or other temporary employee to work at least 10 hours every week. Returning employees must enroll during the district's annual enrollment period. New hires are required to submit their application within 30 days of their hire date. Substitute and temporary workers are not eligible for TRS-ActiveCare coverage if they are a TRS retiree who is receiving, or who has declined coverage, under TRS-Care or has retired from a Texas State College or from ERS. Also, substitute's/temp's paychecks must be sufficient to cover premiums in full. See the 2016-2017 TRS-ActiveCare monthly rates and benefit summaries on the CFISD website at: www.cfisd.net under staff / HR / Insurance.

Employees electing to decline coverage must submit this form to the substitute or Insurance office before beginning work but no later than August 31, 2016.

Refer to CFISD Insurance Dept. Website for 2016-2017
Monthly TRS-Care Premiums for Substitutes, Temporary, Seasonal and Part-time Employees

EMPLOYEE CONTRIBUTION	TRS ActiveCare 1-HD	TRS ActiveCare Select	TRS ActiveCare 2	FIRST CARE HMO	SCOTT & WHITE HMO
Employee Only					
Employee & Child(ren)	**Refer to Insurance Website for 2016-2017 Rates**				
Employee & Spouse					
Employee & Family					

2016-2017 Health Care Election and Decline Form:

_____ I elect to enroll in TRS-Active Care Health Insurance and will submit the attached Enrollment form to the CFISD Insurance Dept. by August 31, 2016.

_____ I decline TRS-ActiveCare Health coverage for the 2016-2017 School Year. Return form to Substitute or Insurance Office by August 31, 2016.

Name: _____ Employee ID # _____

Date: _____

CYPRESS-FAIRBANKS INDEPENDENT SCHOOL DISTRICT

Medical Insurance Offered to Substitutes, Temporary, Seasonal and other Part-Time Employees Expected To Work 10 Hours or More Per Week

Open Enrollment Period: July 18 - August 19, 2016

Cypress-Fairbanks ISD offers medical Insurance coverage to eligible substitute, temporary, seasonal and other part-time employees through TRS-ActiveCare. A district substitute, temporary, seasonal, or part-time employee is eligible to enroll in TRS-ActiveCare if the district reasonably expects the employee to work at least 10 hours per week. Hours worked for other school districts are not considered in determining whether a substitute is eligible for benefits through Cy-Fair.

The district reasonably expects these employees to work at least 10 hours per week, although the district does not guarantee that you will receive 10 hours every week. The district's need for substitutes varies from week to week. In some weeks, you may not receive any assignments. Similarly, the district understands that some weeks you may not be able to accept assignments due to illness or other personal reasons.

If you are a new substitute or temporary employee, you must enroll in or decline medical coverage within 31 days from date of hire. If you are a returning substitute, you must enroll in or decline medical coverage during the annual open enrollment. If you decline coverage, you cannot enroll again until the next plan year unless you experience a special enrollment event.

If you elect to enroll, you will be responsible for the full premium. One half of the premium will be deducted from each of your semi-monthly pay checks for the current month of coverage. Your paycheck must be sufficient to cover your premiums. Non-payment of premiums will result in termination of coverage. Your coverage may also be cancelled if you lose eligibility for TRS-ActiveCare for other reasons.

A substitute or other temporary employee who is enrolled in TRS-Active Care and who is then terminated and becomes ineligible for health coverage will be provided notice regarding continuation coverage under COBRA (if eligible). Cancellation due to non-payment is considered a voluntary drop: Therefore you would not be eligible for COBRA.

Employees are not eligible for TRS-ActiveCare coverage if you are:

- A TRS retiree receiving, or who declined coverage, under TRS-Care, including a retiree who has returned to work.
- Receiving health care coverage as an employee or retiree under the Texas State College and the University Employees Uniform Insurance Benefits Act or under ERS and the Texas Employees Uniform Group Insurance Benefit Act.

2016-2017 Cypress-Fairbanks ISD
TRS-ActiveCare Medical Monthly Insurance Rates
For Substitutes, Temps, Seasonal and Other Part-Time Employees
Expected to Work at Least 10 Hours per Week
Part-Time Employees Working 15 Hours or More per Week Are Not subject to These Rates - Refer to Insurance Dept Website

EMPLOYEE CONTRIBUTION	TRS ActiveCare 1-HD	TRS ActiveCare Select	TRS ActiveCare 2	FIRST CARE HMO	SCOTT & WHITE HMO
Employee Only Employee & Child(ren) Employee & Spouse Employee & Family	2016-2017 Rates to be Announced by TRS Trustee on June 17, 2016. Refer to the CFISD Insurance Website.				

Steps to enroll:

1. Determine if you work 10 or more regularly scheduled hours each week, receive a paycheck every pay period (twice a month) during the school year, and your paychecks are sufficient to cover all premiums through payroll deductions.

2. Complete the TRS-ActiveCare Enrollment Application and Change Form attached and submit to the Insurance Department at the Instructional Support Center (North), 10300 Jones Road, Suite 334. The form must be received in the Insurance Department by the end of the open enrollment period, August 19, 2016 or within 31 days from date of hire if a new employee.

3. The Insurance Department will confirm your eligibility and process your application with an effective date of September 1, 2016 if enrolled during open enrollment or on the 1st of the following month for new hires.

4. Important Note: Substitutes, Temporary, Seasonal and other Part-Time employees must either enroll in one of the TRS-ActiveCare Medical Plans or submit their " Decline " by submitting the attached Election / Decline letter to the Substitute or Insurance Office before their first day of employment.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014. ***Please note, all individuals in the United States will be required to have health insurance by January 1, 2014. Under TRS-ActiveCare, (the district's medical insurance plan), this individual mandate is not a special enrollment event. New hires who wish to enroll in TRS-ActiveCare must do so no later than your 31st day of active employment.***

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. *

All TRS-ActiveCare plans, including the three HMO options, meet the minimum value requirement under the Affordable Care Act (ACA).

Note:: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or visit Your Benefit Station, posted at www.cfisd.net and located under Departments/Insurance.

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

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name CYPRESS-FAIRBANKS ISD	4. Employer Identification Number (EIN) 74-6000654	
5. Employer address PO BOX 692003	6. Employer phone number (281) 897-4000	
7. City HOUSTON	8. State TEXAS	9. ZIP code 77269-2003
10. Who can we contact about employee health coverage at this job? INSURANCE DEPARTMENT WWW.CFISD.NET		
11. Phone number (if different from above) (281) 897-3882	12. Email address Insurance@cfisd.net	

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

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

☐ All employees.

☒ Some employees. Eligible employees are: Employees of the district and are either active contributing TRS members or are employed for 10 or more regularly scheduled hours each week.

• With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

- A spouse (including common law spouse)
- A child under the age of 26, who is one of the following:
  - A natural child
  - An adopted child or a child who is lawfully placed for legal adoption
  - A stepchild
  - A foster child
  - A child under the legal guardianship of the employee
- "Any other child" under the age of 26 (unmarried) in a regular parent-child relationship with the employee, meeting all four of the following requirements:
  - The child's primary residence is the household of the employee;
  - The employee provides at least 50% of the child's support;
  - Neither of the child's natural parents resides in that household; and
  - The employee has the legal right to make decisions regarding the child's medical care.
- A grandchild under age 26 whose primary residence is the household of the employee and who is a dependent of the employee for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.
- An unmarried child, age 26 or over, of a covered employee may be eligible for dependent coverage, provided that the child is either mentally or physically incapacitated to such an extent to be dependent on the employee on a regular basis as determined by TRS, and meets other requirements as determined by TRS.

☐ We do not offer coverage.

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

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

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

Enrollment Application and Change Form

ELIGIBILTY:	Are you an active employee and making monthly contributions to TRS? ☐ Yes ☐ No If no, are you regularly scheduled to work 10 or more hours per week? ☐ Yes ☐ No	(If no to both, you are not eligible for TRS-ActiveCare coverage)

SECTION 1: ENROLLMENT/CHANGE TRANSACTION TYPE

☐ Annual Enrollment ☐ New Employee ☐ Add Dependent ☐ Special Enrollment

☐ **For New Employee** (check one): ☐ Effective on Actively at Work ☐ Effective 1st day of month following

Special Enrollment Event Date: ___ / ___ / ___ ☐ Marriage ☐ Court Order ☐ Birth/Adoption ☐ Loss of Coverage ☐ Other:

Change Only:
☐ Name
☐ Address
☐ Plan/Coverage

Decline Coverage:
☐ Yes (Complete Section 6)
☐ N/A

Effective Date of Change/Cancel
____ / ____ / _____

Cancel Employee
☐ Death
☐ Loss of Eligibility
☐ Retirement/Terminated
☐ Non-Payment
☐ Other: _____

Cancel Dependent
☐ Divorce
☐ Death
☐ Loss of Eligibility
☐ Dropped Coverage
☐ Other: _____

For District Use Only

TRS District #

Actively at Work Date:

Effective/Change Date:

Employer Approval:

_____

Were you covered by another district? ☐ Yes ☐ No
If so, which: _____

SECTION 2: EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	Social Security #:
Mailing Address:	City:	State:	Zip:
Home Phone Number:	Cell Phone Number:	Email:	
Date of Birth:	Sex: ☐ M ☐ F	Language: ☐ English ☐ Spanish	Ethnicity:

Do you have a disability affecting your ability to communicate or read? ☐ Yes (Please complete Section 8) ☐ No

Is the Employee Covered By Other Insurance? ☐ Yes Carrier/Plan: ☐ No

Is the Employee Covered by Medicare? ☐ Yes ☐ Part A ☐ Part B ☐ Part C ☐ Part D Effective: ☐ No

Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐ End Stage Renal Disease (ESRD)

SECTION 3: COVERAGE SELECTION (Please select a Plan of Coverage and Coverage Type)

PPO Selection: ☐ ActiveCare 1-HD ☐ ActiveCare Select ☐ ActiveCare 2

HMO Selection: ☐ FirstCare ☐ Scott & White Health Plan ☐ Valley Baptist Health Plan

Coverage Type Selected: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

SECTION 4: DEPENDENT INFORMATION (Use additional form for additional dependents)

SPOUSE Last Name: First Name: MI:

Street Address: ☐ Same as Employee

City: State: Zip: Phone Number:

Sex: ☐ M ☐ F Date of Birth: Social Security #:

Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

CHILD Last Name: First Name: MI:

☐ Natural/Adopted ☐ Stepchild ☐ Foster Child ☐ Grandchild ☐ Legal Guardian ☐ Disabled ☐ Other

Street Address: ☐ Same as Employee

City: State: Zip Code: Phone Number:

Date of Birth: Social Security #: Sex: ☐ M ☐ F

Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

CHILD Last Name: First Name: MI:

☐ Natural/Adopted ☐ Stepchild ☐ Foster Child ☐ Grandchild ☐ Legal Guardian ☐ Disabled ☐ Other

Street Address: ☐ Same as Employee

City: State: Zip Code: Phone Number:

Date of Birth: Social Security #: Sex: ☐ M ☐ F

Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

PLEASE CONTINUE ON NEXT PAGE

CHILD Last Name:	First Name:	MI:
☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other		
Street Address:		☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F
Other Insurance: ☐Yes. Carrier/Plan ☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D		

CHILD Last Name:	First Name:	MI:
☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other		
Street Address:		☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F:
Other Insurance: ☐Yes. Carrier/Plan ☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D		

SECTION 5: DISABLED DEPENDENTS OVER AGE 26 ☐ Dependent Child's Statement of Disability Attached

Please note that a Dependent Child's Statement of Disability form is required for coverage of a disabled child over age 26. See your Benefits Administrator for the form, which must be completed in full and submitted to your Benefits Administrator.

SECTION 6: DECLINATION OF COVERAGE

This is to certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage available to me and my dependents and have voluntarily elected to decline the coverage as elected below.

Name:	SSN:	☐Employee	Reason:	☐Other Coverage	☐Other:
Name:		☐Spouse	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:

SECTION 7: COVERAGE CONDITIONS

- I am employed by the Employer named in this Enrollment Application and Change Form. I am eligible to participate in the coverage(s) offered by the TRS-ActiveCare program which is administered by Aetna, with HMO benefits provided by SHA, L.L.C. dba FirstCare, Scott and White Health Plan, and Valley Baptist Insurance - Company dba Valley Baptist Health Plans. On behalf of myself and any dependents listed on their Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.
  - o If I am enrolling a grandchild in Section 4, I certify that my household is the grandchild's primary residence and the grandchild is my dependent for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.
  - o If I am enrolling a child as an "other Child" in Section 4, I certify that my household is the child's primary residence, that I provide at least 50% of the child support, that neither of the children's natural parents reside in my household, and that I have the legal right to make decisions regarding the child's medical care.
- Only those coverage(s) and amount for which I am eligible will be available to me. I understand that if this Enrollment Application and Change Form is accepted, the coverage(s) will become effective in accordance with the provisions or the TRS-ActiveCare program.
- I understand that by enrolling for coverage with Employer named in the Enrollment Application and Change Form that any TRS-ActiveCare coverage I previously elected under another TRS-ActiveCare participating district/entity will be terminated under TRS Rules.
- I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.
- I understand that by declining TRS-ActiveCare coverage now or by terminating TRS-ActiveCare coverage during the plan year, I am not eligible to re-enroll in TRS-ActiveCare until the next plan year, unless I experience a special enrollment event.
- I state that the information given on the Enrollment Application and Change Form is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).

Applicant Signature: _____ Date: _____

SECTION 8: SPECIAL NOTES REGARDING MY ENROLLMENT (Please indicate any special information regarding my enrollment for Aetna, Caremark or my selected HMO)